FACE TO FACE with Stigma

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FACE TO FACE WITH STIGMA

Face to Face is a anti-stigma workshop created, driven and led by people with lived/living experience. Our goal is to educate, inspire empathy and reduce fear towards people who are experiencing homelessness and or substance use disorder.

We use our stories to foster equality in the hopes to change mindsets and perspectives of the members in the community to decrease stigma.

In a safe enviorment we provide the oppertunity for essential conversations about various topics. We learn form our audience and they learn from us.

Starting the Conversation

Ending the Stigma

Please contact Kay at 250-580-2751

Stigma Checklist

Things to think about when trying to have positive interactions with people in the vulnerable community

- *Try checking in with yourself to make sure it is appropriate to make an interaction and that you are comfortable doing so.*

- *If you feel fear arises, take time for yourself before you approach to try to identify where it is coming from and to avoid any uneasy feelings during the interaction.*

- Check your body language, do you notice any physical changes? *Try to approach with non-confrontational body language and a smile.*

- *Are you aware that your uniform may cause a traumatic response? Try to be mindful that people may have had negative past experiences.*

- Do I have an open mind in this interaction? *Try to have an open mind when talking to someone, you don't know what this person is currently experiencing.*

- Are you making appropriate eye contact before approaching? *Try to make sure the person knows you are approaching by talking to them before walking up.*

- Could you see someone that you love in this position? *When starting a conversation, try to use kind words and treat people respectfully even when they may be short with you. You will have more successful conversations when starting the interaction with empathy.*

- Have you made any assumptions about this person? *Are you seeing a person or stereotype? Try not to label or judge a person by their appearance or the place that they are in.*

- Have you approached this interaction with compassion? *A little empathy goes a long way.*

- After interaction with someone, try to keep their privacy and confidentiality.

Your personalized checklist for successful interactions

Please fill in suggestions into your own stigma checklist.

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FACE TO FACE with Stigma

EDUCATE YOURSELF

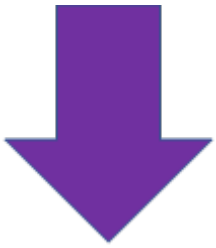
Challenge myths, and stereotypes

Educate others.

CHECK YOURSELF

Be aware of your own judgements,

Actions, and language



BREAK DOWN BARRIERS

Promote equal opportunity,

And respect the dignity of all people

STIGMA IS ONE OF THE BIGGEST BARRIERS TO TREATMENT AND RECOVERY FOR SUBSTANCE USE DISORDERS TODAY. OFTEN THE LANGUAGE WE USE CONTRIBUTES TO STIGMA.

THERE ARE A LOT OF STIGMATIZING WORDS THAT ARE COMMON IN OUR DAY-TO-DAY LANGUAGE.

WHAT YOU SAY		WHAT PEOPLE HEAR
ABUSER		IT'S MY FAULT
DRUG HABIT	VS	IT'S MY CHOICE
ADDICT		THERE'S NO HOPE
DRUG USER		I'M A CRIMINAL

BY CHOOSING ALTERNATE LANGUAGE, YOU CAN HELP BREAK DOWN THE NEGATIVE STEREOTYPE ASSOCIATED WITH SUBSTANCE USE DISORDER.

INSTEAD OF	TRY
ABUSER, ADDICT	PERSON WITH A SUBSTANCE USE DISORDER
DRUG HABIT	REGULAR SUBSTANCE USE, SUBSTANCE USE DISORDER
FORMER/REFORMED ADDICT	PERSON IN RECOVERY/LONG-TERM RECOVERY

THINK BEFORE YOU SPEAK. HELP REMOVE THE STIGMA.

JOIN THE **CONVERSATION**

#WORDSMATTER

Canadian Centre on Substance Use and Addiction

Evidence, Engagement, Impact.

Face 2 Face with Stigma's

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Healthy Language Guidelines

Stigma stems from society and the human brain's need to categorize everything, even people. While you are not to blame for creating stigma, you are responsible for ending the cycle with you. We are taught societal norms from birth all the way to adulthood. Stigma comes in all forms, as outright as a slur and as subjective as a character portrayal in a TV show or newspaper comic. We subconsciously learn stigma from the media we watch, the community atmosphere and especially your parents. But how can you change it if you don't understand it?

RESOURCE: https://www.ccsa.ca/sites/default/files/2019-09/CCSA-Language-and-Stigma-in-Substance-Use-Addiction-Guide-2019-en.pdf
RESOURCE: https://www.shatterproof.org/about-addiction/stigma/stigma-reducing-language

Healthy Language and Stigma

Stigma is any attitude, belief or behaviour that discriminates against people.

For example, it is important to remember that a substance use disorder should be treated as a medical condition. Shifting language to more accurately reflect the nature of the health condition can lead to increased support.

We reinforce stigma with the words we choose, how we treat others and how we view ourselves. Most of us encounter stigma in our daily lives and we can amplify or extend it without meaning to.

Stigma can look like:

- prejudice towards a person's identity by saying that they 'are' the problem, rather than saying they 'have' a problem
- Belittling a person's value based on their use of substances or housing circumstance
- Dehumanizing a person through labels

WE INTERNALIZE ALL OF THIS. For instance:
We believe, as people who use substances, we will not receive help if we ask for it. We hold a sense of shame that stops us from seeking help and feel we are not heard, seen or cared about.

Why is it important to use person FIRST Language?

First of all, what is person first language? Its language that acknowledges someone as a person before describing their personal attributes or health conditions. Person-first language does not identify people by secondary or incidental qualities or conditions.

A) Instead of saying, you're homeless, say 'you're experiencing homelessness.' Think about that sentence: You are homeless. You are not one word. You are not one characterization. You are not 'homeless.' That's not all you are. It's just an experience you are having.

B) Instead of saying, you're an addict, a user or an abuser, say 'you have a substance use disorder.'

C) Instead of saying 'substitution or replacement therapy' when you're referring to methadone or suboxone, say 'treatment or medication for addiction.' Saying replacement therapy makes it sound like you think we're just replacing one drug for another, when it's really equivalent to sobriety and a huge leap forward.

D) Instead of 'former/reformed addict,' say 'not using substances' or 'person in long term recovery.'

Reasons to use person first language:

- The change shows that a person "has" a problem, rather than "is" the problem.
- The terms avoid elicit negative associations, punitive attitudes, and individual blame.

Some people will think the terms should elicit negative associations and punitive attitudes and individual blame so that they are pressured to stop, but it DOESN'T work like that.

The person using substances ALREADY feels pressure and drive to stop, but lack of community and support makes it difficult to stop, and the more you use this type of language, the more it reinforces the insurmountable identifier that you ARE your addiction and there's NO way out.

Other Examples:

AVOID USING LANGUAGE LIKE ASKING SOMONE IF THEY ARE 'CLEAN' OR had a 'DIRTY' test result.

These terms decrease self-esteem and effectiveness of treatment and have no relationship or correlation with actual cleanliness.

- Instead of, 'You've been clean for 6 months', SAY: 'You haven't taken any substances in 6 months'
- 'Substance use affects Canadians from all walks of life' SAY 'Canadians from all walks of life are impacted by the use of substances' it's like French, even the sequence of word placement can make all the difference. But I promise this won't be as hard to learn as French.
- Instead of, 'I can smell alcohol on them. They're in our wait room all the time. They'll probably feel fine soon,' don't place alcoholism or withdrawal as a less worthy reason for a medical visit and instead say: 'The person may have been using substances. They deserve a full medical treatment.'
- Those who have experienced withdrawal will know this, but just because you are sick because you're dependent on a drug does not make the symptoms any less valid.

Now, let's talk about when you're CONFRONTED WITH STIGMA:

You hear: "When I see those addicts downtown, I can't imagine why they don't do something about their lives. You'd think they'd show a little self-respect; it's disgusting how they choose to live."

What someone suggested to me was to imagine a child in front of me who had done their very best. Then ask myself what problems they must have encountered as they grew up, and be dealing with today, to be suffering so much. Once I started doing that, it struck me that they must be leading a life they never imagined. I wonder if there is something we can do to help? At the very least, we can offer our respect for their humanity and use person-first language."

"I.E we never had a childhood or a chance to grow with love and support"

"I didn't choose to be homeless. I did the best I could. Circumstances led me to this".

We stigmatize in 300 milliseconds. We need to undo that automatic action.

Our brains are wired for

CONNECTION,

but trauma rewires them for

PROTECTION.

That's why healthy relationships are difficult for wounded people.

Ryan North

tinybuddha.com

The Seven Types of Stigma

TYPE 1	TYPE 2	TYPE 3	TYPE 4	TYPE 5	TYPE 6	TYPE 7
Public Stigma This happens when the public endorses negative stereotypes and prejudices, resulting in discrimination against people with mental health conditions.	**Self Stigma** Self-stigma happens when a person with mental illness or substance-use disorder internalizes public stigma.	**Perceived Stigma** Perceived stigma is the belief that others have negative beliefs about people with mental illness.	**Label Avoidance** This is when a person chooses not to seek mental health treatment to avoid being assigned a stigmatizing label. Label avoidance is one of the most harmful forms of stigma.	**Stigma by Association** Stigma by association occurs when the effects of stigma are extended to someone linked to a person with mental health difficulties. This type of stigma is also known as "courtesy stigma" and "associative stigma."	**Structural Stigma** Institutional policies or other societal structures that result in decreased opportunities for people with mental illness are considered structural stigma.	**Health Practitioner Stigma** This takes place any time a health professional allows stereotypes and prejudices about mental illness to negatively affect a patient's care.

FACING HOMELESSNESS

"There's not enough housing for everybody" - ***Montana***

Each year the Greater Victoria Coalition to End Homelessness (Coalition) and the University of Victoria's Centre for Addictions Research of BC release a Report on Housing and Supports.

The report outlines data from six key areas of homelessness: housing, income, temporary accommodation, emergency shelters, and housing and outreach programs. This research helps us understand the factors that contribute to homelessness and poverty in Greater Victoria, and to identify specific service and infrastructure needs in the community.

CONTRIBUTORS TO HOMELESSNESS

- The gap between income and housing costs is one of the most important contributors to homelessness in Greater Victoria
- Although vacancy rates the region overall have risen, there are fewer low end of market suites available to those living on low incomes.
- Resources available to individuals and families on low incomes have not increased – they still cannot afford current rental market rates.

EXTENT OF HOMELESSNESS

- More than 1,600 unique individuals used an emergency shelter bed in five of six emergency shelters in Greater Victoria
- The number of individuals may be similar to 2011/12, the occupancy rate of emergency shelters has increased from 111% to 112%
- On a single night, more than 1,000 people were counted in temporary accommodation in our region

AT RISK OF HOMELESSNESS

- 27% od housingholds in Greater Victoria are in core housing need, nearly 11% are in severe housing need.
- Subsidized housing continues to be difficult to access with more than 1,445 people on the Housing Registry

COMMUNITY RESPONSE

- Greater Victoria service providers are consistently housing people and keeping them housed
- While some new subsidized units have been added for families and seniors, no new units have been added for those who are homeless or Aboriginal people.

RECOMMENDATIONS

- Increase the number of Homeless Outreach Program rental supplements available.
- Revisit the criteria for rental assistance programs to broaden their reach.
- Increase the number of subsidized housing units in our community
- Undertake specific assessment of the needs of youth and families, including Aborigial peoples experiencing homelessness.

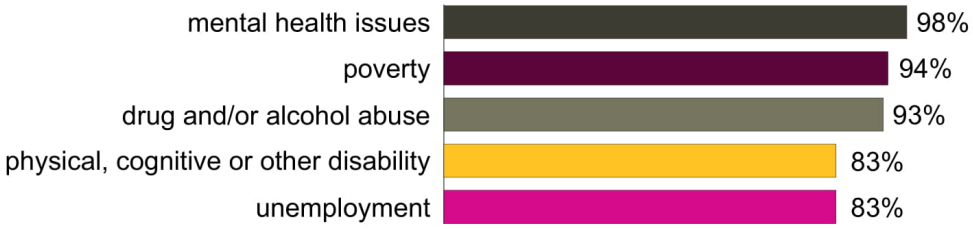
Report on Housing & Supports 2012/13

Source: Pauly B., Cross, G., Vallance, K., Wynn-Williams, A., Stiles, K. (2013). Report on Housing and Supports 2012/13 Facing Homelssness. Greater Victoria Coalition to End Homelessness and Centre for Addictions Research of British Columbia

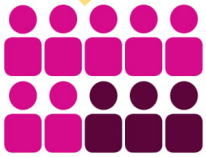
homelessness in greater victoria

according to greater victorians

greater victorians cited these as the primary causes of homelessness:



homelessness costs more...



7 of 10 surveyed agreed *'it cost more in government services... for a person to be homeless than it does to provide them with housing'*.

73% know someone who has experienced mental health or additions issues.

41% know someone who has been homeless.

4% have experienced homelessness themselves.

90%

agree affordable housing would help reduce homelessness

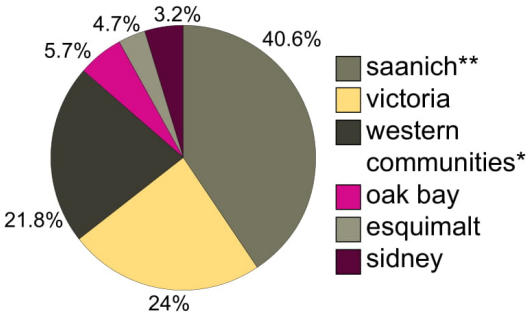
85%

agree ensuring access to affordable housing is the responsibility of government

is homelessness an issue in your municipality?

municipality	"no" (%)
sidney	53.8
western communities*	50.0
saanich**	36.0
oak bay	34.8
victoria	33.0
esquimalt	31.6

survey participants by region:



*western communities include colwood, highlands, langford, metchosin, sooke and view royal.

**saanich includes central and north saanich

This data is the result of a R.A. Malatest & Assoc survey done in February 2014 on Greater Victorians attitudes towards homelessness. The survey was commissioned by the Great Victoria Coalition to End Homelessness. Survey margin of error is 4.9%

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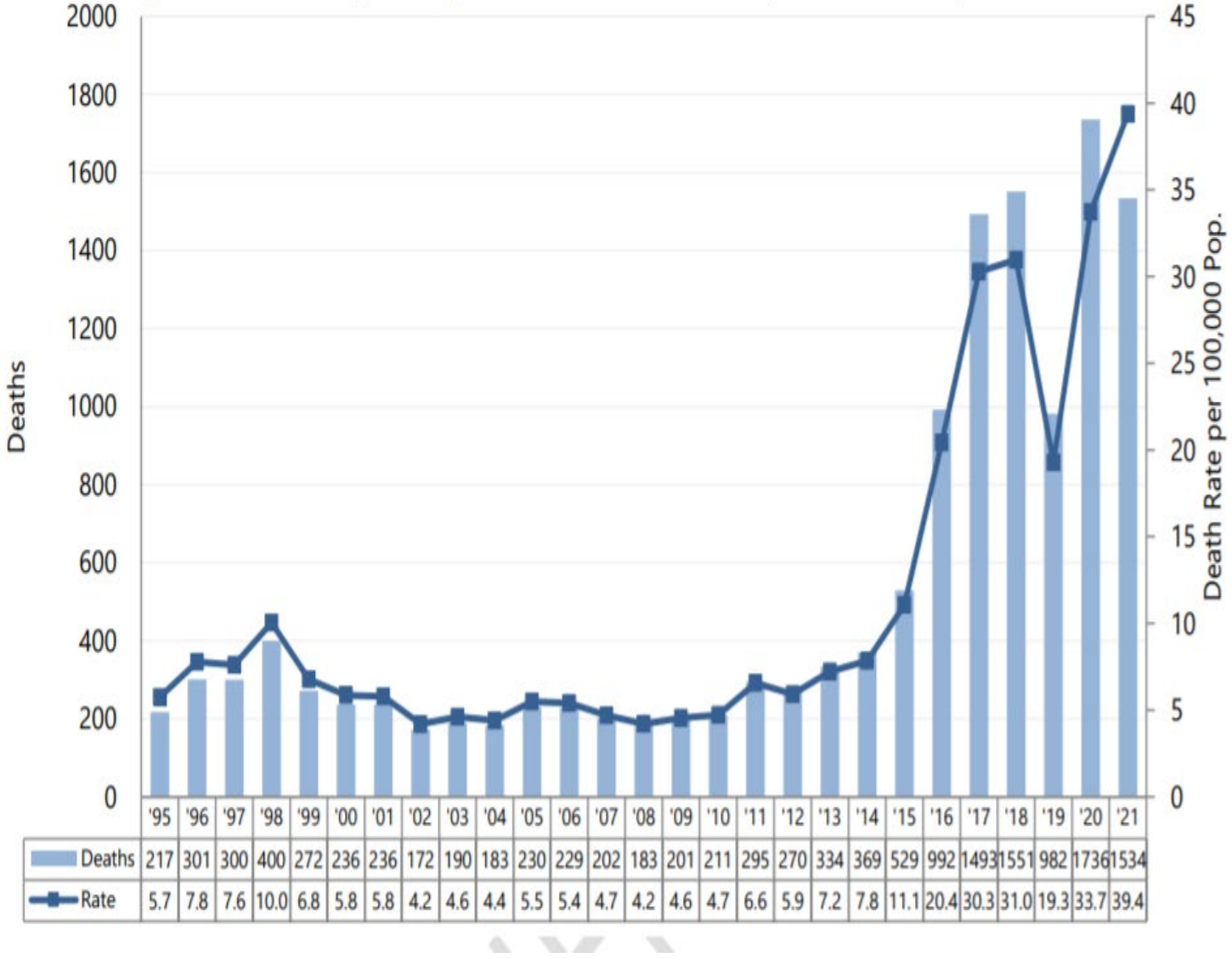
victoriahomelessness.ca

Figure 1: Illicit Drug Toxicity Deaths and Death Rate per 100,000 Population [3,5]



	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	'21
Deaths	217	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	295	270	334	369	529	992	1493	1551	982	1736	1534
Rate	5.7	7.8	7.6	10.0	6.8	5.8	5.8	4.2	4.6	4.4	5.5	5.4	4.7	4.2	4.6	4.7	6.6	5.9	7.2	7.8	11.1	20.4	30.3	31.0	19.3	33.7	39.4

youth homelessness

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how many homeless youth are there?

There are an estimated 157,000 people who are homeless each year in Canada, with **65,000 estimated youth***.[1] Because they have different risk factors and face different challenges, homeless youth must be viewed as a separate entity from the adult homeless population.

Within Greater Victoria, the *2008 Youth Housing Survey* by the *Community Social Planning Council of Greater Victoria* conservatively estimates the number of **youth and young adults facing homeless in Greater Victoria at 616.**[2]

is youth homelessness increasing?

Service providers working with homeless youth and youth at risk in Greater Victoria believe these numbers are on the rise. This assumption is supported by data and trends in other cities like Vancouver—where youth homelessness saw a 29% increase since 2008.[3]

how do youth become homeless?

There are push and pull factors that make homelessness the only option for some youth.[4] Push factors include family conflict, sexual orientation, poverty, abuse and neglect, learning and development disabilities, and alienation; pull factors include substance abuse, addiction, and relationships.[5] Youth who leave living situations of conflict or abuse are often distrustful of adults, making it difficult to access the few services run by adults that are available to help youth escape homlessness.[6]

Many youth are employed and try to acquire housing, but their age and inexperience leads to barriers: most jobs for youth are part-time and low-wage, so it is difficult to pay for high rent costs, utilities, internet and phone bills. Other barriers to housing include age discrimination and limitations, such as a lack of income assistance or rental references.[7]

why are homeless youth hard to find?

As many as 80% of youth experiencing homelessness **do not sleep rough on the streets, but are "hidden"**.[8] Youth may not be able to access certain shelters designated for adults or women only.[9] They may be sleeping in cars, at friends' or strangers' houses or couch surfing.[10] Youth experiencing homelessness are a transient population, often living in five or more different places over a one year period.[11]

* The term "youth" commonly refers to those between 12-30 years of age.

[1] Trypuc, B., & Robinson, J. (2009). Homeless in Canada. *Charity Intelligence Canada*

[2] Community Social Planning Council of Greater Victoria. (2008). A youth housing study for BC's capital region. Preliminary Report.

[3] Org Code. (2011). Metro Vancouver Homeless Count 2011

[4] Winland, D. Gaetz, S. Patton, T. (2011) Family Matters - Homeless youth and Eva's Initiatives "Family Reconnect" Program.

[5] Winland, D et al. (2011)

[6] Ending youth homelessness, (2012). Ending youth homelessness. *Canadian Housing and Renewal Association Policy*

[7] Community Social Planning Council of Greater Victoria. (2008).

[8] Evenson, J. Youth homelessness in Canada: the road to solutions. (2009) Raising the Roof

[9] Community Social Planning Council of Greater Victoria. (2008).

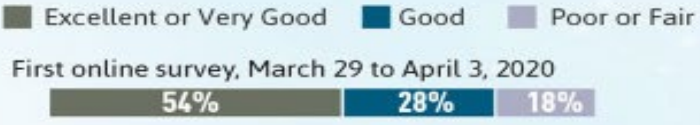
[10] Evenson, J (2009)

[11] Evenson, J (2009)

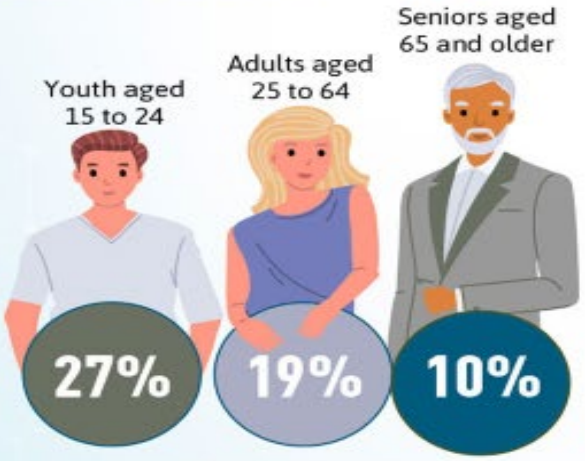
MENTAL HEALTH OF CANADIANS DURING THE COVID-19 PANDEMIC

PERCEIVED MENTAL HEALTH

In May 2020, 48% of Canadians reported having excellent or very good mental health. However, this was 6 percentage points lower than it was at the end of March.



Note: Differences for those who reported having good mental health are not significantly different.



Compared with younger Canadians, Canadians aged 65 and older reported lower rates of symptoms of moderate to severe anxiety.

There were 18% of Canadians who reported symptoms of moderate to severe anxiety in the previous two weeks. All regions reported similar rates.

Women were more likely than men to report symptoms consistent with moderate or severe anxiety.

There are many things you can do to help improve your physical and mental health during stressful times. Here is what Canadians reported doing in May.

If you are in distress, please contact your nearest crisis or distress centre. If it is an emergency, call 911 or go to your local emergency department.

Health Canada's Wellness Together Canada is a new mental health and substance use support portal available on Canada.ca/coronavirus and the Canada COVID-19 app.

Note: Generalized anxiety disorder (GAD) is a condition characterized by a pattern of frequent, persistent worry and excessive anxiety about several events or activities. Respondents who scored of 10 or higher on the GAD-7 were considered to have moderate to severe symptoms of GAD in the two weeks prior to completing the survey. The data reported do not necessarily reflect a professional diagnosis of GAD. In the context of the COVID-19, it is important to note that feeling of anxiety can be understood as natural reactions and not necessarily indicators of a long-term mental health disorder.

Source: Canadian Perspectives Survey Series, May 2020 and March and April 2020.

EVERYONE COUNTS

2020 GREATER VICTORIA POINT-IN-TIME COUNT

HOMELESS NEEDS SURVEY
KEY HIGHLIGHTS

PiT COUNT

The night of March 11, 2020 at least **1,523** people were experiencing homelessness in Greater Victoria.

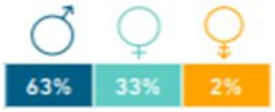
270	350	145	198	545
UNSHELTERED	EMERGENCY SHELTERS	COUCH SURFING	PUBLIC SYSTEMS	TRANSITIONAL HOUSING

15 WERE IN UNKNOWN LOCATIONS

On the night of March 12, 2020, **854** individuals participated in the homeless needs survey, representing over half of those enumerated.

GENDER

Two thirds identified as male.



SEXUAL ORIENTATION

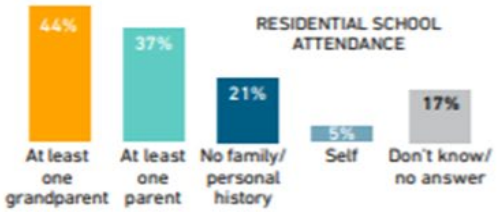
12% identify as LGBTQ2S+

Among youth, the number rose to 30%.

INDIGENOUS

35% are Indigenous, compared to 5% of the Greater Victoria population. 44% are **women,** 59% first experienced homelessness as a **youth,** and 55% have experiences with **foster care**—which are all higher rates than the general survey population.

62% have personal or close family history of attending **residential school.**

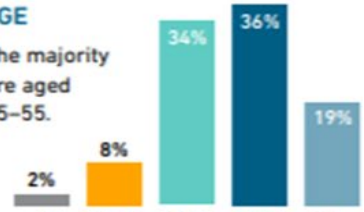


FAMILIES

30 individuals had children with them. Of the 42 children/ dependents, 28% were unsheltered or slept in vehicles.

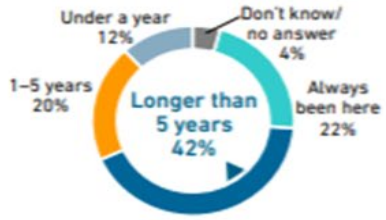
AGE

The majority are aged 25–55.



TIME IN GREATER VICTORIA

Only 12% have lived in the region for less than one year.



EXPERIENCES OF FOSTER CARE

1 in **3** were in government care as a child or youth. A third became homeless within a month of leaving care.

HEALTH CHALLENGES

90% have at least one health challenge, including 29% with an acquired brain injury. Research indicates that homelessness exacerbates some health challenges, such as substance use.

LONG-TERM HOMELESSNESS

- **1 in 2** respondents first experienced homelessness as youth (under 25).
- **82%** have been homeless for a total of 6 months or longer over the past year—this is an increase from the previous PiT survey (72%).

INCOME SOURCES

- **94%** have at least one source of income, with the most common being welfare/social assistance (37%), disability benefits (36%), employment, including full-time, part-time and casual (17%), and informal sources of income (16%).

NEED FOR HOUSING AND SERVICES

- **92%** want permanent housing.
- The top three obstacles to finding housing: **high rent, low income, and lack of available options.**
- Top three needed services include primary care services, services for substance use, and mental health supports.

CRD Making a difference...together

greater victoria coalition to end homelessness

Canada

JULY 2020

BC Coroners Service Illicit Drug Toxicity Deaths in BC, January 1, 2011, to October 31, 2021

Posting Date: December 9, 2021

• In October 2021, there were 201 suspected illicit drug toxicity deaths. This is the largest number of suspected deaths ever recorded in a month.

• The 1,782 suspected illicit drug toxicity deaths between January and October 2021 are the highest ever recorded in a calendar year.

• The number of illicit drug toxicity deaths in October 2021 equates to about 6.5 deaths per day.

• In 2021, 71% of those dying were aged 30 to 59, and 79% were male.

• The townships experiencing the highest number of illicit drug toxicity deaths in 2021 are Vancouver, Surrey, and Victoria.

• By Health Authority (HA), in 2021, the highest number of illicit drug toxicity deaths were in Fraser and Vancouver Coastal Health Authorities (602 and 494 deaths, respectively), making up 62% of all such deaths during this period.

• By Health Authority (HA), in 2021, the highest rates were in Vancouver Coastal Health (48 deaths per 100,000 individuals) and Interior Health (45 per 100,000). Overall, the rate in BC is 41 deaths per 100,000 individuals in 2021.

• By Health Service Delivery Area (HSDA), in 2021, the highest rates were in Vancouver, Thompson Cariboo, Northwest, North Vancouver Island, and Fraser East.

• By Local Health Area (LHA), in 2021, the highest rates were in Upper Skeena, Lillooet, Merritt, North Thompson, and Enderby.

• In 2021, 83% of illicit drug toxicity deaths occurred inside (55% in private residences and 28% in other residences including social and supportive housing, SROs, shelters, and hotels and other indoor locations) and 15% occurred outside in vehicles, sidewalks, streets, parks, etc.

• In Vancouver Coastal, other residences (47%) were the most common place of illicit drug toxicity deaths followed by private residences (35%) between 2018 and 2021.

• No deaths have been reported at supervised consumption or drug overdose prevention sites.

• There is no indication that prescribed safe supply is contributing to illicit drug deaths.

• Male illicit drug toxicity death rates have remained at a high rate, while female rates have remained relatively stable.

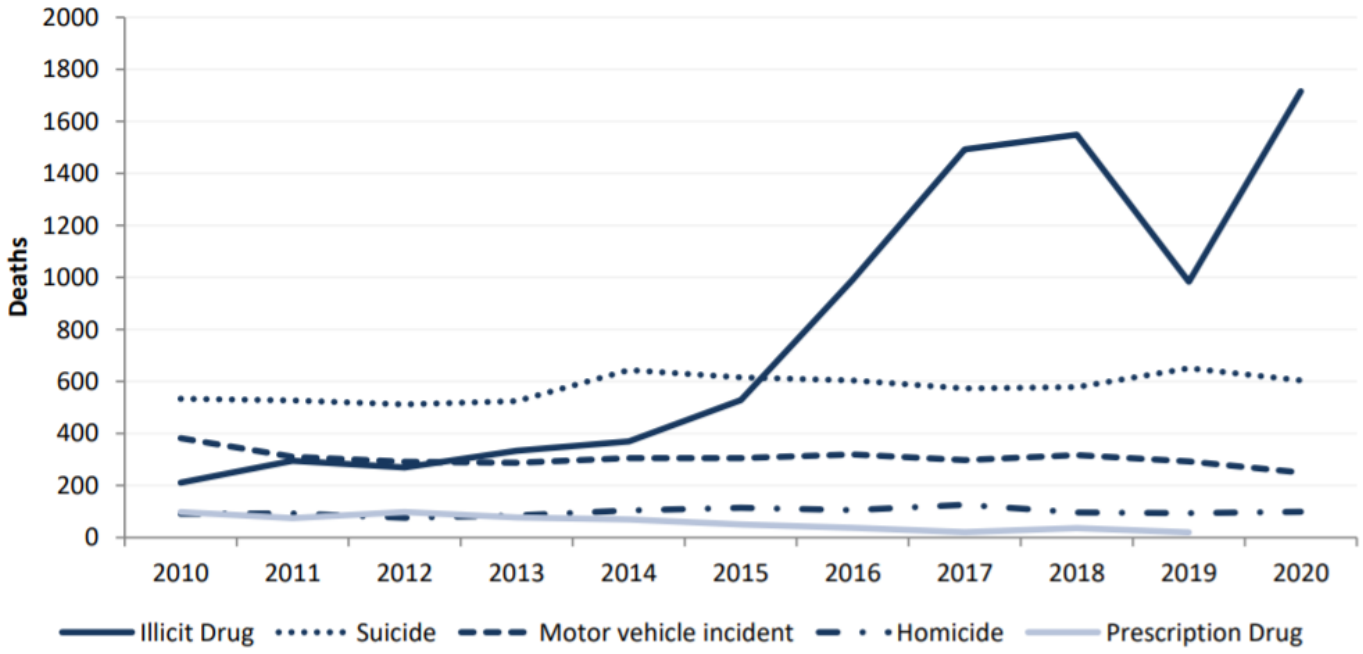
• Illicit drug toxicity death rates among 19+ years have remained high, while rates among 0-18 years remain stable.

• The proportion of deaths that are 50+ years of age has steadily increased year after year for the past 6 years. In 2021, 39% of deaths were 50 years or over.

• Illicit drug toxicity death rates for all health authority rates remain high.

Comparison to Other Common Causes of Unnatural Deaths from 2010 to 2020:

Figure 2: Major Causes of Unnatural Deaths in BC



**Data is preliminary and subject to change. Prescription drug toxicity deaths (accidental and undetermined) include cases where only a prescription drug is involved and reported for closed investigations only to 2019.*

References for resources

- Checklist suggestions created by Face-to-Face team at the Greater Victoria Coalition to end homelessness, January 2019.
- Stigma barrier table from Canadian Center for Substance Use and Addiction; 2019, Search | Canadian Centre on Substance Use and Addiction (ccsa.ca)
- Stigma images from Bing in creative commons
- Illicit drug toxicity Death in BC table is from the BC Coroners Service: January 1, 2010 – November 30, 2020, Age Category (gov.bc.ca)
- Mental health statistics during Covid-19 Pandemic from the Government of Canada website. June 4, 2020, Mental health of Canadians during the COVID-19 pandemic (statcan.gc.ca)
- Greater Victoria Point in time count, 2020, created by the Greater Victoria Collation to end homelessness.
- Youth Homelessness infographic: Greater Victoria Collation to end homelessness
- Homelessness in Greater Victoria according to Greater Victoria; Greater Victoria Collation to end homelessness
- Facing homelessness; Greater Victoria Collation to end homelessness
- BC, Coroners Service Illicit Toxicity Deaths in BC, January 01/2011-to October 31/2021, Posting date: December 09/2021, Age Category (gov.bc.ca)
- https://victoriahomelessness.ca/f2f/