

Connecting Stories
and Ideas on
Overdose and
Drug Use in
Private Residences
in British Columbia

BEHIND THE NUMBERS

Journey Map & 25 Stories From People with
Lived Experience and Support Providers

About the Stories

Problem context

In 2017 1,451 people died of a drug overdose in B.C. The B.C. Coroners' report (published August 2, 2018) shows that 4 out of 5 people who died were male and 9 out of 10 deaths occurred indoors, including more than half in private residences. First Nations people are disproportionately affected by the crisis. What these numbers don't tell us is: who are the people behind these numbers, what drives them to use substances alone, and what are their ideas for change?

How we collected the stories

Between August 2017 and March 2018 the Ministry of Mental Health and Addictions and the Service Design team set out to learn more about this situation by engaging with people with lived experience and people who work in this field throughout B.C. Through more than 100 conversations, we met with people with lived experience (folks who use substances like cocaine, crack cocaine or heroin alone, and their family and friends), and with support providers (like health care practitioners, first responders, policy makers, community action groups, researchers) to understand their experiences and the challenges they face.

In conversations and workshops we learned about people's life histories, their positive and negative service experiences, their social networks and their ideas for change. Conversations lasted about an hour and were held in a safe location in a social or private setting of their choice.

With every conversation we upheld important work principles to create a safe space for the storyteller: keep the person telling the story and the team emotionally and physically safe at all times, meet each other with curiosity and compassion, listen without judgement, and follow-up if a need arises. We paid people for their time, and read out and signed consent forms to protect people's private information.

Throughout this work the project team worked with a paid peer researcher. His name is "Voices" and he has lived experience in using substances alone. Voices contributed to the project through co-designing conversation questions, connecting the team to folks with lived experience, facilitating conversations, accompanying the team to stakeholder meetings, talking to executives and holding us accountable throughout.

The 25 stories included here are parts of the conversations we had in the field. All storytellers have pseudonyms to protect their identity, unless people specifically requested to use their own first name. Specific events and places have been anonymized to ensure privacy. People who share their story in this booklet have consented to having their story published online.

Working with the stories

Through analysis of the stories, we have created artefacts to communicate our findings and insights. These artefacts are meant to increase our understanding about why people use substances alone (journey map, stories), the circumstances that contribute to the situation and leverage points for systemic change (systems map), and people's ideas for change (stories).

The artefacts are intended as tools for learning and understanding, and can be used in meetings and workshop settings to decrease stereotyping, validate ideas, generate discussion and support action.

About the Stories

Thank-yous

This work would not have been possible without people opening their homes, hearts and minds. Thank you to each person who bravely shared their story. We also appreciate the generosity of people in support provider roles (practitioners, community action groups, Health Authorities) for taking time out of their important work to talk to us. A special thank you to our co-op student, Leila Mazhari, and peer researcher, Voices. Without your valuable time, brilliant ideas and connections we would not have been able to do this work.

We hope this work can contribute to the diverse work that is done by many people, and we look forward to collaborating in continuous efforts to keep people safe and to support people to thrive in life.

About the Service Design team

The Service Design team, located in Government Communication and Public Engagement's Government Digital Experience Division, is changing how citizens access government services by bringing innovation and a human-centred approach to areas such as health care, transportation, education, policy and finance.

The focus of service design work for us is about people—what they do, how they do things, why and when they look to access public sector services. As outlined in the Service Design Playbook, we take a holistic approach to designing service experiences by working directly with citizens, developing prototypes, testing, analyzing and implementing results.

I want to learn about...

Men's perspective on using substances alone 4 6 7 10 11 13 22 23

Women's perspective on using substances alone 1 2 9 12 14

First Nations' perspective on using substances alone 1 4 12 23

A **parent's story** about helping their children 3 5 8

The role of **prescription drugs** 4 5 7 8 16 17 21 25

People's **health care experiences** 1 2 5 7 8 9 10 11 14 15 19 21 25

People's experiences with **the justice system** 1 12 13 21

The role of **community action** and (peer) support 4 10 11 18 19 23 25

The role of **the workplace** (e.g. dangerous jobs, the trades industry) 6 10 11 22

The **rural aspect** of the overdose crisis 15 16 19

Perspectives of **health care providers** 15 16 17 19 20 21 23 25

The roles of **injuries and chronic pain** 4 5 7 11 16 17 21 22 25

The role of **education, media and public messages** 3 6 8 22 24

Legend

Starting points



The starting point for using substances lies in the family sphere, ie. emotio-nal trauma, abuse, genetics.



The starting point for using substances lies in the social sphere, ie. a friend group who uses substances



The starting point for using substances was an injury that happened in a private and/or work setting

External Influences



A person expresses experiencing stigma within themselves, stigma in society and/or stigma in a support service experience



A person has experienced a significant life event (ie. the loss of a job, income, a home, a loved one). Experiencing a signficant life event can trigger substance use or a relapse into substance use.

Experiences



A person has an experience with a support service in the area of housing



A person has an experience with a support service in the area of the justice system



A person has an experience with a support service in the area of education or training



A person has an experience with a support service in the area of health care, treatment, harm reduction or outreach



A person has an experience with a support service in the area of child and family care



A person with lived experience expresses suffering from physical or emotional pain, and/or a need to manage- numb pysical or emotional pain



A person expresses their reason for using substances alone is a negative experience with a public service they were seeking support or help from

Legend

Reasons for using drugs alone



A person expresses their reason for using substances alone is a sense of shame over using substances, or over their physical-emotional state



A person expresses their reason for using substances alone is their need for comfort when using substances



A person expresses their reason for using substances alone is their need to be free from unwanted intrusion or disturbance in one's private life or affairs, to be free from public scrutiny



A person expresses their reason for using substances alone is their need to not share their substances with others



A person expresses their reason for using substances alone is their need to have control over the amount they are taking or buying, or their environment they are using substances in



A person expresses their reason for using substances is their need to remove themselves from the community of folks who use substances, for example because of experiences of aggression, fear or not identifying with the community

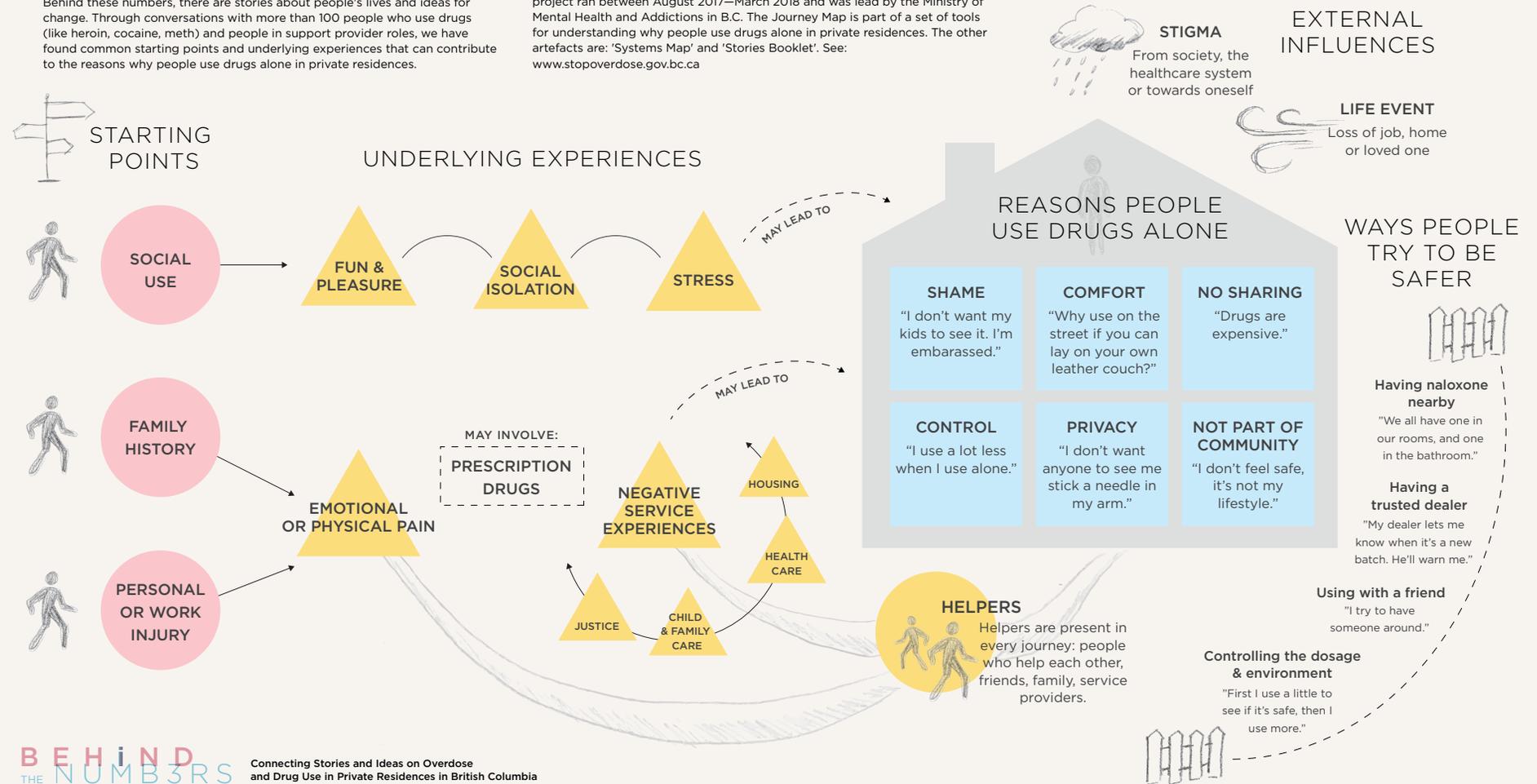
Journey Map: Routes to Using Drugs Alone in Private Residences in B.C.

In 2017, 1,451 people died of a drug overdose in B.C. The B.C. Coroners' report (published August 2, 2018) shows that about 4 out of 5 people who died were male and 9 out of 10 deaths occurred indoors, including more than half in private residences. First Nations are disproportionately affected by the crisis, with research from the First Nations Health Authority showing that First Nations people are five times more likely to experience an overdose event.

Behind these numbers, there are stories about people's lives and ideas for change. Through conversations with more than 100 people who use drugs (like heroin, cocaine, meth) and people in support provider roles, we have found common starting points and underlying experiences that can contribute to the reasons why people use drugs alone in private residences.

Understanding people's experiences, the contributing external factors and their current strategies for trying to stay safe will help us focus on designing public services, ways to engage and actions to take to move towards a province where all citizens are supported and connected to services they are looking for.

This journey map was created for the project "Behind the Numbers: Connecting stories and ideas on Overdose and Drug Use in Private Residences in B.C." The project ran between August 2017—March 2018 and was lead by the Ministry of Mental Health and Addictions in B.C. The Journey Map is part of a set of tools for understanding why people use drugs alone in private residences. The other artefacts are: 'Systems Map' and 'Stories Booklet'. See: www.stopoverdose.gov.bc.ca



Part 1: Stories from people with lived experience

Just Someone To Talk To

Sharon's story about experiencing stigma in health care services

Sharon, born in the 70s

My mom died when I was young, and my dad was an alcoholic his whole life. I grew up unaware that people were there to help. I always felt lost and alone. When I was a teenager, I'd see my boyfriend snorting coke with his friends. I didn't know what they were doing at first, but after a while I got curious. One day they offered, so I got high with them at age 16. It kind of spiraled after that. It went from every weekend to almost every day. Then I got pregnant, so I got clean.

I stayed clean for 3.5 years, but then I lost my son to the Ministry. I wasn't getting along with his dad; he was volatile. That's when I started using again. The drugs helped numb the pain of losing my son. I've been trying to bury that hurt. I've been in and out of treatment ever since then. I think the main reason people use is because of trauma, or because something emotionally painful happened to them.

My family has been in and out of my life, but counsellors and nurses are like my family. They are always there.

But doctors and hospitals are another story. Now whenever I need to go to the hospital for something small, I'll put it off for a long time until it becomes something bigger. Like the one time I had an abscess on my arm. I didn't know what it was, but eventually I had to go see a doctor because it was so painful. Once I got there, they treated me like garbage because I'm an addict. They just wanted me out of there.

I have to live with this fear of being judged or treated poorly. Some people won't even call an ambulance over and they overdose in their house because of that fear. Or because they're afraid they'll get in trouble with the police, they just put the person OD-ing outside and call 9-1-1 from another phone. Do you know how much time that takes? A lot of us are losing family and people that we care about.

When it comes down to it, I think a lot of people are trying to bury their hurt, and would just like someone to talk to.



Twinkle In Your Eye

Rose's story about shame being a barrier to accessing health care services

Rose, born in the 50s

I started using drugs many years ago. My husband abused me for 38 years... all kinds of abuse... and after he died, I was doing horribly. Even though there was abuse, 38 years is a long time. When he died, I felt like I had half a heart. That's why I do what I do now: it's to numb myself. I don't want to think about the bad past memories.

I mostly use alone by myself because I want my privacy. I'm too old to be doing this kind of crap. I'm an embarrassment to my daughter and I can't blame her. I'm ashamed, and that's been a barrier to getting help.

Now I got to counselling, which helps. My counsellor is a super great guy. All I have to do is call him and say 'I need you' and he's there as soon as he can. He's seen my weight loss and weight gain; he can tell when I'm doing good and when I'm doing bad.

Last week he said: 'You look good, you have a twinkle in your eye!' I needed that. I need someone to talk to who helps build me up because I'm my worst enemy. I'm down on myself more than anyone else could be.



Ending social stigma

Jennifer's story about her son and ending social stigma

Jennifer, born in the 50s

My son Dylan was going through a stressful time in his life. He was 21 and in his last term of University before graduating. He had a job and a long term girlfriend. Drug use was the norm in his social circle, and one drug led to another. He was an occasional user, even though he didn't have an addiction, we sought professional help for him.

One day he went to the mall to get art supplies with his Dad and girlfriend. He was very lethargic and his girlfriend asked if he had taken anything, which he denied. Upon returning to his Father's house, he fell to sleep, and eventually started snoring, which was unusual for him. Early the next morning the snoring was very loud and was accompanied by a gurgling sound. As we later learnt these are classic signs of an overdose. Prior to this incident he hadn't been sleeping well, so they decided not to waken him. When his girlfriend later attempted to wake him he was unresponsive. He had died from Fentanyl poisoning.

I think that what really needs to happen is that we need to end the stigma around drug use. We often hear about indigenous males and blue-collar workers... but these are stigmas in themselves. There are many people that this epidemic is affecting that don't fit these characteristics.

We need to put a face to our drug users, it can happen to anyone. It's people like you, me, your next door neighbour. It's in every social-economic group, it does not discriminate.



A Better Way Of Life

Bryan's story about his work injury and opportunities for change

Bryan, born in the 70s

I was quite young when I first started using drugs. My mother was a user as well. I started hanging out with a group of friends, and I guess one thing led to another. But things really turned for me after a work injury when I chopped off a few fingers. I had many broken bones. My doctor had me on morphine for a long time... it helped me cope with the pain.

But then, out-of-the-blue, my doctor accused me of misusing. I wasn't misusing. My tolerance was getting higher though, so I needed more to cope with the pain. So I had to self-medicate, and that's when I turned to street drugs. For a period of time, I lived on East Hastings. Things are better for me now. I'm on the methadone treatment and outreach has been a huge help.

They pick me up at 10am every morning, and I'm very grateful for that. They don't even knock on my door - I'm already outside and ready for them. I'm nearly 45 years old, and I've had enough... but

luckily, I'm on the tail end of getting out of this world. My wife keeps me focused.

And now I've been working with the outreach people a lot, distributing harm reduction materials like naloxone kits and clean needles. Making outreach services more accessible such as at public swimming pools, shelters, sobering centres, Overdose Prevention sites, friendship centres, prisons, hospitals and youth centres are important as people don't always reach out for help as they may be ashamed or scared or just don't know.

I'm happy to take the time to talk to people, but really, I want to show people that there is a better way of life. There should be more opportunities for men to go out together and talk over coffee. Get them engaged with the rest of the community. If people have more opportunities to connect like that, I betcha a lot of good things would come out of it.



Small Window Of Opportunity

A mother's story about wait times and navigating the health care system

Elin, born in the 50s

My son has had quite a few injuries – concussions, car accidents, hockey injuries, workplace injuries – but the underlying issue for him is Crohn's disease. He has a lot of pain from that. He was getting opioids prescribed by his medical doctor for some time, at an unsafe rate.

Eventually his doctor weaned him off the prescription, but my son was dependent at that point and there was no plan in place. The doctor essentially just ended the prescription. My son was still in pain, so he started buying off the streets.

I wanted to help him, but the options were not clear and the system is difficult to navigate through. There were points I would be calling every day to make a referral happen, but they would never pick up.

I had to leave a message and be ready by my phone when they finally called me back. We had to go through so many people and hurdles to get help.

Wait times really need to be shorter. Just to get an in-take appointment, my son had to wait two months. We are missing these small windows of opportunity to help people turn their lives around. When I heard it could take 6 months for him to get into treatment, I thought, will he even be alive by then? It's such a lengthy process to get help, even though this is a medical emergency. It was difficult enough for me to navigate the system... how is my son supposed to navigate all of that? He doesn't even have a phone.



A Very Cool Thing

Axe's story about using cocaine, looking out for friends and social media campaigns

Axe, born in the 90s

I started smoking weed in Grade 10 with a couple friends. They introduced me to social scenes and I saw my friends catching on. Eventually I got curious, and one thing led to another. First smoking weed, then doing MDMA and cocaine.

One of my best friends is a drug dealer so there's that influence from hanging out with him. He always has cocaine. It's hard to stay away from it. Generally I use drugs with friends, but from time to time I'll use alone after a night out or on the weekend.

A close friend of mine overdosed and died. We always think: is this the batch that could kill us? If there was a test to check what goes into my body, I would use it. For now, I trust my source, my drug-dealer friend. He always tries it first before he gives it to anyone else. We joke about not doing it alone. "Loser, don't do it alone!" Guys don't like to talk about it though, they like to protect their ego. I have one friend who had Naloxone training. That's pretty cool. Being safe and looking out for your friends is a very cool thing.

I went to college and now I work for a construction company, and I see lots of guys who use drugs. The concrete guys, the drywall guys - it's a known fact. What helps is that my boss is very open about this stuff. He's not just a boss, but also a friend. There was a time he had a talk with me, he asked me how I was doing. He suggested that I slow down. He doesn't make it too serious. He's being a friend and that's a true help.

What would also help is more publicity around this. Share the real stories and get people to listen through those forced ads on Facebook and Instagram. But you got to make sure that the stories appeal to the person watching. So if there's a story about a 27-year-old, target that to a 20 to 30-year-old audience, and connect to feelings about family and being missed if you weren't there anymore. That would really touch home.



Not A Street Person

Iceberg's story about pain, home nurses and ending social stigma

Iceberg, born in the 50s

I'm a chronic pain sufferer. I have scoliosis and I also had a work injury. I was one of the ones who they told my doctor to cut me off prescribed opioids. Instead I had to switch to methadone. It was wrong. They took away my quality of life. I had to go to the street and use heroin.

I could have been dead by now, with all the fentanyl around. I just take my dealer's word for it. They say they take the fentanyl out of it. It's scary. I won't buy off anyone else though.

I hurt all the time, so I have to do this. But all of this made me go indoors and hide. I am scared. It's to be hidden, it's taboo. No one wants to talk about it, or have anything to do with it. I don't go to supervised consumption sites because I don't like coming down here.

It's a violent place and it's not my kind of people. If they had some pods somewhere else, in more high-end neighbourhoods like mine, I would go. I'm not a street person – I'm not better than they are, but this isn't my lifestyle. I don't feel comfortable. I don't feel safe always, like I might get robbed or beat up. I feel safe with people I know.

If a home nurse would come, twice a day? That would make me quite happy. I struggle with this thought of OD'ing all the time. However, this whole problem has to be made more public. People have to be more educated. Put it on the buses. You shouldn't stigmatize addicts. If my landlord found out I was using, I'd get evicted. That's so wrong. You can have a glass of wine, but I can't do this?



The One With a Pilot Light

Ryan's parents' story about their son

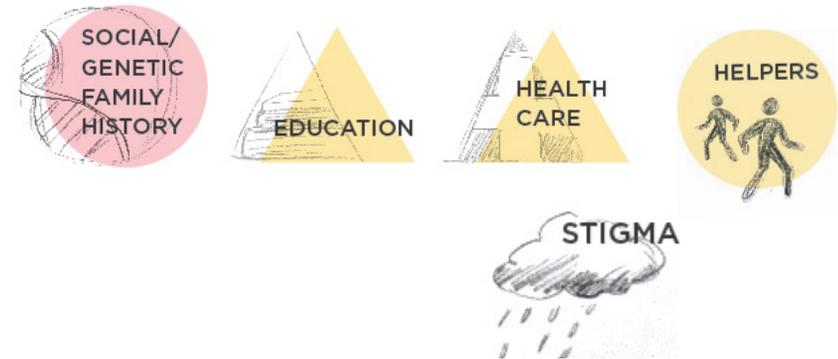
Ryan's parents, born in the 60s

Our son died in April 2017. He was 1 out of 123 overdose deaths that month. But we don't want him to be a number. He's our son and this is his story.

Ryan was a little boy once. Good natured, imaginative, loved to play. He was a reader, loving, social and active. The first time he drank was in grade 10, on New Year's Eve. That night kids drank, but Ryan was the only one who ended up in an ambulance with alcohol poisoning. Ryan started smoking pot frequently in his teens.

Ryan's family has a history of addiction. His dad, grampa and uncle. They all have been clean for a long time now. His dad couldn't ever just have one. It's like there's a wiring in you; one drink lights the pilot light. Ryan had the pilot light. He really wanted to control it but he couldn't.

Even while Ryan used drugs, he was still getting A's, still had friends, completed college programs. He used everything, with Oxycontin leading to heroin. We got him into an 8-week treatment program when he told us he was using opioids. It was a



private, expensive treatment, very strict, corporate. He felt it was 'them' versus 'him' - it was too institutional he told us. After treatment he moved back into our house. He got a job as an electrician at a construction site. Soon he was using again and then he lost that job.

When Ryan finished the eight weeks he had to wait more than five months for an appointment with a psychiatrist. When the appointment came, Ryan's dad looked for him but couldn't find him. The doctor's secretary said: "Do you know how busy we are?" Ryan's dad responded: "Do you know how long my son waited?"

Ryan had tried to detox at home. I [dad] went to my doctor and he sent us home with two prescriptions. Ryan told his dad: "It's not gonna do it for me." Then I [mum] took him to the ER to get help when he was in withdrawal. We waited and then they just gave me a card and told us to talk to a nurse another day. I sat with him the whole time and no one cared about him. Addicts are judged as weak, self-inflicted, deserved. What other disease would you go to the ER and just get a card to call someone?

Ryan left home right after that. He stayed connected for a bit but then we lost all contact for months. Finally, Ryan phoned and asked for help. He went to a private treatment facility. He had a great experience there. It was laid back, it involved community. They went on outings together, they went to the gym, movies. It mirrored real life. We had our son and brother back.

After eight months there, Ryan moved out with two other guys from the treatment facility. He was happy to be working as an electrician again. He talked about work and life goals. He was clean, excited and grateful. Then on Monday April 24th Ryan died at work on a lunch break. No one saw it coming. It was a shock for everyone. We couldn't see his body for ten days because the Coroners had an autopsy backlog that month because of so many Fentanyl poisonings. It ripped our hearts out.

We have ideas for change. First of all, the windows of service availability don't line up - we'd never treat another disease like this. We also have to find a way to give safe drugs to someone

who is severely addicted. We force them down that dangerous alley. We are so, so far from helping people.

We also believe addiction issues have to come out of the closet. There's AA and NA - but why is it anonymous? It's not cancer anonymous. There is so much diversity in our world, like people who are colour blind, LGBT, addiction. We have pride parades. But we are punishing people who use drugs for being different. Who planted those ideas in our heads? Let's make it okay, let's talk about it. I'm not ashamed of my son [his mother said while showing photos of Ryan wake-boarding, with family, with friends].

We want to go into schools with his story. Ryan didn't want to be an addict. What do we do before they become an addict? Are you the one with a pilot light? Kids need to know and have these conversations with each other and with their parents. We need to learn how to talk about it with compassion and have real options for help.

Stuck In A Boat Without A Paddle

Sue's story about abuse, recovery and its challenges

Sue, born in the 60s

I started smoking and drinking at five at grandma's house. Learned how to snuff gas at ten years old. By the age of twelve, I was out selling acid. It was to escape from my state of mind. My dad was very evil, told me I was useless. Abuse was the only attention I would get in life. There were no social workers, no one intervened. I'd cope by just getting loaded.

You might be surprised but I never did crime. And I never had to prostitute myself. Because of the type of abuse I experienced, the only thing that was sacred to me was my body. I would rather kill myself than bring myself to do it. Instead I dumpster dived to survive.

I had my children in my 20s. Those were the only clean years I had. I made sure it was safe for the kids. I was about to go and study to become a medical lab assistant when the Ministry came to take my kids away. Someone told them I looked haggard, but that wasn't from drugs. It was because I was working so hard. I felt so low, that's when I started using heroin.

I always only used alone. Because to me, it was personal and private. It was a quick, easy thing. I didn't want anyone to see it.

With help of a social worker I got my kids back. For the longest time I had no idea of any kind of help. AA or recovery or anything. Once my kids graduated, I moved to Vancouver and that's where I learned about recovery. You really need someone to take your hand and like babysit you. Only then can you feel comfortable to try it.

It would help to make the methadone process less difficult. You have to find a clinic by yourself, find time to get in, usually six weeks down the road. You have to meet criteria, do a pee test, pick up every single day. It makes people lie. It makes people hide. Also it's not designed to help you withdraw, it's designed to keep you on methadone your whole life. They don't explain that to you. They don't help you figure out a plan to stop. I went in and tried to make a plan to quit and the doctor was baffled. You get stuck in a boat without a paddle.



Too Much Opinion

Voices' story and ideas for being safer

Voices, born in the 60s

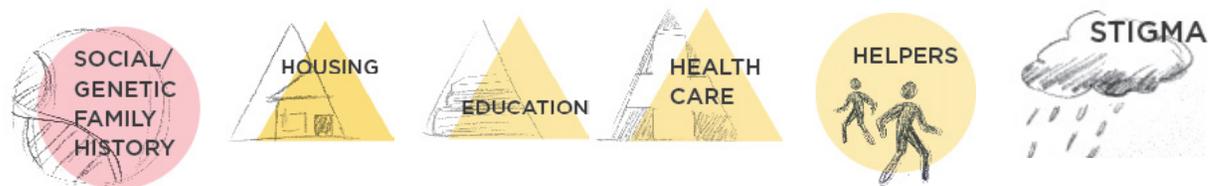
I come from an upper middle class family. I started smoking cigarettes at the age of seven, and smoking pot at nine. It was the hippie time, you know, my mom was open to it. My dad and uncle were alcoholics. I didn't try crack cocaine until I was 32. When I did heroin for the first time I wanted to watch TV for the rest of my life. So I didn't do it for another 20 years.

I am a surveyor at construction sites and I've used at work. I'm sure I wasn't the only one. They once brought us together for a safety meeting. I went to the bathroom and used cocaine. When I came back, nobody noticed. That amazed me.

I try not to use alone. If I try something new, then we say to each other: "if you don't hear from me in a few minutes, come check on me." Whether they remember or not is another thing. Why use alone? Circumstance more than anything, really. You happen to be alone and you wanna do some. I went into treatment once. As soon as I got out I started using again. I'm on methadone now,

and I use, but less than I used to. Where I live there isn't a safe injection site, so I supply harm reduction materials to 10, 15 people. I let people who I know use at my house, to keep them safe.

I think the solutions are all connected. More money should go to social housing, a house gives you roots somewhere. Then the only way to wipe out the unsafe supply is through a safe supply. But there's currently too much opinion in the public for that to happen. Another idea I have is to distribute information at the work place. Men fear getting in trouble, so they sneak around hiding their drugs. Especially tradesmen, they tend to live by themselves. They do a line before the boys get there... and boom, he's dead. A panic button kind-of thing might help them. But only if there are no ramifications. But then there's no time for that really. It's like *snap* then they're blue and down.



I Won't Turn My Back

John's story about using alone and men's perspective

John, born in the 50s

I was working in the automotive industry, 1,500 guys were working there all at once. When you have that many guys, something's gonna be available. Any kind of drugs you want.

I got a work injury, and I got prescribed painkillers for it. Then something happened with the BBQ. I burnt my arm and had to have surgery for that. That's when I got prescribed bottles of pills. When they ran out, I would get dope from guys at work. I would dabble with heroin on the weekends. But I know what really keeps me using: my son committed suicide when he was 22. That tragedy compiled with previous use. It just got worse and worse.

My wife cheated on me and left. I also started using more after that. I kept it hidden at work. I would go from getting off work, cash my cheque, go get dope, go get high, and then I would keep some for the next day. I was a working addict. Never missed a shift, never screwed anything up. That never changed, I still work every day. It keeps me going.

I went into treatment once, didn't enjoy it. I came back and everything was a trigger. I ran into old friends and then there you go.

I like to use alone. I can do what I want; it's my own space. It gives me security. With heroin, I know I'm taking chances with the fentanyl. I know a few people who have passed away. Dealers will warn you if they don't know the supply chain. They'll tell you: "be careful." They're not all bad, they're people too.

A lot of guys have big egos. They have too much pride to ask for help. That's why they use alone, they are too embarrassed. They go to school, make money and feel good about themselves. If people find out it's the end of them. They don't want to feel ashamed. It should be brought up a lot more in society. People look down on people who use drugs. There should be more people with an attitude to help. I'm here to help, talk to me and I'll talk to you, I won't turn my back.



I use less when I use alone

Kendra's story about abuse and her dream of hope

Kendra, born in the 80s

My biological mother was only twelve years old when she had me, and my dad was 19. So I was adopted into a straight-edged military family... my dad was away a lot, and my mother was bipolar and abusive. She would hurt kids, including me, to get attention from doctors. She always thought that there was something wrong with me, so I was in and out of psych wards for much of my childhood. I also experienced sexual abuse, from my mother and from my mother's male friends.

The first time I came into contact with drugs, I was about six or seven, through my babysitter. She often had marijuana and coke around. The first time I actually used marijuana I was eleven, but it wasn't until I was about 18 or 19 that I started using hard drugs. Once I started using intravenous cocaine, I became highly addicted.

I spent a year in jail because I took the blame for an armed robbery that my boyfriend did. I was sober for 14 years, but then my boyfriend's mom died, and we both started using a lot. That's when it really became a full-blown addiction. We tried to remortgage our place but we didn't get as much money as we wanted... and then

we ended up on the street. Now I'm on disability and I spend it all on drugs. I run out of a months' worth of money in a day.

It's really hard to find housing. A home is so helpful - it provides routine and gives you something to do. I remember a time when I was 280 pounds and had a home... can you imagine that? Look at me now. Because of the sores on me, people look at me differently. It is what it is. If I fall asleep at all, the first thing I think when I wake up is that I need drugs. I'm always trying to sell something to get the next high. I know my dealers don't have a safe supply. But if I die, I die. I use alone because I don't want to share my drugs. I use a lot less when I use alone. How do I stay safe? I guess I don't. Because I know that even if a group of people take the same amount of drugs, they can respond differently. It's hard to find friends when you're using. I don't trust me, so why would someone else trust me?

There really isn't a golden answer. It's been the same thing for ten years now. Homeless people need homes, and people with drug addictions need hope.



I Took It Once, and That Was It



David's story about dealing drugs, martial arts and substance use

David, born in the 70s



My grandparents raised me. I pretty much had the best years of my life until I was about ten years old. That's when my mom took a hold of me and took me to East Van, right in the hood. I had never seen that scenario. The first day that we went to the Sky-Train I saw a street gang. They had guns on their waistbands and everything.

Soon my mom turned into a crazy cat lady. There was nothing in the cupboards - not mustard, nothing. At school I noticed that one of my buddies had a lot of money. One day I asked him how he had so much money, and he told me to meet him at Main and Hastings. That was my first time there. I saw a herd of people walk up to him; he dealt them coke, and got a wad of money in return. Right in the moment, he smiled and gave me \$40. The next day at school he bought everyone lunch, and they all loved him. So I wanted in. I started unloading everyday before school.

After some time passed, I got into martial arts. I was like a duck to water. I got out of drug dealing and gangs, I stopped it all and started training from 6 AM to 11 PM. I wanted that track suit. At one point, I was fighting every weekend for two months straight. Then one night the martial arts crew had a bonfire out on the highway - we were all listening to ACDC, drinking, sitting in our hatchback on the side of the road. A truck driver hit us at 140 km/hr.

After that accident, I had to take a break from martial arts. That's when I started dealing drugs again to get money, and that's when I took heroin for the first time. I took it once, and that was it. Eventually I ended up on Hastings, and I got into every other drug. At first people use socially, but then you become dependent. Then it's no longer a drug, it becomes medicine. You have to do it, you don't even enjoy it. That's when you start thinking: "fuck all these people, they're not my buddies, drugs are my buddy."

I've been in and out of prison for a good portion of my life. Detoxing in jail is rough stuff. I'd be so sick. I remember one time I couldn't sleep for twelve days straight. I tried to hang myself, but I was too weak to tie the sheet tight enough. The only relief I felt was when I accidentally rolled off the bed and knocked myself out.

Guys don't want to admit they're getting sick or getting weak. They're all tough and feel like they can't show their weakness. But I'll talk about my emotions, I'll tell anybody. I don't care what anyone thinks. I mean, look at me... I know when I walk into a place like this everybody is looking at me. I'm not stupid. I remember the first time I realized this. I was at a restaurant with a friend and he said, "We're not normal, eh?" Then I looked around and everyone was staring at us. But fuck the world. Honestly, people in general are corrupt, and would walk over their mother to get a buck.

Out to the Hallway

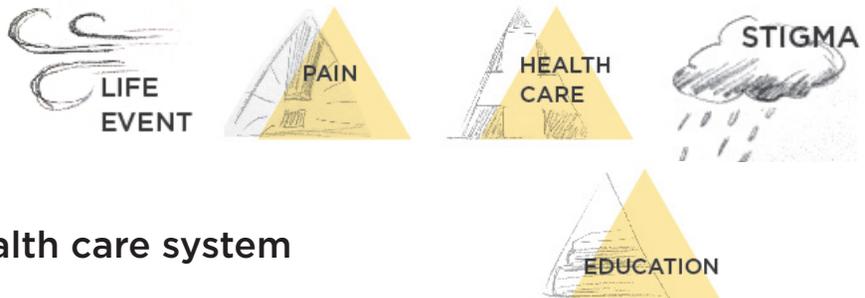
Eva's story about cancer and stigma in the health care system

Eva, born in the early 70s

I never liked going to the hospital. I always put it off for as long as I could. Once I had a bad infection. It was just getting worse and worse, so eventually I had to go. That's when they found the cancer - it was breast cancer and it was really far advanced. The doctors told me that I must have had it for a really long time. I didn't know I had it, so when they told me I was shocked.

I had to get treatment for the cancer, a double mastectomy. I was waiting to go into the operating room, 5 hours after arriving at the hospital. They had put me in a private room and all of the hospital staff were being super nice to me knowing that what I was just told by the doctors was a lot for anybody to take in. They hooked me up to an I.V. with a morphine drip for pain control which made me feel very comfortable and out of pain for the first time in 2 weeks. They talked to me in depth about what was going to happen in the operating room, offering me ginger ale.

I was very scared and feeling alone and worried as to what was going on, it was all too sudden. Then .. a nurse came into my



room. She didn't say anything to me. She took out my I.V. and moved me onto a gurney and took me out of my private room. She pushed me down this dimly lit hallway and just left me there. I never saw that nurse again. As a matter of fact I never saw anyone again until about 15 minutes before my surgery. When the O.R. nurse came out she asked me: "So how long have you been an I.V. drug user"?

My heart sank. At that point I realized they had somehow found out. How could they have done that? They do not know me. They never asked when, or how long ago, and why? They'd never walked in my shoes. After the surgery and I woke up from the anesthetics. The nurse came over to ask me how I was doing. I told her that I was in a lot of pain. She said to me: "well get up, get dressed and you are free to go now". And I did just that, 45 minutes after a major operation. I was in pain yet no pain meds were prescribed. I had staples in me and was all bandaged up. She said I would have to come into the hospital every day to have the bandages changed and for the site to be looked at. I could

barely move, let alone having to get up and drive myself back and forth every day to the hospital. Was this really happening? I could not even lift my arms up over my head, let alone drive. I needed help, help that never did come. Leaving the hospital that day I was devastated, scared, very alone, worried sick, in great pain and very, very lost. That day changed my life for the worse. Were all patients treated this way?

What I needed was an ear to listen, compassion and to simply be treated like everyone else. They should have done their job. People need to realize that we're all different. I can't get the kind of pain medication that works because doctors won't prescribe enough of a dose to help. Doctors need to make these decisions on a case-by-case basis, not with generalizations. If nurses and doctors can't provide the support for everyone, then get some-

one who can. If you can't be compassionate, get a different job. I want to see hospitals build more training around anti-oppression, outreach, reducing stigmas and peer support. Because peers get it. Peers give people what they want and they treat people as individuals. They make people feel like they are a human being. The hospital made me feel like I was not even a human being. We are here in Canada, and we treat our animals better than how they treated me that day.

Because of what happened, I'll never go back to a hospital. I don't even know if I still have cancer. I hope that nobody goes through what I had to go through. This tears me up inside to think that this could. Changes within the hospital system is vital in order to do their jobs properly, and that is to save lives.

Part 2: Stories from support providers

Health Care As A Trusted Space

A Medical Health Officer's perspective on reducing stigma and reframing substance use as a chronic, relapsing medical condition

One challenging aspect of the crisis is the geography in B.C.. In some places health care is so far away. Some rural places have a doctor only once week, if it all. Sometimes there's a nurse practitioner. There's isolation, there's stigma. The rural aspect of this crisis is really challenging.

But that's not the only challenge. The situation is equally challenging in places where there are hospitals and health care services [but no safe consumption sites, red.]. There are so many barriers when it comes to accessing these services: there is such stigma, and so little understanding about substance use as a chronic medical condition. People come in and crash in hospital bathrooms, because they don't have anywhere else to go. They hope someone will find them in case things go wrong. If they survive, they often get the label 'substance user', while their medical condition is much more complex. They get sent away, and that's a missed opportunity. Which other people with chronic medical issues do we put in jail?

It's the stigma and the lack of openness of services that prevent people from getting out of their homes to engage with health care services, and that's why people die alone, I believe. Research shows that people who use drugs and die alone were often in touch with health care services before. We should capitalize on those opportunities.

Health care needs to become a good experience, a trusted space. We have to normalize harm reduction in health care facilities. Health Authorities need to consider how to train their staff to better work with people who are already accessing their services, but for whatever reason aren't returning because they had a bad experience. Health Authorities could collaborate more closely with unions and community-based groups. People can learn lots from each other about how to engage people without stigma.

Another change I'd like to see, is to move away from this focus of reducing deaths. Instead we have to think in 'whole spectrum interventions': from prevention to better access to methadone and suboxone treatment, from providing a safe and stable supply of drugs to housing, to having more physicians who can prescribe, to open conversations on decriminalization of substance use.

You might think 'That's big picture thinking!', but I believe that we can all take action on the local level. Everyone can do something. One opportunity I'd like to explore myself is this one. I know of a rural community with many folks with substance use problems. This community has many people who are suboxone prescribers, but have experienced 0 overdose deaths. Why is that? Is it because of the personal approach to care, because of their community approach? They seem to manage this situation really well and I'd like to find out why so we can learn from it.

A Community of Pain Practice For Doctors

An Addictions Medicine Doctor's perspective on chronic pain and a community for Doctors

Factors that play a role in the context of people who use drugs alone are shame, guilt and fear of discovery. People who use drugs are very isolated. It's not just people on the street in the Downtown Eastside. That's the visible minority. The vast majority, we don't even know. The services and programs we have sound nice and it's lovely or whatever, but timely access to the services and geographical location are a huge problem in B.C.. And the outcomes we have in Canada are not good, as only a few can access good multidisciplinary programs, and even then, there is a lack of longitudinal follow-up in most communities. We aren't getting to the core of the problem, which I see it as overzealous prescribing, and a society that expects "a pill for every ill", and to not tolerate any degree of discomfort or pain.

I believe there's a silent looming problem of physicians prescribing opioids. It's a piece of the puzzle that's never really been addressed in a holistic way. But why is it so big? Why is chronic non-cancer pain perceived and treated so differently than, let's say, 30 years ago? Our pendulum has swung so far over in terms of willingness to prescribe opioids, and often very potent opioids, for chronic musculoskeletal injuries or conditions. It will take time to undo what we've been doing for 30 years.

I have some ideas for change. First of all, we need the public to understand the notion of pain better. It's okay to have pain. We need to learn how to live with pain again, and how to manage it. People always have and always will live with chronic non-cancer

pain. Opioids are rarely the answer. What can we learn from other cultures in how they deal with pain?

Second, we need to help doctors and other prescribing health care professionals. You might not think so, but doctors are isolated. They work under pressure, they have a strong impulse to help or to palliate the pain. Here's a problem, fix the problem. We've created an outreach pilot program for health practitioners who prescribe. What we do with our current education module is we bring them into a community of practice, a community that can help. Why are opioids good drugs and when can or should they be prescribed, and for how long? What's the harm? What is the evidence about other options, pharmacological and importantly, non-pharmacological? What can you do for this entity that we call 'chronic non-cancer pain'? So far it's been going really well, our sessions are well attended by pharmacists, doctors, nurses. But it's also going very poorly. We're reaching only small groups in various communities throughout BC; we need to expand our penetration if we really want to effect a behavioural change, particularly in the health care prescribers.

We need to expand and reach all the people we want to reach. We have to get away from the medical model, and consider chronic pain in a biopsychosocial spiritual as well as economic model. We have to get to a new model of extensive aftercare and supports for people. Otherwise it's all doomed to fail.

Taking The Time

Two Nurse Practitioners: their perspective on chronic pain and the role of having time

There's no evidence for this, but there's a trend where people come in with an injury, get put on medications and somewhere along the line some people become addicted. The symptoms become blurred from the original problem. Once the Fentanyl Crisis emerged the B.C. College told doctors to curtail their prescriptions. People went on the streets looking for replacement. Enter: the tainted supply.

One of the differences between the Nurse Practitioner and the Doctor is that we have more time. Most physicians work by billing per patient, and they have to meet a quota to run their practice. A lot of MD's refuse to prescribe replacement therapies because it takes so long. There's the time-commitment, paperwork is huge, and people skip appointments. Nurse Practitioners are paid on a fixed salary, we have the luxury of time, we have space to see a complex patient. When seeing patients, it's important to ask about people's life, the context. Taking the time can lead to a different solution to a problem.

Nurse Practitioners also practice in people's homes. We can see how clean it is, how connected they are to family, if they have enough food at home. It gives us just that extra insight into people's lives; it's an opportunity to give help.

Depending on what we hear and see, we can offer alternative pain treatments, like mindful exercises, websites, cognitive behavioural therapy, podcasts, apps, massage therapy, physio, acupuncture. However, people need money or a benefit plan and that's not always available.

It's important to show that people who take drugs are just like you. It would soften people's opinions about heroin-assisted treatment programs. Because it's a real way forward, as shown in countries like Portugal where they said: If you're not ready, carry on. If you're ready, we have resources ready for you. Radical? No, it's comfort theory: if you meet a need, one comes to a state of ease, and can eventually transcend it. Then they want to make a change.

Note: The role of the Nurse Practitioner (the role in between a doctor and a nurse) is in its infancy in B.C. Nurse Practitioners have recently been given the authority to prescribe opioids and provide Opioid Replacement Therapy.

Peer Researchers Bring Nuance

A researcher's perspective on the role of research

I am working with people with lived experience using drugs to develop a model of culturally appropriate and safe primary care. What do people think of as safe care? What does it mean to feel safe? Why are they not seeking primary care?

In this kind of research inclusive relationship building is key. We work with peer researchers, folks with lived experience, as well as with the Health Authority, with doctors and community-based groups. People often have traumatic experiences with the health care system and with research, especially when they feel they aren't being listened to after participating in research. Working over long periods of time is important to bring about change. That can be challenging, because people leave, there are shifts in policy.

Including people with lived experience as peer researchers can provide more nuanced information about what is really happening. We provide folks with training through video modules to familiarize our peer researchers with ethics, methods, why we do things the way we do. There are great resources out there, like University without Walls, the Dr. Peter Centre.

There's a role for monitoring and surveillance, continued description and analysis of the problem – who is dying, the numbers – it helps to draw attention to the matter. But that's not the only role for researchers. Researchers can also bring awareness of the history of the situation – we've been documenting these trends prior to the health crisis emergency. We can consider critically what's already been tried, the context, things that work in other countries, and provide guidance to these complicated issues. We are careful about how we go about advocacy work to ensure it's situated in evidence. But it can be difficult to step back and know where your role rightly ends.

Make Harm Reduction More Accessible

A community-based action group's perspective on using illicit drugs safely

I think one of the biggest barriers to accessing supports for people who use (illicit) drugs is the lack of education, experience and understanding on the part of service providers. Service providers are often frightened or uncomfortable around people they perceive to be using illicit drugs because the connection around drug use and criminality is so strong. We need to include people with lived experience of illicit drug use more into health and social services provision because they are incredible teachers and can play a really important role in making harm reduction services more accessible.

A harm reduction approach recognizes the link between criminalization and the deadly stigma that causes people to remain in isolation and at high risk for overdose death. Criminalization and stigma are more damaging than Hep C and HIV, and they prevent people from accessing support, which significantly endangers their lives. Until people who are there to help can be challenged around their own assumptions and learn how to discuss drug use in a non-judgmental, open and informed manner, they will not be effective in supporting people at risk for overdose. The manner in which helpers, whether they have lived experience of drug use or not, are engaging with stigmatized people is what makes harm reduction services accessible or not, whether they're delivered in a community centre, public health unit, hospital, mobile van, outreach team or supported housing.

A real challenge as well is expanding support services to outside of city centres – the health care services there are scarce and most public health units aren't a welcoming place for someone who uses drugs, there is still a lot of stigma and shame. People working in

those areas don't have a lot of experience with talking about drug use from a harm reduction perspective and they make assumptions about who is using. For example, when I go see my doctor she doesn't even ask about drug use because I'm a middle-class white woman with a job. Even when I talk about stress and having trouble coping. That door isn't open. We need to learn about culturally safe care, in hospitals, nursing schools and social housing.

One way to expand into rural areas is to make harm reduction services more mobile, for example with a van. If people are concerned about stigma and confidentiality, the vehicle could be unmarked and supplies can be given out discretely in unmarked packaging. You need a basic safety plan in place for your employees, check-ins with cell phones, texting an address before going. We need to have supportive policy in place so that these kinds of services can also observe people using in case of overdose, and people do ask us to help in this way. This support happens amongst peers. They are trying to connect folks and serve themselves and others. These are strong networks. It's challenging to tap into those networks when there's so much stigma and shame.

Technology could play a role, yes. But my experience is that if people on limited income even have a phone, it's usually not a smart phone or they don't have access to WiFi or data. The rural community using pain meds, they might be more likely to use technology. But sometimes technology, like a panic button, wouldn't be fast enough. Around six or seven minutes is when severe brain damage occurs after someone stops breathing. You need help immediately.

Design For Privacy and Rituals

A safe injection site worker's perspective on designing for privacy and better treatment options

We started seeing a real spike in overdoses about two and a half years ago. More and more people started overdosing in the washrooms in our Centre. We pulled them out, they were often not breathing. Our outreach workers turned into first responders and it traumatized our staff. We came up with a safe space to use; it's a cargo bin with a built on extension in the courtyard. It's staffed with a peer support worker and two paramedics. So far we've responded to over 350 overdoses, no one died. We're open from 7 AM to 8:30 PM.

But what can we do for people who don't come to us and use at home alone? This is one of our biggest questions. You could have all the Naloxone handy, but when you're alone... An emergency phone number wouldn't work. If they don't call back then they will send out emergency services? People just drop to the ground. The body will just be a bit warmer.

How do we get people out of their houses? Maybe that won't ever work. It's about getting services to them. A challenge is the issue of internalized shame and privacy. At the safe injection site people watch you when you use. But people feel shame. Sometimes the only part of their body they can inject to is in their upper leg. They would have to take their pants off, but they don't want to show their dirty underwear. Would you? People who use for a long time often have a ritual. For example, they always use in their bathroom. Some people like to smoke it, but we don't allow that there because we don't have the right ventilation system. We have to design for privacy and rituals.

I see more opportunity in better treatment options; we have to shorten the waitlists. Someone who's addicted told me once: "It's like you're on fire, and you call the fire department for help, and they tell you: sorry, we can't come today, maybe tomorrow, just burn a little bit slower."

Personally, I think prescribed heroin is the way to go. People would have routine, structure, access to safe drugs and wouldn't be sick all the time. It's the most important piece.

Take Responsibility For Making Political Changes

A General Practitioner's perspective on the medical system

I understand why opiate dependent people use in their homes. Why shouldn't they? This is not a behaviour dependent on social interaction, as far as I know. Using indoors provides protection against risk of exposure to police and doesn't require a rushed preparation of the fix and provides a more relaxed vein access. It's a private setting where no one will know what you are doing.

Time is a big issue for General Practitioners with complex cases like addiction to a substance. For subscribing Suboxone you need training, you need time. Doctors in hospitals are paid by the hour but as a General Practitioner I'm paid per patient (\$25 for a 10 minute consult). Then the paperwork for each patient I have to do in my own time. When a patient doesn't show up, it costs. To do pain management properly, like talking, a urine test, it would take 20 or 30 minutes to do it right, but I don't get paid for it.

I suggest to start with specific addiction centres where doctors are paid on a salary with proper work conditions and where all the additional services (like physio, psychiatrist) are available. I also suggest cutting wait times for common surgeries in B.C., like back, hip, knee surgery. Can anyone justify that someone who's at home with a very painful hip has to wait for over a year to get help? It drives people into using pain killers in the meantime. They become dependent because the medical system is failing them. It forces them onto the street to purchase unsafe drugs.

I feel so hopeless sometimes. This is a first-world country and I counsel a lot of people whose lives are really awful, and I can't do anything about it. Instead I'm on the hook, I'm being blamed for overprescribing opioids. Then the B.C. College is on our case and punishes and threatens us with audits and what-not. Ethically I have to make sure my patients are safe and doing well. But there isn't always that option beyond prescribing opioids. There are no services for folks to follow-up; they have no access because it's not covered. It's unrealistic for the College to put pressure on people like me unless there are viable pain management alternatives.

Most importantly I think we need to decriminalize opiates and provide controlled prescription opiates, like heroin to those people dependent on this drug. Add additional counselling, which has been made available in countries where this has already happened. Once there is decriminalization, there will be a greater willingness for people to reveal their addiction, and over time they will seek help. How can anyone live a life where the cost of maintaining an addiction requires a life of crime, dealing, prostitution and theft? I don't know why politicians are dragging their feet. Everybody wants it go away, but no one wants to take responsibility for making political changes.

A complex patient case – experienced from a doctor’s perspective

This patient is 45 years old. He has a longstanding knee injury, he has chronic pain. Initially he was prescribed Dilaudid by another doctor. His use escalated, and I was seeing him to help him reduce his intake. We tried a number of other drugs but it didn't work efficiently because of his opioid dependency. Then he left to Alberta, and the doctor there increased his dose. He came back about a year ago, and I've worked with him again to decrease his dose. However he acquired a cocaine issue, off the street. He also lost his job as a truck driver. He lost his income and started using more. I got him into a Suboxone clinic. He started Suboxone, but then stopped. For some reason he felt humiliated by the experience and by the doctor there. That doctor then suggested to me to keep prescribing to him, to keep him safe. The patient told me he was going to buy heroin off the street to take care of his dependency and manage his own pain. I subscribed two weeks to him haven't seen him since. Now the B.C. College is on my case for prescribing to him.

Pain Can Kill the Bravest Hero

A men's health researcher's perspective

Why are men disproportionately affected by the opioid situation? Men work in dangerous jobs. For most men, concepts like honour and pride are very important. They feel good when they work hard and when they are connected to family, kids, or friends. They like to carry that kind of responsibility, to have something to live for. If they feel troubled, they tend to withdraw, turn to alcohol, drugs, and they lose connections and networks. Male psychology is in its infancy. We're only recently starting to learn about men's positive coping strategies. Men don't respond well when one points out their weaknesses. For men it's important to identify their strengths and find resilience factors like working out, eating well.

We need to seriously look at the overall patterns here, for example through a trajectory analysis. What services were men accessing, how did that go for them? There's so much opportunity to learn from Family Doctors and WorkSafe BC's data. It will tell us where the most powerful place is to intervene, and how to spend our money before people start to fit the category of addiction. Is it the club, the pub, school, the work place or the doctor's office? Catch them where they are, early.

As for public campaigns, I have a couple of ideas. The first one is for young people, Facebook-based. It needs to be a message with high credibility, like Macklemore's rap. People will listen to that. Let's not do this "all drugs are bad, do you want another

drink?" thing. Kids see that hypocrisy. Young people are receptive to learning about safety and looking out for each other. Second, I think there is a message in knowing that your party drugs are being cut-up in the same facility as Fentanyl and heroin, it's an untrustworthy chain. People don't know that. You're getting that pill from someone who doesn't have cleanliness standards. So pick up that Naloxone kit somewhere, provide addresses.

Third, I suggest changing that public image of a crazy wild hard party kinda guy who takes stupid risks into something more like: You do a dangerous job, because you're responsible and brave. But when you get hurt, there's pain that can undermine everything else, pain can kill the bravest hero. The courageous and most honourable thing to do is to reach out, connect to those values of camaraderie, respect, connection. Start conversations with: "How did you get to this dark place? Did it start because you were brave and doing this hard job, and then you sucked-it-up until you couldn't anymore? And now what? Reach out for help. Because that's the next brave, responsible thing to do."

I think going to construction sites to train workers to be peer supporters for their colleagues is an opportunity to explore. Find a guy who is already trusted, people already go to them to talk about their problems. Provide special peer support training to them.

A Men's Centre Is My Dream

A community action worker's perspective on men's health services

I am working hard to set up new types of housing and health care services for people, especially men, in a remote community in B.C. Some people ask me why people don't access the services that are already available. Well, I think it's not the people, it's the services. There is a chronic homeless population in B.C., and many people suffer from mental health issues. Take Johnny, he grew up on a Reserve. Johnny gets intoxicated and belligerent all the time. He then gets taken to the ER because there is nowhere else to go for him. From there the RCMP picks him up, jails him for the night and gives him the boot at 6 in the morning. Out on the street he is again. Or this other gentleman, Jim. He's 42 and came into my office, crying, in despair. He said: "I'm ready, I need help. I need to do something.". I said: "Let's go!". I literally walked him to the addiction services clinic and told them: "He needs help right now." But they said: "You have to make an appointment, come back next week and we might get him in." Well, by the time they had space, Jim's momentum was gone.

In my opinion the system is broken, especially for men. Men find it difficult to ask for help. We're not meant to be seen as weak or inadequate. And it's even more difficult if they're asking for help from women. There are lots of women working in the health care services. And the services on offer don't work for them, and that's why so many people who overdose and die alone are men. If a guy needs help, he'd rather just turn to the bartender to talk to.

What I'm saying is that services or care don't have to be costly or difficult to access. You don't have to be a counselor to help people, it can be with peers too! That's what I've created myself. It's a men's group. There are dads with their kids, they come in for a cup of coffee, to fix things that are broken, to chat.

For the future I want to create a service hub that captures and helps men like Johnny and Jim. You can come in, sit down, have a coffee and a chat, and tell them what you need. Even if it's just sitting down and having that coffee, that's all good. I think if we were to have a men's centre, crime rates would drop, which would make local businesses happier. And the burden on ER and the police would be much lower. And it could be a point of service connection: the community action groups could come to them, Mental Health and Addictions could come, instead of the other way around. I also want to get the First Nations involved, because culturally it has to be correct and reflective of the community. That's my dream, and I am going to realize it.

It Takes Time to Shift Attitudes

A media perspective on data, stories and getting the right messages across

The news continues to show images of people shooting-up on the Downtown Eastside, but I'm trying to spread the message that the crisis impacts many beyond this small group of impacted people using substances. It's people in their private residences. There's a lot of stigma. People are ashamed to tell friends and family that they're using - and what they see on the news has an impact on that.

There seems to be a level of media fatigue. Because of the reports and numbers that have been released, there's now an expectation that data is regularly provided. It's important to share that information, but I worry that people are becoming too used to the statistics. And I worry that we aren't sharing positive stories, success stories of those who survive overdoses. Rather than creating fear, we need to show people that it's possible to help and make an impact, and to explore what steps are needed to be better equipped. There seems to be an appetite and willingness to show the survivor stories. Have a survivor tell a story about how a treatment center or supervised consumption site saved their life. They can say something like, "It's okay to use, but don't be stupid, use safely." Use conversational language like that. It would be great to show not only people who have been using drugs for a long time, but also someone that had a workplace accident perhaps and was prescribed opioids to start.

We could educate ignorant people about what's really going on. The people that use drugs need to be delivering the messages. There's so much societal stigma around drug use. People seem to equate drug use to failure, rather than the correlation to people not having the choice. People are playing with the cards that they were dealt. It takes time to shift those attitudes. Think about seatbelts: it wasn't cool to use a seatbelt for many years, but now people use it and we have the evidence to prove that it saves lives.

Another challenge we face is that there's no current national standard for what kind of illicit drugs are contributing to these overdoses. In B.C., we know that there have been no deaths at overdose prevention sites, but the reporting structures are different in each jurisdiction across the country and beyond, so we are essentially trying to compare apples and oranges. I know there are some senior-level conversations happening that are aiming to resolve this, but I don't foresee it being put into policy and procedure for some time.

The Band-Aid is Getting Stretched Too Thin

A supervised consumption site peer worker's story about making the right spaces

What I see in people is real pain. Real, physical pain. People get prescription drugs from their doctor, then they get taken off it. And then what do you do? You go on the street, to the tight-knit heroin community, and you start asking around. That's how desperate people are to treat their pain. It takes a long time to get into the community, and to build trust. But once you're in it, you never get out.

I'm going to be honest with you. The government, the decision-makers, they need to come off their high-horses. They need to understand that these are real people. Why don't people go to a hospital? Because they are being treated like dogs. They get sent away by doctors and nurses. They hear, "You have an abscess on your leg because you're a user, so it's your own fault. Go away." People get laughed at. They get told, "There are other people who need our care more than they you do."

The thing is, most people are addicted to something. There's always going to be addiction. We just need to have facilities. 90% of us are addicted to sugar, TV, alcohol, their phone, computers, porn. People are doing drugs because they are disconnected from other people. And that's when you get addicted, when you don't have meaningful connections to people.

Working at the supervised consumption site, I've saved over 100 people. It's spiritual to save that many lives. But it's a band-aid, and the band-aid is getting stretched too thin. There's no overnight stay in my city right now. It's only there when it's gets really cold. You need to have a place where people can bring in their bikes, their dogs, their belongings, and stay safe for the night. They should be able to use, they should be safe.