Going Beyond - Episode 1 Transcript

Jo: In this episode, we speak to Oliver Standing. Director of Communications and External Affairs at Humankind, [00:01:00] and Debra Hertzberg, Research Manager at Homeless Link. We speak about the prevalence of drug and alcohol use for people experiencing homelessness, discuss some of the reasons behind these statistics, and question whether the system allows adequate support for those most in need.

So, welcome to Oliver and Debra. How are you both today?

Oliver: Very good, Jo.

Debra: Very well. Thank you.

Jo: Well, thank you so much for being here today for the Going Beyond podcast. So to start us off for the listeners, can you tell us a bit about yourself and the work you do? [00:01:30] Oliver, I'll go to you first.

Oliver: Thanks Jo. Yeah. Pleasure to be on the podcast and thank you for the invite. My name's Oliver Standing, I am Director of Communication and External Affairs at a charity called Humankind. So Humankind is a, is a large, National charity. We work across England, primarily, but not exclusively supporting people with drug and alcohol challenges.

But as I'm sure we're going to discuss those challenges when we come alone. So there's a whole, whole kind of array of stuff that we do. But I only started in January just to, just to make that clear. Previous to that, I was director of a charity called Collective Voice, which is the National Alliance of Drug and Alcohol Treatment and Recovery Charities.

So Humankind being one, but others, listeners may have come across like Change, Grow, Live and Turning Point and We Are With You. So those charities kind of came together to set up a specialist. Policy vehicle, basically. So, so a structure to bring people together, which could engage with [00:02:30] policymakers around treatment and recovery policy.

And before that I was at a charity called AdFam, which is the national charity for families affected by drug and alcohol use. So yeah, about 12, 13 years in total of kind of policy systems, project management, leadership around, around drug and alcohol treatment recovery and associated. Associated issues.

But I think that's the sort of job history, but kind of by inclination, I'm very much trying to see [00:03:00] things in a sort of holistic joined up way and using some of those, I suppose, systemic approaches that increasingly we're seeing in policy and practice, I think, to try and move beyond the siloed models, which we've all, you know, been frustrated by and kind of come up against.

And certainly the people we're trying to make the system better for have, have lived those frustrations very frequently, too frequently.

Jo: Yeah absolutely. That's brilliant. Thanks, Oliver. Debra, I'll go to you now.

Debra: Thanks Jo, [00:03:30] and thank you for the invite. Good to be here today. So I am one of the research managers here at Homeless Link.

I've been working here for eight years and I lead our health inclusion research. So that looks like lots of working with local authority areas to support them to understand the health needs of people experiencing homelessness in their area. What kind of health needs people have as well as how people are using and able to access local services.

So, um, unpicking people's [00:04:00] perceptions and kind of experiences of health care and that includes a whole range of things. So we look at physical health and mental health as well as people's use of drugs and alcohol. So it's a really kind of broad picture of how health and housing interact as well. Um, and I also look after our national data set on the health of people experiencing homelessness.

So we produced a report, The Unhealthy State of Homelessness, about this time last year. Which, if I can [00:04:30] recommend my own work, has a lot of information in there, um, around this.

Oliver: You should recommend your own work, Debra, that sounds really important.

Jo: Yeah absolutely. Thanks, Debra. So, so this series of the Going Beyond podcast is aimed at frontline staff and managers to increase knowledge and understanding of supporting people experiencing homelessness who are using drugs and or alcohol.

So for this first episode, I wanted to talk about the trends and prevalence of drug and alcohol use. So I guess my first question is just [00:05:00] that, what is the prevalence of drug and alcohol use for people experiencing homelessness.

Debra: So if I can speak to that a little bit, Jo, the Homeless Health Needs Audit, which is the kind of methodology that we use to, to gather this kind of information, tells us that around just over half of people, so about 54 percent of people experiencing homelessness, use drugs.

And as a kind of general, general population comparison, that figure stands at about 8%, so really [00:05:30] really big kind of over representation, if you like, lots more kind of drug use amongst people experiencing homelessness, and that stayed fairly constant, so. from 2015 to 2021, and that figure stayed about the same.

And when we look at alcohol use as well, um, we can see that about 20 percent of people are routinely drinking above the chief medical officer's low risk drinking guidelines. And as a general population comparison, that's, um, [00:06:00] 24%. So much more kind of aligned with what we see. Yeah, in the general population.

So there's a, within this, there's a whole range of different ways that people might be using substances and ways that it kind of affects. at people's lives. Um, when we ask people their relationship with the drugs and alcohol that they use, 38 percent of people told us that they have or they are in recovery from a drug problem.

And 29 percent of people, so just shy of a third, told us that they have or are in recovery from an alcohol [00:06:30] problem. So that tells us, as well as the kind of prevalence, it tells us the impact that that's having on people's lives as well.

Oliver: Thank you, Deb. I mean, I could come in to, to, to follow that. I think those are really useful.

Kind of walk through of experiences of some of the people that we're, we're talking about and that we, you know, ultimately our organization serves. And I suppose my brain at this point always, always goes to the why question, you know, why people using drugs and alcohol? Of course, alcohol, alcohol is a drug, which we, we sometimes [00:07:00] overlook in society.

Why are people using alcohol and drugs in these ways? And I suppose. You know, a conclusion it feels like a lot of us are making is that these experiences are rooted in what I think of as kind of bedrock issues, you know, the issues that underpin the issues that underpin everything else. And they seem to be, uh, experiences of trauma, poverty and social exclusion. I mean, that's my conclusion. I'm not claiming that's [00:07:30] original, you know, obviously like lots of people are thinking that and try and read and get as many different perspectives as I can. But certainly I know in your world of homelessness, the move to therapeutically informed ways of supporting people and psychologically informed environments is in response to a wider recognition of the role trauma plays.

I think in my world, Uh, focus on adverse childhood experiences, going back in time, what's led to people developing an unhealthy [00:08:00] relationship with drugs or alcohol, because it's usually the case that that problematic relationship is a symptom of something which is a bit deeper for that person. It is very rarely the case that someone's led a happy life where they're basically content and happy with everything and everything feels in balance and they're socially connected.

And then a drug, a drug comes into their life as this kind of disturbing agent, which throws all their, you know, throws everything aside and disrupts their life and they end [00:08:30] up with a serious problem. I'm not saying that never happens, but if you look at, you know, at the big picture, the big data sets, there's very clear trends that it's people who have had those experiences.

And unfortunately, when you look at maps of, say, drug related deaths next to maps of, say, Uh, household income by decile, i. e. poverty, you

know, i. e. affluence and deprivation. They map on exactly to see the highest rates of drug related deaths [00:09:00] in northeast of England. I think I'm right in saying, and then you can put a whole series of maps next to each other, which look quite similar, even down to stuff like, you know, where the coal mines were in this country, because it's those areas which were de industrialized, which then had the mass unemployment, which then had all the impacts on people's livelihood and well being and community.

Which then saw the kind of impacts of heroin, particularly in the 1980s. So those, you know, all that stuff is still completely picked up in, in [00:09:30] data. And I think the, you know, Debra talked about the kind of the health inequalities lens is so important that we think in those terms, and it does feel like in society, there's a sort of bigger acceptance of the fact that there's like structural stuff that's not like made up of an individual well it's made up of all of us. We're all the system, right? You know, people are talking about structural racism. That wasn't in the public discourse to the same level, even just a few years ago, was it?

People talking about health inequalities, people are kind of attributing these [00:10:00] characteristics to systems and not just individuals. I think that's quite an important realisation because we have to work at this kind of. systemic level, the structural level, to reduce some of these really, really appalling inequalities, I mean, there's stuff like the, you know, the poorest areas of the country. If you happen to be born there, you're going to live 10 years less. And if you're, we're one of the richest part of the country, and the difference in healthy life expectancy is even more. It's like 17 years or something. I mean, that, that just seems [00:10:30] intolerable, doesn't it?

When we take a step back and look at that and those trends and those inequalities are unfortunately played out through things like homelessness and drug and alcohol problems, but also mental health and poverty and domestic abuse and involvement in the criminal justice system. So. I suppose it's trying to get that broader way of thinking about all these things as a whole series of interconnected life challenges, which are arising from these experiences of poverty and trauma and social exclusion.

But then the difficult thing as a system is, okay, how do [00:11:00] we actually organize ourselves to address them? Because, you know, if you've not got somebody decent to live, it's quite difficult to do the hard work around the drug and alcohol recovery and, and, and, and heart reduction as well.

Jo: Yeah Absolutely. And I, there's obviously so many sort of links between kind of drug use, homelessness, as it's all about interlacing, you said, of mental health, criminal justice, trauma, and it kind of, this underpins everything.

Um, I wondered, Debra, if there was any kind of [00:11:30] information from the health needs audit about mental health within people experiencing homelessness and how that might sort of connect to substance and alcohol use.

Debra: Yeah, absolutely. So as Oliver just so beautifully explained, that kind of macro systemic, all of these kind of influences working together.

It's very hard to look at, um, the way that people use substances is not in a, in a kind of, in a vacuum, I guess. And it can be really difficult. It's [00:12:00] very important to look at this issue, these issues on a systemic level, but it can be hard to pinpoint, I guess, what that looks like. And some of the data in the health needs order, I think, start to be able to do that a bit.

So we know if we look at the mental health data, There's quite a clear story that seems to come out. So, um, we've talked about the kind of level of, of, um, drug and alcohol use. 82 percent of people, so more [00:12:30] than four fifths of people that respond to the health needs audit have a diagnosed mental health condition.

So that's a huge number of people. And 45 percent of people, so almost half of the people that we speak to, tell us that they use drugs or alcohol to self medicate. So to manage their mental health, they're using, um, drugs and alcohol. And we see that, um, half of people with a mental health diagnosis want more support to manage their mental health than they're currently able to access.

So, a huge amount of, [00:13:00] of kind of diagnosed mental health, um, and a lack of support seems to be, I mean, we can't, this is correlation rather than causation, but there's a, there's a clear kind of through link seems to be there between a lack of support for mental health and, um, and use of drugs and alcohol.

Um, and as kind of we know in the sector as people start to use kind of increased use of drugs and alcohol, then makes it even more complicated to access the drug and alcohol support and the [00:13:30] mental health support as people can be kind of excluded bounce back and forwards from both. with a dual diagnosis, can't, kind of can't access your mental health support because you're using drugs and alcohol, can't access drugs and alcohol because it's an underlying mental health issue.

And that then just becomes more and more and more complex for that individual to navigate and is another example of how the system, um, the system doesn't work around the individual. The individual is kind of boxed out of everything. [00:14:00] And as well as that, we can just seeing the data, more evidence of that kind of complexity of the lives that people are living.

So we ask people about particular experiences of homelessness that they may have had. We ask people if they've rough, if they've slept rough. We ask people if they have stayed in a homeless accommodation service, if they have ever sofa surfed, or if they've ever kind of applied to the council as homeless.

70 percent of people have experienced three of these forms of [00:14:30] homelessness. So it's, it's not a kind of, it's a, there's a complex history to the people that we're, that we're speaking to. And we know also when we look at some of the other kind of, um, indications of, of multiple disadvantage or of trauma that people may have experienced in their lifetime, 22 percent of people have been a victim of domestic violence and 14% have spent time in local authority care and 25 percent of people have spent time in prison.

So I guess this speaks again to the complexity [00:15:00] of lives that, that, that people are living. Um, and another thing to kind of say on this, when we're kind of thinking about the systemic, um, or the systems that

people are interacting with is the importance of transitions kind of within and between these systems.

So for example, I was speaking to someone, um, a couple of weeks ago who had, um, really complex experience of trauma in their childhood, was a drug [00:15:30] user, had been in prison and in prison had received support where they had stopped using drugs and had started for the first time to engage with mental health support.

And that was resurfacing a lot of trauma and really challenging. But at that point felt really positive to that person, and they were then released from prison and lost that mental health support, tried to reconnect to mental health support in the community, but was ineligible or kind of fell between services and described that being the point at which they really needed [00:16:00] that the most because everything had kind of resurfaced.

And as a consequence of being unable to access that person and then started using drugs or alcohol to self medicate to cope with what was kind of coming up for them. And that's an example, I guess, of, of an individual case of where people, the, of where the individual systems fail to work together, or where we fail to kind of understand, we fail to follow the person, rather than, um, These bits of a system that [00:16:30] need to work together.

Jo: Yeah absolutely. Well said, Debra. So, I'm wondering, Oliver, actually, just to move on a little bit from this, if you could tell us a bit more about kind of the new government's drug strategy.

Oliver: Yeah, thank you. Um, thank you, Jo, absolutely. Well, we've got currently a drug strategy which is called From Harm to Hope.

And The drug strategy has a kind of 10 [00:17:00] year ambition to it, and it came with three years of funding attached to it. So, March next year will be the end of the second year of that funding. So there's a few interesting things there, you know, typically with government strategies, they are contained within the parliamentary cycle.

So it's rare to have something with a 10 year ambition, because obviously that would extend beyond the maximum amount of time which

a parliament could run for around five years. So I [00:17:30] think that's a real positive. Now an ambition is of course, not the same thing as money. But just having that as a statement of something which goes beyond the parliamentary cycle I think is good and certainly one of the messages kind of from the field to the policymakers and the politicians was always this stuff takes a long time because we're talking about trauma, you know, all that stuff that Debra said, we're talking about trauma, we're talking about people who are locked out of The, the goods [00:18:00] of life and the goods of society, which many of us are lucky enough to access to, so unpicking that and rebuilding lives and supporting and enabling people takes a long time.

So that is the current strategy. Now, taking a step back from that, I guess one of my pieces of learning in recent years is that all policy is made in a political context. And politic can be a fickle business. So we've got an environment, a political environment at the moment, [00:18:30] which is volatile, isn't it?

Basically, we've got a general election, which isn't going to be too far away. Any general election could bring the possibility of a change of government. We've got volatility in, within the governing party itself. And we've seen lots of ministers come and go in the past couple of years. And it's just the point in history that we're in.

So, cycles, peaks and troughs, but that does mean that some of those key political actors who were kind of necessary agents for that, um, strategy to be written have moved. So I [00:19:00] suppose that's just to say, it's fantastic that we've got a strategy. Any strategy is only good. As good as its implementation, you know, the best strategy in the world, who just sits there without any money and ambition and accountability and commitment and all that stuff, which the government and the civil services is working hard on without that.

It's kind of all for naught, isn't it? So I think the strategy is, is good and does a good balance, uh, does a good job of balancing recovery, ambitions for recovery and heart reduction, [00:19:30] meeting people where they are, which is particularly relevant to some listeners today. So we've had this big injection of money.

It's quite significant investment in the order of hundreds of millions of pounds. So this is a big injection of investment into drug and alcohol. Although it's an interesting thing we'll come back to later. Drug and alcohol treatment, but it's a drug strategy with a focus on drugs. Now, that's the good news I suppose, the bad news is the previous decade that we've [00:20:00] just come out of as part of austerity measures in terms of policymaking, local government was hit so terribly hard during those austerity years. And the amount of money which was taken out of local government is very, very significant. Now, the Health and Social Care Act moved the funding and commissioning of drug and alcohol treatment into local government in 2012. So that meant just as we were coming into local government from central, more central position. [00:20:30] The, uh, austerity was biting. So we, we had a really, a kind of stagnant decade of major disinvestment. And, you know, we can talk in this language of policy in December. What does that actually mean? Fewer services, reaching fewer people.

And we know that these services can deliver life saving support. So it doesn't, you know, it stands to reason that actually people potentially died because the services weren't there to meet them. So I'm just putting that in very stark kind of human terms. So the bad [00:21:00] bit is a lot of money was taken out of the system.

The good bit is that money is coming back into the system. But as ever, as ever, there's caveats because It's a three year funding commitment, which is subject to a process of spending reviews, which is where the government decides how it's going to spend, you know, money, our money as citizens often, and part of that kind of the social contract, how do we want to fund public services and all of that stuff that happens.

So all those arguments will have to be remade if this money is to continue and, you know, it's absolutely [00:21:30] vital that it does continue. So that is kind of the context. Now, I suppose listeners are saying, might be saying to themselves, well, okay, great. What does it mean for me, you know, in Lambeth or Hartlepool or whatnot.

Because funding and commissioning for drug and alcohol treatment sits at the local authority level, that is to say in your council, most likely. There is quite a high degree of variation, basically, in local authority to local authority. So, those local cabinets, those local politicians will have

taken different views during those austerity years [00:22:00] about where the money should go, what should be cut and what should be protected.

You know, one council might have a political make up dominated by a particular party, its neighbour might not. So, I'm just saying there's a lot of variation. Some commissioners. Go, go for a model of a kind of a big integrated model where a large provider could be the organization work for other others are available, um, comes in and kind of delivers most of the system.

Other commissioners more go for that sort of [00:22:30] alliance commissioning model or a mosaic or however you want to describe it, where actually they might be working with that complexity and that kind of place level, bringing in the local family support charity, the local domestic abuse charity, you know, the local recovery community working with people with lived experience to kind of stitch everything together.

So I suppose that's just a bit of a caveat for your listeners that the support that exists in your local area could, could differ somewhat. Um, but all that money that is coming in is funding [00:23:00] more people, you know, hundreds and hundreds of extra people have been recruited into the setting and this is a good news story and new projects are starting up and some of those things which I think we lost during the years of disinvestment like assertive outreach, which is particularly relevant to people experiencing homelessness.

Some of those things, you know, are being built back in. So there's there's green shoots coming back. But of course, the environment is Thanks. Thanks. post COVID, you know, still the after effects of COVID moving through the system, cost of living [00:23:30] crisis, you know, inflation was at 10%, at one point, that's just going through every single supply chain.

So providers are having to deal with that. And because this new money's come in after a decade of disinvestment, there's actually just not enough people to do the work in simple terms. So like most areas of health and social care. We can't recruit enough people. So that that is that is a challenge. But as I say, it is a good news story that we have got the strategy and this kind of political intent [00:24:00] and political interest.

I just hope that can be sustained after these initial three years of funding.

Jo: Yeah, absolutely. Thanks, Oliver. That's really useful. I mean, given what you've said, I mean, we've sort of touched on this already, but do you feel like the system is currently equipped to give adequate support to people using drugs and alcohol?

And I guess it would be good to touch on what does, what does adequate support actually look like?

Oliver: Yeah, really good question, Jo. I'll speak [00:24:30] briefly and pass over to Debra. Yes and no, if you'll forgive the, the evasive answer. We do have this quite, um, we do have this high level of regional variation. There is some absolutely amazing practice going on.

I'll give one example from the Humankind service, just because obviously they're the ones I know best. So in Leeds, we lead a big, you know, Leeds is a, is a big area, a big local authority, you know, lots of people who need support is right across the city. [00:25:00] And we lead a partnership there, which is not called Humankind Leads. It's called Forward Leads. Humankind is the lead partner, but actually we felt it was important that this, this service, this kind of living system, which was meeting the needs of the people in Leeds, had its own identity. So we've tried to put as much of that complexity of partnerships and pathways and all this stuff, Debra, details, that is confusing to people, to citizens that we're helping.

We tried to put as much of that [00:25:30] complexity as possible below the waterline. You have to use the classic iceberg metaphor. So we'll deal with that. Yeah, we'll deal with all that behind the scenes. That's not your job. If you need help, you just go forward leads. Great. I'll go to forward leads. So I'm sure a lot of people getting help from forward leads think that is an organization and it isn't.

It's actually the name of a partnership. But all that, all the complicated bit, all the wiring, if you like, we, we will handle with that. So we've tried to make it as simple and clear as [00:26:00] possible for people who need help that they can just go to this one place and they might see someone you. Who is actually employed by humankind next to

somebody who's actually employed by the local NHS trust next to someone who's actually employed by another charity locally.

They've all just got a T shirt on that says forward leads. So he's trying to, that, that bit where we're basically designing services, you know, I feel strongly that's our job to do that really well and try and wrap around people and try and reduce complexity and have as much of that as possible, [00:26:30] kind of, you know, below the waterline or under the hood or whatever the metaphor is, to make it simpler for people. And, you know, I think that principle can be applied right across the different domains of multiple need and to support for people, you know, with, with the dual diagnosis or co occurring conditions.

Jo: Absolutely. Debra, I didn't know if you wanted to comment on that at all.

Debra: Yes, just to, and I mean, I'm going to say a very similar thing, which is like on the one hand, And all the others. And, um, I guess to, to [00:27:00] add to what Oliver said, there is that kind of like brilliant multi agency kind of place based, um, model that we see in, you know, increasingly, I think.

And another kind of model as well, which is more of the kind of pathfinder navigator model. So whether that's in a housing first service and it's a housing first worker that is supporting an individual to access kind of multiple services or something more like that. the kind of groundswell health peer advocacy model that is really building a [00:27:30] trusted relationship between, you know, an individual and a worker where that worker is able to do all of that kind of behind the surface stuff that Oliver was talking about and kind of removing some of those barriers.

Um, and then the other thing that I wanted to, to kind of add to that is the increase or the kind of greater embeddedness of trauma informed and psychologically informed practices within, certainly within the kind of [00:28:00] homelessness sector and within the health sector more broadly and the kind of substance use sector as well.

So where people are engaging with services across a kind of. You know, that kind of system, wider system, if you like, um, people are better able

to be met where they are. Um, and there's a greater kind of flexibility there. But of course all of that takes the kind of resources and, um, individuals, which, you [00:28:30] know, as Oliver was explaining, um, in the context of many years of austerity is sometimes a challenge.

Oliver: I'd give a shout out as well to the Making Every Adult Matter, which, you know, I know Homeless Link's a kind of founding member of, and Collective Voice, the organisation I was director of, is also a member of. So that is trying to put into practice just what we've been speaking of having those two organisations, plus MIND for mental health, and CLINCS for criminal justice, to come together.[00:29:00]

And to look at a sort of integrated approach to policy and practice to enable local level, local systems to kind of. Do the work that we've just been talking about, actually integrate some of these things, get beyond the silo, you know, wrap around the human being, the individual, the citizen, and to try and get some of those kind of pathways improved.

And, you know, we've done some brilliant stuff. So yeah, just to plug to your listeners to kind of check out the website. And there's, there's loads of great resources and stories. So yeah totally agree.

Jo: So unfortunately, I think that's all we've got [00:29:30] time for. But thank you so much Oliver and Debra for speaking with me today.

It's been really useful to understand more about the reasons behind the prevalence of drug and alcohol use for people experiencing homelessness. But yes, thank you both for your time.