Going Beyond - Episode 2 Transcript

Jo: In this episode, we speak to Chris Rintoul, Head of Harm Reduction for the charity Cranstoun. We speak about how [00:01:00] harm reduction approaches compare to abstinence based recovery and how frontline workers can approach conversations with people who are using substances.

Hi Chris, how are you today?

Chris: Hi, Jo. Yeah, I'm great. Thank you. And you?

Jo: Yeah, I'm good, thank you. So thank you so much for being here today to record 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?

Chris: Well yeah, sure. My name's Chris Rintoul. I'm the head of harm reduction for Cranstoun, which is a third sector drug treatment [00:01:30] service provider, but we also do some other things as well within the criminal justice system with young people, with people who are experiencing homelessness. and the domestic abuse field.

Jo: Brilliant. It'll be great to hear a little bit about some of Cranstoun's harm reduction services.If you're able to sort of go through some of those, that would be amazing.

Chris: Well it's been a real pleasure for me to, to join Cranstoun in a time of a lot of change actually. Uh, so there was a change in CEO in around [00:02:00] 2020, and then I joined, uh, the following year. Um, Before then, I think Cranstoun had been a good but quite traditional service provider, very much tied in with kind of drug treatment and the recovery and abstinence kind of agenda that's come in the last 10 or so years, really actually since 2010.

But it also became aware that there were some, let's say, unanticipated negative consequences of that agenda, which has [00:02:30] flown through kind of, or which has flowed through drug treatment services across the UK in the last 10 years. And we, we kind of got to a point where we realized, well, the, the people that most need to be in

treatment and need some help and support around their, their substance use tend not to be, and that wasn't the way it was years ago.

Generally, there were people who stayed in treatment for quite long periods of time. In fact, in many cases for, for decades. And [00:03:00] that was somehow seen as a, a negative when this new agenda came in, which was about getting everybody off drugs. And what that did was lay waste to them and they exited drug treatment because these unrealistic goals were, were set for them and certainly not by them, and they were pushed to the margins. So treatment became all about kind of, you know, you know, get the people in and get them in the recovery. And, you know, that, that sounds and [00:03:30] first kind of hearing probably a really good thing. And it's not in itself a bad thing, except when you realize that for many people abstinence isn't the goal.

Many people want and need something a lot more nuanced and that provides them opportunities to reduce risk and harm over the course of their lifespan actually, and constant opportunities to engage in perhaps reducing their substance use or stopping substance use. So actually, perversely in a [00:04:00] way, if you really want to help people stop taking drugs, keep them in treatment for as long as you possibly can.

And that's in particular for those who are experiencing all sorts of other kind of additional issues, which I'm sure your listeners will be more than familiar with. People who are experiencing homelessness, people who've had a background in the care system. people who have had early trauma, people who have mental health challenges, and in fact probably got mental illness but never really diagnosed because [00:04:30] apparently you can't be diagnosed with mental illness if you use substances, which is news to me throughout my career because I've very much found that a lot of people I've worked with have underlying mental health challenges, if not mental illness. And they seem to be very, very closely correlated.

So anyway, to weighing the storage story a bit further forward again, so we, we kind of realized as an organization that we needed to go back to basics. We needed to get people back into treatment. And the way to get people back in the treatment is to make it attractive to them and to [00:05:00] allow them to be the authors of their own plan and to allow them to be in control of their own destinies and what the treatment goals

are, rather than forced upon them, which is what really has been happening for over a decade now. So in terms of practical, like we're working, the first thing is get people back in the treatment. But you have to, it's like, you know, regaining a contract. Once you've lost it in business terms, you have to put in several [00:05:30] times the amount of effort that you would have done, had you not lost them in the first place. I do not lose that contract in the first place. So the people that we most need to be working with, and I mean, we as in a treatment sector throughout the UK are those who are on the edges now and not really involved within drug treatment services. So you might find them within a wider population of people who are now in prison often, who experience homelessness [00:06:00] often, or rough sleeping in particular.

They might be in contact with sexual health services and various other ones as well, but they don't tend to have been recently within treatment services. So what we need to do is flip that around and make sure that we have people in that whole kind of palisade. So when you're trying to get people back into treatment, you have to go and work with the homeless services, you have to go and work with the sexual health services. You have to work within and outside [00:06:30] of the criminal justice services, particularly at the point of That's where you need to go. So that's a lot more work than it would have been had we not all kind of stepped away from this.

Really, people talk about chaotic. I'm not sure it's chaotic. I just think that, you know, there's, there are some people who are so broken. And so, um, who have so little hope and who. really have a very little faith and trust in us as workers, but also sometimes and very often [00:07:00] in themselves. So to be able to get those people engaged in the game, we've got to make an awful lot of efforts that we probably wouldn't have to have done.

Jo: Yeah absolutely. So this series of the Going Beyond podcast is aimed at frontline staff and managers to, to increase knowledge and understanding of supporting people experiencing homelessness who are using drugs and or alcohol. So for this episode, I wanted to explore the principles of harm reduction.

So I wanted to start by asking you, Chris, what do we [00:07:30] mean by harm reduction? And I guess what are the main principles of this approach?

Chris: What we mean by harm reduction is easier explained by example, I think, rather than sort of a list of the principles, which we certainly can go into as well. But if we think about harm reduction as being something which is primarily decided by the individual who uses a substance, the best example, and one which has come out of nowhere really, has been vaping.

You know, vaping hasn't, vaping didn't come from the [00:08:00] NHS, didn't come from anywhere except through the communities of people who, who use tobacco. And whilst vaping is not without its risks, they are unlikely to be anything like 10 percent of the risk of combustion of tobacco, and it's changed the whole way things have been done.

So those kind of hardcore smokers, and I was one of them, that weren't able to do it with the patches and with some medications here and there, have managed to be able [00:08:30] to make a switch to vaping, sometimes on a permanent basis, sometimes for a period of time, but other times just to manage their smoking, so that, you know, I don't have to go outside, be freezing, you know, trying to find a lighter or whatnot, you know, there's my vape, I'll use that instead this time. So vaping for me is, is kind of the, uh, the most interesting and obvious example of harm reduction, which is not associated with illicit drugs that we have in recent times. I mean, I find [00:09:00] it quite fascinating that there's so much hullabaloo about kids vaping in the toilets in school. Well, yeah, okay, it's probably not desirable. I mean, the stuff can be a bit stinky, to be honest. You know, those very sweet sort of smelling vapes and so on and so forth.

And certainly there are environmental issues, particularly with the single use vapes. But a generation ago, I, fellas my age, You know, we were all smoking in the toilets in school or smoking out the back or, you know, hanging around risky places, trying not to get found by the [00:09:30] teachers, you know, we had gone down by rivers and things like that when we were kids, you know, or we would have got kind of we would have been entering into kind of quasi criminal hierarchy by going and

buying single fags or single cigarettes in your kind of local fairly dodgy corner shop.

So that, you know, is what those young people now would be doing, was it not for vaping?

Jo: That makes sense. And a very current example as well. So I guess it would be useful for the listeners to [00:10:00] think about what might be the risks of promoting say an abstinence based recovery over harm reduction.

Yeah. What, what are the risks in saying, well, it's, it's all or nothing basically.

Chris: Yeah. Well, firstly. It has to be acknowledged that for some people the goal of abstinence is absolutely spot on and it really improves their lives and it really improves their family's lives as well. It improves their employment chances.

It improves [00:10:30] the opportunities that they have to move into a competition where there's less kind of stressors in the community, etc. around them. There's opportunities for people to rebuild their lives and to redevelop or make new relationships that they didn't previously have. So. You know, you know, recovery or abstinence is really means for for that group of people is a fantastic thing.

And I would not like to see that lost at all. But the [00:11:00] pendulum has gone way, way too far. And what I and others within Cranstoun are trying to do both internally and as kind of using our, our voices within the field is to rebalance that. Because the pendulum has just swung over to recovery too much. I sense in the last year in particular, a lot more people kind of standing up and saying pretty much the same thing now.

Whereas in the past, it was all kind of hushed voices. You know, you can't say that because you [00:11:30] might lose contracts with the kind of the commissioners, etc. If you, if you rock the boat or if you tell people the truth. So what I'm going to do now is tell you the truth. and say that for those who most needed our help and support, they have ended up outside of treatment and a significant proportion of them are dying.

People will tell you that it's because they're getting old, you know, the train spotting generation, they used lots of heroin in the 90s and crack in the [00:12:00] noughties and they're now in their mid forties, early fifties and so on and so forth. Yes, there, there is some truth to that, in particular for people who have lung conditions and one of the things treatment services is trying or trying to do is to improve kind of respiratory health with people who have been smokers of all sorts of drugs, including tobacco.

So that there's a challenge in and of itself. But my main concern is if you track the kind of the [00:12:30] the history of the recovery agenda and plot it against the number of drug related deaths in the UK, you'll see something very interesting. And you'll see that as this agenda has come in. And being the dominant modality of treatment over the last 10 or so years, drug related deaths have gone up and up and up and up alongside this.

So does that prove that it's caused deaths? I think that would be hard to say [00:13:00] yes to. But I don't think it's any coincidence at all. So one of the things for me, I live in Belfast now and one of the things for me has been interesting is watching what's happened in England before I started to work in England.

And like the friends of mine who used to be in drug treatment for years and were doing great and, you know, lived in England, happy with their drug treatment service or largely happy with it. Had plenty of access to injecting equipment if and when they decided to have it. I rattle at the drugs again, you know, [00:13:30] we're in contact with key workers and we're pretty stable.

They suddenly just start an accident, right? Just now I'm never going there again. I am not going anywhere near treatment. You get some 22 year old kid who sniffed a bag of coke a couple of weekends in a row and now it's decided they're in recovery and everything's great and, you know, I did it so you can, and not only did I do it so you can, but I did it this way, so you need to do it this way too.

And that doesn't wash with people who are, let's say, a [00:14:00] lot older, a lot more experienced and know that that's actually not the case. So, the drug related deaths are the things that really worry me. In terms

of, we're now presented with these things called nitazenes, which have contaminated a lot of heroin in England over the last, over the summer, really, of this year.

And then the autumn of this year, we see them. Of these nitazenes contained in all sorts of tablets, which are thought to be Xanax, but really aren't. They're probably [00:14:30] bromazolam, and a certain proportion of them, especially in Northern Ireland, seem to contain a nitazene. Anyway, back to Northern Ireland.

When you're looking at this across the water and seeing what was happening, you get a kind of slightly different perspective because you're not immersed in it. So we watched all this and we're going, what the hell are they doing? I mean, England was the home of harm reduction. It was where it started. In fact, Liverpool or Mersey, actually, more accurately, is indisputably the home of harm reduction.

And we kind of realized that for [00:15:00] whatever reasons, for an ideological, sort of, from an ideological drive, you kind of just got rid of it all. And it was sad to see. In Northern Ireland, we have a bit of a history of maybe resisting ideas that come from Westminster or from Britain generally. And we, we, we said, no, we're not doing that, that will not happen. And there's a good reason for that is because we actually very, in Orkney Island we came very late to the table in terms of harm reduction. So in England, Scotland, Wales, [00:15:30] for example, you would have had needle exchange services that they were called then from about 1988 and they were implemented by Thatcher's government, which is quite interesting, you know in and of itself, and that's a different story on a longer one, whereas we only got them in 2001.

So we're 13 years later. We also only got substitution treatment, which is usually thought to be kind of methadone or buprenorphine in 2006. So in 2010, 11 and [00:16:00] 12, when this new wave of kind of recovery was sort of spreading throughout England, this new policy, you know, um, we were looking back and going, look, we remember how bad this was.

You know, we are under no illusion that this is not going to work, you know, and we know exactly what it's like when you don't have good options in terms of treatment. You don't have injecting equipment, which is fit for purpose and you don't have options in terms of substitution

treatment. And so that was the reason for [00:16:30] fairly vociferous resistance to, to that.

And actually in the period of time where in England, a lot of the kind of old school outreach type services. We're being dismantled and the best became kind of community engagement opportunities, really not real old school outreach. We were building ours and continuing to build them. Uh, so we could see quite clearly, you know, the difference between what was going on in England in particular and then what we were doing at that time in Northern Ireland.[00:17:00]

Jo: Well, it's been a bit of a journey then. I think it'd be important to think about, again, about the risks of sort of promoting this abstinence based recovery in like settings such as hostels. So for, I think we spoke, we spoke before about this, where potentially some support accommodations might have drug policies that say.

You know, if you're, if you're found to be using, you could lose your accommodation, I guess, like, what, what risk does that now then bring up for that individual?

Chris: Well, this is [00:17:30] quite a complex area, in my opinion, anyway, and one that I've kind of worked in as well, because not only did I work within kind of drug treatment services or, as we call them then, addiction services, but I'd also worked with very closely alongside our kind of homelessness or housing support type services.

The first thing to say about. accommodation services for people experiencing homelessness and that have either, you know, currently kind of using [00:18:00] drugs or have in the past, is that you need a range of different types of hostel provision. And I know I'm just going to use the term hostels because it is much shorter.

It's unsupported accommodation. Hey, I'm aware that it's not necessarily the best term, but forgive me just for brevity, I'll use it in this occasion. So you need a range of different hostile policies when it comes to alcohol and drug use. And some of which you need, you need protective spaces for people who are perhaps post detox and [00:18:30] rehab and need some support in a supported setting for maybe a couple of years or

maybe longer before they might return and be fully integrated back into a community or a new community.

And so they definitely need that supportive environment where abstinence is desirable. And where everybody's marching in the same direction. So that's, that's a good thing. And it's not something I want to see us lose a provision. The problem is a lot of supported [00:19:00] accommodation services, certainly in the past, you know, have tried to squeeze 100 percent of people into that kind of 10 percent of beds, so to speak.

So what happens to the other 90 percent who aren't? Seeking abstinence or overtly aren't seeking abstinence, I suppose, is that they have to pretend that that's what they're doing, because to do anything other than that, to use substances, puts you at risk of losing [00:19:30] your accommodation. And what we do is we, we create a perverse system then, and we create a perversion in it ourselves, because we're not realistic and we're not saying, well, look, there's an awful lot of people who either aren't willing, maybe aren't ready or aren't able to become abstinent. And I'll give an example of why I think it's happened in the, in the beginning, really.

And I think it's down to a moral thing, actually. If you think back in the past where the state had less [00:20:00] of a role in society and it was more run by the churches or religious institutions of the time, a lot of this kind of accommodation for people who are homeless was kind of warehouses. It was kind of, you know, large dorms full of usually older male drinkers, actually, you know, or men who become homeless after break up the relationships, you know, at home, etc. You know, the wife just got fed up and couldn't stick him any longer. Out you go, out in the street. So, now I'm going to find myself down [00:20:30] in this night shelter and it's run by Church X, right?

And Church X says, well, we're a very decent God fearing people here, you know, and you know, because we're so good and kind as to provide you accommodation, you know, because that's what God will, God's will for us is something like that, right? You being a very nice little boy and don't you'd be doing any of those naughty things that we don't like, you know, like drinking or taking drugs and so on and so forth.

So it was, it was [00:21:00] conditional acceptance. But if you think about it, it's quite the opposite, really, the, the religious concept of, of grace, which is unreward or undeserved kind of acceptance or, or favor. So, they kind of set that up, and I think we've still kind of got a legacy of that running through quite a lot of our accommodation services.

You know, people may argue with me on, on this point because they'll might look at it at a more legal perspective, and there is that perspective as well to cover off, and I'll do [00:21:30] that. So legally, there are people who are pretty concerned about providing accommodation to people who might use something which is illegal within that setting.

That is not actually the case. You do have to do things to prevent people continuing to do something which is legal and, and laid down by the Misuse of Drugs Act. And so there's a couple of examples. You aren't allowed to tolerate as a hostel or a accommodation provider or a [00:22:00] business provider, somebody smoking opium or cannabis on your premises, if they smoke heroin or crack, it's got nothing to do with the Misuse of Drugs Act bots or whatever. You may want to deal with that for other reasons, but under the Misuse of Drugs Act, it's not a problem. People necking tablets all day long, it's not a problem in terms of the legal risk to staff. It's certainly a risk to them and the use of illicit drugs is also a risk to them because they might become, they're liable and they could be prosecuted if the [00:22:30] police decide to bust it, you know, bust into the hostel, etc.

And Northern Ireland about 2008. Well, it was 2008. The organisation I worked for at the time, it's rebranded, changed the name, but it was called Council for the homeless Northern Ireland. And I was tasked with delivering a conference, I think, from memory. It was called Accommodation for Injecting Drug Users, which is a bit of an old, old school term now, but it was 15 years [00:23:00] ago.

And we were finding people that could not get into accommodation services because they were known to use heroin or they thought to use heroin. And a lot of the problem was that, you know, people just said, no, I don't use drugs at all. No, not me. Oh, I did that years ago. No, I haven't touched that in years, you know.

Whereas in reality, they're out the back alleys injecting, using puddle water and, you know. In places which were very, very [00:23:30] unhygienic and highly risky. And we also had a, a risk, which was reasonably still current. It wasn't quite current at that time, but people remembered that there were a number of people who were targeted by, we would call organized crime groups now, used to be known as paramilitaries, et cetera, and they were.

Heroin use was not tolerated, uh, at all, and sometimes the policemen exacted on people who used drugs, especially heroin, included [00:24:00] actually being, being killed. So, you know, people knew it was not a safe place to be found out using heroin. If you were outside and somebody came across you and that information came to a particular organisation, you might become serious risk and you'd probably be, uh, at the very least you'd be exiled from the area that you come from, and then to try and get into hostels, you had no chance if you disclosed drug use. So people didn't disclose it. But what happens then is [00:24:30] secretive drug use is so much more risky. And that's what I was saying about this perversion. You know, it kind of creates the risk. People think it's a way of managing risk, it’s actually a way that you increase the secretiveness. And if you increase secret drug use, you increase risk, increase risk. You increase risk in particular of overdose, but you also increase risk of kind of, you know, rushed injecting. In a bid to not be discovered by staff, and that leads to more blood, it leads to more kind of [00:25:00] wounds.

It leads to trying to inject into places where it's probably easier to do it quickly and in a discreet way, and that's normally groin injecting. But groin injecting is so much more risky than other types of injecting. But by comparison, and I know you have another speaker within this podcast series, Kevin Fleming, who's probably going to cover this in more detail, but in comparison to be the arms, somewhere in the arm, anyway, not, not the armpit, but somewhere down the arms, between the elbow [00:25:30] fold and the fingers, whilst not without risk, a lot less risky than injecting in the groin.

So if you create the circumstances in which people have to inject quickly and in more risky places, you're elevating the risk. So what we did after that conference in 2008, we decided to work together with a number of statutory and voluntary agencies and find a way through this. To be able

to provide accommodation for people who are known to be active, ongoing [00:26:00] heroin users.

Northern Ireland has a separate piece of legislation over and above what you have in the UK. That's called the Criminal Law Act. And actually from the Misuse of Drugs Act perspective, there were no real issues with accommodating this group of people. But we did have potential issues for, for staff under the Criminal Law Act.

It's a bit of a long story, but basically what it means is, in Northern Ireland, if you know somebody's doing something which is illegal and would be an [00:26:30] arrestable offence and you don't tell the cops, then you're liable and the cops can come and bust you. And the real purpose of that legislation, actually, when it came in in 1967, was to curb what they call terrorism.

And remember, troubles didn't really actually start in Northern Ireland probably the next year, but in full by 1969. So a piece of legislation was never intended to be able to be used. In terms of accommodation for injecting drug users was potentially [00:27:00] applicable to them in this context of the criminal law act.

So we had to find a way around it and we worked with the police, the, we call the housing executive, the housing executives do. Equivalent to local authorities in England where accommodation is kind of provided through the health service, a range of other organizations to find a hostel, which would be prepared to allow a proportion of its bed space to be used by people who are injectors, not one person has died in that facility ever since. [00:27:30] In that, in that part of the facility. And yet before that, people were dying all over the place.

And that was before we had a real influx of heroin. It's really occurred around 2014. And Belfast has become a more normal Western European city with what happens in normal Western European cities, including heroin and cocaine.

A lot of drugs that we probably previously wouldn't have had. Available or readily available or as readily available. So, I think that's testament to [00:28:00] sensible drug policies and accommodation settings. So, just

to recap, I'm not saying that we shouldn't have options based facilities, but really. It's 10 percent of the overall stock.

The other stock needs to be in these kind of everything from what I've just described, what we set up in Belfast through to, you know, that 10 percent where it's for people who are, you know, abstinent and want to remain abstinent and need some sort of protected space to do that. You don't need every single bed in every [00:28:30] single hostel.

To be what I've described what we did in Belfast, but you certainly need 10 or maybe 20, perhaps 30%. And the only way you'll ever find that out is by being open with people and saying, Look, you know, what is it you need from us? You know, do you need us to help you to support you to abstinence? Is that what you want?

Or do you want, you know, what Helping support to remain alive so that you don't overdose here. You know, talking to people about, you know, [00:29:00] Naloxone. Talking to people about having their own rescue plan. You know, I've done some work recently over the summer around the medicines with some of the harm reduction leads from the main kind of drug treatment service providers like CTL, Turning Point and Humankind, and we decided that what we really need to do more than anything else in response to the zines is to get people talking about their own rescue plan or what I call the stay alive plan. So it's [00:29:30] only that individual person who uses substances that knows, you know, where and when and how. you know, that substance use is going to occur and therefore when, where, when and how and who might need to be involved in preventing that episode of substance use contaminated by awful potent drugs becoming a fatal outcome.

So we've, we've worked hard and that's one of my encouragements, I guess, for the homelessness sector is to think about using a staying alive plan. Don't call it an [00:30:00] overdose plan, just call it a staying alive plan or a safety plan. Certainly if you contact any of those, any of our four organisations that I've just mentioned, ourselves with CGL, Turning Point, Humankind, we will, we will provide you those and you can then use it as part of your care plan with people who you provide accommodation to and use substances.

Jo: Yeah, and I mean, my next question was definitely going to be about kind of how can, like, you know, frontline workers and managers in the homelessness sector can promote that the harm [00:30:30] reduction approach, but also kind of have those conversations with the people that they're supporting, I guess. For frontline, just to sort of end this discussion, kind of for frontline workers, how might it be best to approach that conversation about having that safety plan, or kind of talking about the different ways that they could reduce harm to their use?

It might be quite, for someone that's maybe new to the sector, that might be quite difficult to have those conversations. So I guess, what's a good way of starting that, starting having that [00:31:00] conversation with that individual and making sure that it's them that's deciding on on their care and their plans?

Chris: Well you have to state it to begin with, right? But you also have to remember that probably by the time you're working with somebody, they have come across a load of different services in the past, some of which might have told them exactly the same thing. We are not going to punish you if you take drugs, right?

And hopefully that has been the case, but sometimes it's not. Sometimes people then, [00:31:30] or certainly they either are punished whenever their substance use is, is. finite, you know, or they think that they've been punished as a result of their substance use being found out. You know, in some ways it doesn't matter, it's the perception that's the more important thing. So there's a bit about trust there and being able to eyeball people and say, look, we are really not going to push you. punch you out of here if you, if you're using, right. There's certain things we can't tolerate. You [00:32:00] can't be smoking weed in your bedroom or anywhere else within the place, you can't be smoking opium. Well that's fine because you can't get opium really in the UK or very rarely anyway and you can't be selling drugs or sharing drugs or whatever, right, okay.

And those are reasonable and they are legal expectations and that's the, that's the kind of the bottom line I guess. So when you have that conversation with people and say, look, other things we will work with you about, you know, then we have to expect that there's a degree [00:32:30] of maybe suspicion.

Maybe that's not all that true. I'll wait and see. And what I think you have to do is develop a culture where people are able then to turn around and say, look, I'm way off the maroon here. Come 10 minutes time. See when that happens, nobody dies. No one dies at all. You know, you can completely stop deaths, deaths from overdose anyway, in supported accommodation settings if somebody can [00:33:00] have that very simple conversation with you. You go, bye, right, dead on, be back in 10 minutes. Come up to see you. Fine. If there's a problem, you know about it. Some people can die in less than 10 minutes time, but generally it takes a minute or two to cook up in a minute, maybe to get into a vein or something like that. You know, you, you're unlikely to find the person dead within 10 minutes.

If you go up beforehand and rap on the door, you're probably going to be said, look, could you leave me alone [00:33:30] a bit here? I'm struggling, you know, I'm trying to get into my arm or my leg here, you know, just. Give me, give me another five minutes. And when people say that, well, you know, they're alive. That's the thing, you know, uh, you know, any form of response from the person, including, will you F off and leave me alone, you know, means the person's very much alive and therefore they are not overdosing at that time.

Anyway, so that's kind of part of the answer to it. Another part of the answer is to recognize [00:34:00] that people living in hostels who use drugs are part of the response to overdose. So sometimes I've heard stories, I don't think I ever came across it here in Northern Ireland, but I definitely heard stories about it from wider afield that if somebody identifies to a member of that somebody else is not well, which could be code for possibly having an overdose, and that [00:34:30] person is found to have been having an overdose, and they might, might be dead or they might be alive. Irrespective of that, the person who alerted staff who did their best to try and make sure help got to that person so that they could quickly determine, administer naloxone CPR if required or a recovery position, right?

So they've done their level best to try and stop an overdose. Um, and they experienced some form of punishment as a result because the thought will be then, well, [00:35:00] you must have been there at the time. You were in each other's rooms, you know, you're in his room or he

was in your room, you know, one of you has walked out, you know, and the other one is turning blue here.

If that person's punished, that's the end of your overdose trust and strategy. It's done. So what I, what I would do is say to people, look, thank you so much for what you did. What you told us yesterday kept Bully alive and Bully's alive today because of you. You know, we are so grateful to you. Thank you.[00:35:30]

That just changes everything, man. You know, and it's kind of, you have to flip things around in an intelligent way to work out how are we going to stop this. And for the homelessness services in the UK, because of the madness of this kind of recovery era, you're dealing with the people that Are they excluded and aren't the people that are still sadly in treatment?

We want to get them back and we want to work with you as a collective of English drug treatment service providers. We want this group of people back, but we need [00:36:00] to keep them alive and we need you to do that before we can get them back.

Jo: Yeah. Absolutely. Unfortunately, I think that's all we've got time for, but thank you so much for speaking with me today, Chris.

It's been so useful to understand kind of the importance of using a harm reduction approach to save lives, and sometimes those riskiness behind the abstinence based approaches. But yeah, thank you so much, Chris, for your time.