Going Beyond - Episode 4 Transcript

Jo: In this episode, we speak to Ellie McNeil, Chief Executive for YMCA Together, and Kevin Flemen, [00:01:00] Founder and Manager of the Drug Awareness Service, KFX. We speak about drug use in supported accommodation settings, and the importance of policies in this area.

So, welcome to Kevin and Ellie. How are you both today?

Ellie: Good, thank you.

Kevin: Good, thank you.

Jo: Great. So thank you so much for being here today for the Going Beyond podcast. So to start us off for the listeners, could you tell us a bit about yourself and the work you do? Ellie, I'll go to you first.

Ellie: So I'm Ellie McNeil. I'm chief exec at an organization called YMCA Together. We're based in [00:01:30] Merseyside and we work with people experiencing challenging times in their lives. So that could be homelessness, domestic abuse, drug and alcohol issues. Or poor mental health and it's mainly through a kind of support and accommodation model using a psychological Framework called cognitive analytic therapy.

I've been in my role for nine years And I've been working in the voluntary and community sector for 20 years supporting people who were really experiencing multiple disadvantage.

Jo: That's brilliant. Thank you so much, Ellie. Kevin, I'll go to you now.

Kevin: Hi, I [00:02:00] manage the Drug Awareness Service, KFX. I've been running that for 20 years now.

We provide website training, literature, resources, and a collection of other tools to help both drugs services and non drug specialists do their job well. Before that I used to work at, for Release Drugs, Drugs and the Law Charity, and prior to that. Big issue as a drug and alcohol counsellor and street outreach worker for Turning Point.

So starting off with street homeless populations and now working much more on trading and policy.

Jo: Amazing. Thank you [00:02:30] so much. 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 episode, I wanted to talk about substance use in supported accommodation settings and the use of policies in this area. So I want to start by asking you both about the often high prevalence of drug use in supported accommodation and why you think this might be.

Ellie: I mean, I guess, [00:03:00] I guess it's both simple and complex, isn't it?

You know, people use drugs to, to feel good or to avoid feeling bad. And, you know, a lot of the people that we're working alongside in our services have experienced significant adversity in their lives. And the, the kind of healthy aim is to, is to often to kind of avoid those feelings of, of difficulty, of trauma, of disconnection, of relational challenges.

And, uh, and drug use is, is great for all of those things, you know, for often the people that [00:03:30] we, that we work alongside, it's a, it's a social connection, as well as, kind of an escapism out of the realities of their life. For the people that we support often who have had significant, you know, trauma or early life, early life difficulties who haven't received good enough care, their personal capital, their social capital, their community capital is obviously, is often lower than people who have had those good enough early life experiences.

And, [00:04:00] and, and drug use is one of those, and alcohol use, one of those ways of coping for people.

Kevin: It's a tricky question in some respects, because when you look at it from the point of view of drug use in housing, it doesn't necessarily represent, or it doesn't actually give a clear picture of drug use amongst people who are in accommodation need, because if you've got housing providers who have policy which is exclusionary to people who use substances, then it undercounts.

So some of the research that was done a while ago, especially looking at street homeless populations, [00:04:30] highlighted really, really high levels of substance use amongst people who were. rough sleeping and on the streets and lower levels in hostels because it undercounts because people are excluded. Just to add to what Ellie was saying, for some people substance use might have been a push factor into homelessness, so some people have ended up losing accommodation because they were evicted, losing accommodation because of relationship breakup linked to substance use, fleeing domestic violence linked to substance use, so substance use could be a push factor resulting in homelessness.

And then the [00:05:00] flip side of that is Especially in terms of street homelessness. Once homeless, I need substances to cope with my experience of being homeless. So it becomes a cyclical thing in that it might have been a push factor why I ended up homeless. Once I am homeless, it's likely that if I was already using drugs, i'll add more drugs to my repertoire, so I might have had relatively low level substance use prior to becoming homeless and once homeless my drug use is likely to escalate.

So for example, Central London. If you end up street homeless, you're going to encounter quite a lot more people injecting, for example, [00:05:30] crack and heroin. Stoke on Trent, you're going to encounter high levels of monkey dust use amongst homeless population.

Other areas may be high levels of spice use. So drugs that I might not have been exposed to before becoming homeless, my repertoire, my range, and my problems will escalate quite rapidly. And in turn, my access to services will be reduced, compounding the problem.

Jo: Thanks both. I guess a follow up question from that is that, why, why do you think it might be difficult for someone who is in supported accommodation, like a hostel for [00:06:00] example, to engage with some kind of drug support.

Ellie: I mean, I think often our, our, our systems and services aren't geared up to meet the needs of the people that they support.

And, you know, examples of that might be, you know, somebody who's got an issue around kind of neurodiversity, who really struggles to attend appointments and they're given half nine appointments in the morning. You know, those, those kinds of examples are real examples of our services and our systems not working for the people who need them.

You know, we, we have specialist [00:06:30] services. based in our, in our hostel accommodation. So we, we work to kind of break down those barriers, but I think for a lot of provision that doesn't, that still, that still doesn't exist, that kind of close partnership working. And, you know, people have different priorities, don't they?

So if you're in active drug use, your priority is. To not withdraw. It's to, it's to top up. It's to not feel, feel the effects of withdrawal. And so your priority to attend an appointment across town where you've got to get two buses, you know, [00:07:00] stop, you know, it's, it's just not a priority for people. And you can absolutely kind of kind of understand that.

And, and I think that services and systems need to be much more aware of, of the complexity of the people that they're supporting to be able to offer. Um, a broader range of access in, into their services in order to, to support people and kind of meet them where they're at.

Kevin: I think for services that aren't as advanced in their policy and practice as for example Ellie's service, the, the problem's very, lots of the same things that Ellie [00:07:30] says, but there's an extra element to it, which is that I can't acknowledge my drug use because I'm not meant to, I wouldn't have been able to access that service if my drug use had been acknowledged at the start.

So I might have almost got into the service, not not on false pretenses, but by downplaying the nature and extent of my substance use. So, for example, we'll have situations where a housing provider might be offering. Say for injecting a needle exchange equipment in the building, but that service isn't being used and they're puzzled as to why it's not [00:08:00] being used But that's because there's a mismatch between their policy and practice and the harm reduction that they're offering So they're kind of they're saying on the one hand no drugs No drug use you'll be excluded and then puzzled why people aren't making taking

access to the service So for some services the starting point is much much lower the barrier is is that we set up a barrier by saying you shouldn't be doing this and Dot dot dot.

But if you are, we're here for you. And then puzzled why people don't take advantage of that service. People who [00:08:30] use drugs are generally fairly naturally distrustful of people in power. And so if there's a power dynamic at work here, such as you can evict me, I will probably downplay the things that would get me evicted.

Jo: Yeah, that's a really interesting point. Thanks, Kevin. I guess following on from about the policies, I wanted to ask, why do you think supported accommodation settings need drug and alcohol policies?

Kevin: Without wanting to start ranting, I just find it incredible that anyone who offers housing doesn't have a drugs policy.

I don't understand how a service [00:09:00] can operate without a drugs policy, because if there's no policy in place, there's no structure, no understanding either on staff or service user, what the rules. are and it becomes arbitrary about how people are treated. It becomes arbitrary about how workers treat residents and it becomes arbitrary as to which, how, how different residents are treated and that increases massive levels of discrepancy in how people engage with the service.

So regardless of what the policy is, whether it's a lower tolerance policy or a higher tolerance policy, [00:09:30] organisations have to have a policy and every now and then I get calls from people saying, Oh, we need a drugs policy. And it's like the gentle noise in the background is me slightly banging my head against a table.

You're going, you realize that now, but it's, it's such an integral part of having a policy. We can talk about what the policy looks like. But it's such a fundamental aspect of, and it does still, it does still amaze me that people sort of say, Oh, do we need a policy? So yeah, it's, you have to have one to make it clear for everyone how the service operates and also for people to [00:10:00] be clear, is this the right service for me?

Because I need to move into accommodation and I need to know what that accommodation stance is on various things, partly because

otherwise you're setting me up for a fail. And if you have a clear policy and say this is our stance on A, B and C, I know quite clearly and people referring me know quite clearly that that service isn't right for me and that reduces the sense of compounding failure, that I will get evicted or excluded because not, not because of my failure, but because the service [00:10:30] was the wrong service for me at that point in my treatment journey.

Jo: Yeah completely. So, I wonder what, what a drug policy might look like. Like you said, it doesn't need to be sort of always high tolerance.

It could be low tolerance. So it'd be interesting to, to see, to hear from you, kind of what, what does that actually look like in terms of the policy?

Kevin: The people who ask for help with their policy, what they want it to look like is two sides of A4. And they want it to be very short, and they're inevitably disappointed when [00:11:00] it ends up being very long and lots of sub clauses, and they then go, can you shorten it a little bit? So the first thing is, there's a real mismatch in expectation. And policy, there's, there's a difference between policy and practice. And one of the things we spend quite a lot of time doing is, is helping organizations understand that there's a policy, your stance on things.

And you'll practice how you will respond to things. And partly the reason why it becomes quite a big document is it has to cover lots and lots of different situations. It has to [00:11:30] cover things like how we're going to work with illicit substances like alcohol, how we're going to work with vapes, how we're going to work with borderline substances like CBD, how we're going to work with prescribed methadone and prescribed Valium, how you're going to work with illicit substances.

And once you start to add all of those elements into it, you sort of realize quite quickly that you can't simply have a, a single line that says, no drugs, no drug use, which is what a lot of policies start off looking like, because then you sort of, someone awkward like me comes along and say, so that's your policy? And they go, [00:12:00] yeah. And we go, okay, so when you say no drugs, does that mean I can't have a cup of coffee? And they go, of course not, that's not what we meant. So that's where you have to start. breaking it down quite systematically. And then

what needs to happen is that policy becomes something that actually works on a day to day basis.

So what one of the conversations I often have with organizations is the policy looks like how you would like to work with your residents. So the right policy is how do you want to work? How would you like to respond to this situation? Not how do you think you [00:12:30] ought to, because, misunderstanding, how do you think you, how would you like to work with this situation?

And part of the aim is to then write the policy that reflects how you, how you'd like to work, and part of the role of that is then to say, well actually that we can't do because it wouldn't be lawful, that you can do. And that's how policy ends up emerging.

Ellie: And I think, I think the things, the thing for us that's really important is that it isn't a policy that just sits in a folder on an IT system somewhere never to be seen again.

You know, I think that the, the most important, [00:13:00] part is that it's visible and it's usable and it's, and it's available for people as well.

Jo: I'm wondering, obviously we won't be able to go through exactly what a drugs policy will contain, but I'm wondering some of the sort of the key elements. that organizations should consider when, when writing this policy?

Kevin: My starting point when we have conversations around policy is what does the organization's aims look like? Because one of the risks about writing [00:13:30] policy is that you You give someone a policy that they think is the right one for them, but it starts with a discussion on who do you work with, what are their needs, what are their aims.

So, for example, a, an organisation that's working with people who are coming from the streets, still in active dependency, still actively using, possibly injecting needs, a radically different policy, for example, to some, uh, a foyer, for example, young person service, which doesn't expect to see such high levels of injecting, for example, or services taking people who are currently abstinent and wish to, and a, a, [00:14:00] a striving to remain so.

So different, the, the policy, the starting point with the policy is it reflects the aims of the organization. And aims are partly based on who you work with, what you're commissioned to deliver, and the, the resources and assets that you've got. So that's, that shapes the aims. What I've ended up doing a lot of is the policy ends up incorporating three or four different kind of key elements. One of which is making sure that it's lawful.

Making sure that it meets duty of care to [00:14:30] everyone, residents, staff, neighbors, and then really important is safety driven. So over time, in the way that a draft policy has ended up really, really evolving in that it's now when, when I'm asking people to think about how do you respond to this situation or how do you respond to a, in a policy, it ends up saying, how do you make the situation safe? In the short term, the medium term, the long term, we can talk about how you put support interventions in place, but those support interventions might come later on. [00:15:00]

So policy actually becomes make it safe now, stabilize the situation, and then look at what the support interventions are. Um, As, as time, and I've been doing this now for writing policies and helping people with policies for 20 years, my own understanding of what it involves keeps evolving and changing over time.

And so now, for example, much less around wanting to say what's the sanction for that breach and much more, what are you going to put together a constructive response? to help that person who's not [00:15:30] on the right side of the policy. How do we work together to get back on the right side of the policy? So, policy is a kind of, it's, it's reflecting all of those things.

It's safety, it's law, and it's also a reflection of the aims of the organisation. Yeah, and I,

Jo: Yeah, and I guess, in terms of actually the creating of the policies. It'd be interesting to know about best practice for that, because for me, what comes to mind is that, you know, we should be involving people that are accessing the service in the creation of that policy.

And I wonder how we could meaningfully do that.

Ellie: I [00:16:00] mean, we, we certainly do that. And I mean, we've had our policy in place and, and kind of tweaked it over, over the years, but we, We do that through our, through our kind of co production forum. So, uh, that would be the way that we would, we would kind of work to develop the policy.

And like Kevin said, you know, we've got, we've got a plethora of different services and, uh, but the importance for us is that our philosophy is right around our policy and that it reflects the values of the organization. So we have services that support people [00:16:30] experiencing that are coming directly from the streets, that kind of first step from the street and right through to rehab.

And so, you know, obviously each of those different points, the expectation around drug use and alcohol use and illicit substances, unlicit substances. will vary per service. And I think that for us, the consultation has to consider all of those different things so that we're engaging with people who are, who are coming in, having just been rough sleeping, but we're also consulting with people who are in our rehab about what [00:17:00] feels safe for them and being able to support people in different ways in, in our rehab that the other rehabs maybe wouldn't.

Jo: Yeah, absolutely. Kevin you touched on this slightly but I'm wondering what the legal complexities of drug use in hostels are and so how can hostels actively allow drug use but be within the scope of the law?

Kevin: The the legislation is archaic and there's one area of law within the Misuse of Drugs Act [00:17:30] which has implications for housing providers which is a specific bit of the Misuse of Drugs Act called Section 8 which creates obligations on people who manage premises to restrict specific activities such as production of drugs, supply of drugs and archaically the smoking of cannabis on site.

It doesn't however create implications around other behaviors such as injecting. So what that does it creates a legal loophole or [00:18:00] ambiguity depending on your perspective on it and that legal loophole says that while the person who's for example injecting heroin in a

building is breaking the law, the person managing the building isn't breaking the law.

We can't incite it, we can't encourage it, we don't, we don't necessarily like it happening, but through careful use of language we say something like, we don't condone that behavior. But we are able to tolerate that behavior. That's the loophole within the Misuse of Drugs Act that has existed since the Misuse of Drugs Act was [00:18:30] written in 1971.

And it's the one, to be perfectly frank, that I've kind of mercilessly exploited for the last 20 years to create a model of high tolerance housing. The government had a go at closing down the loophole 15 years ago. backed off from that because housing providers said if you close this loophole you jeopardize high tolerance housing models and so the loophole has been preserved as a matter of policy.

It's, it's a, it's a conscious thing now rather than an unconscious thing. The government backed off from that [00:19:00] decision and it's a useful loophole. Interestingly. Though it's a little bit controversial. The legislation says smoking cannabis, so in theory at some point as more and more people vape cannabis, that issue might fade into not being quite such a big thing.

But that's the loophole that we've used.

Jo: Yeah, that's really interesting and very useful to know, I'm sure. So I wanted to move on now about kind of how we actually use these drugs policies and in practice, like, what does that look like on the [00:19:30] ground in terms of, for example, high tolerance hostels? So I wondered if you'd be able to share anything, sort of, from YMCA Together's approaches, Ellie?

Ellie: Yeah, so I think the first thing is that, is that good policy, and Kevin's helped us to write off, so we have a good policy, you know, gives us safety and consistency and boundaries and so the first thing within that is to make sure that we're communicating the policy, what it means, so every staff member through their induction is trained on our drug and alcohol policy, they're also trained in harm reduction.[00:20:00]

Everybody that comes into the service has an easy read guide to the drug and alcohol policy and it understands what that means for them in the service. So straight away we're setting that, that kind of premise for people to understand what the expectations are. And then practically, you know, we, we take a harm reduction approach to our work, but we also support people.

Towards recovery as well. And I don't think those two things are mutually exclusive. And I think a lot of people will, will, will, will think that they are, but for us, they're certainly [00:20:30] not. So we have needle exchange in, in our homeless services. We have, that's really well accessed, actually a really well accessed needle exchange.

We also work in partnership with our prescribing partners. And so they're on site. In all of our homeless services, and they are, we're getting people's methadone or subutex delivered every day. We support them, um, through our, our controlled drug policy, which sits alongside our drug and alcohol policy. We support them to then be able to take their [00:21:00] prescription every day, so that helps them to stay stable within their script, and, and inevitably reduces their, uh, street drug use.

And then, And then we also have the things that kind of boundary us and make sure that we're, we're staying within the law and keeping us safe. So we have a controlled drug log, we have our serious incident reporting procedure, you know, we don't tolerate dealing on our, on our sites. And so if somebody is dealing, we have a policy called working relationally to avoid eviction, we would talk to them about the consequences of that.

We would [00:21:30] put in a relational support. plan with them. And if that continued, we would report that to the police and we work really closely with our police colleagues for anybody dealing in on or around our services. And I think it's really important that we have, have those boundaries and those kind of that kind of clarity in place for people, because that's what keeps people safe.

That's what keeps our staff safe. That's what keeps our premises safe as well. And then the other expectation is around, you know, supporting people to make sure that they're disposing of their [00:22:00] works correctly and the needle exchange part of it helps us to do that and

making sure that people are kind of bringing their bins down and that they're keeping their rooms free, free of sharps as well.

Jo: Yeah, that all sounds really brilliant. Thank you for sharing. I wonder, is there, are there challenges in kind of, implementing some of the drugs policies amongst staff teams? I know things like that can take a lot of time, but how can we kind of overcome those challenges of, I don't know, potential resistance, potential just lack of [00:22:30] knowledge, awareness?

Ellie: Yeah, I think, I think training and development is part of it. So the, supporting people to understand the philosophy behind harm reduction, but also our psychological framework. We use an approach called cognitive analytic therapy. It's a relational approach. It helps us to think about actually what sits underneath for people.

So what does somebody's drug use, mean for them? What that might, what, what might that mean in terms of their behaviors? What might that mean in terms of their, their ability to engage? And we [00:23:00] help people to think about actually what somebody's healthy aim around their drug and alcohol use. So, you know, is that, that They are wanting social connection, or are they not engaging because they're, they're avoiding being hurt or they're avoiding being pulled into a relationship where they might need to trust someone.

And that feels really difficult for them. And so that psychological framework and training in the reflective practice helps people to think about. Uh, about somebody's drug and alcohol use in a different way, you know, for us, it's a [00:23:30] symptom of something. So what, what is, what is it a symptom of? And how do we help our team to understand that and think about what they bring into the therapeutic relationship and what they bring into, into the work that they're doing, but also how do we as services and as systems more broadly, do things differently in order to better meet the needs of the people that we work alongside.

Kevin: I think it's a very slow process getting an organisation to move from their existing policy to possibly a more inclusive or a higher tolerance policy [00:24:00] and sometimes it's two years more of work and it involves having to work with the whole organisation from residents to trustees and at various points there's going to be various pushback.

I think when I started doing this work, I was much more evangelical and tried to win the arguments through the moral righteousness of the argument. And as time has gone on, one of the ways through it is actually I'm become much more pragmatic and success tends to work through logical. [00:24:30] Approach to it for me, which is saying, for example, I hit resistance with an organization wanting to put sharps boxes in and what we have to unpick is where that resistance is coming from, how much of it is moral antipathy towards sharps boxes, how much of it is misunderstanding about the law.

Or how much of it is just, we, we don't like them and what I'm trying to help an organization understand is, for example, you'd say, so, you know, you work with people who inject drugs, they go, [00:25:00] yep, we know that, and we go, so you owe yourself a duty of care to your residents and everyone else, and we see that logic of that argument, and this, and the understanding then is that if you don't put sharps boxes in, make them available, you you haven't fulfilled your duty of care and that will get the trustees jumping a lot faster a lot of the time than the moral imperative might.

So what I'll end up is different messages for different people but recognize it's a very slow process. Me shouting at people saying you ought, you must do this, [00:25:30] it's right. It doesn't get the result a lot of the time, explaining how it works, why it works. But the biggest part of it now, because this has been going on for 20 years, is the number of organizations who have started working like this, successfully work like this. And when you go to, it's shattering some of the illusions around what a high tolerance environment would look like, because it's not workers stuck to the wall with large green needles, and drugs everywhere, and [00:26:00] crack pipes at dawn. And it should never be that because high tolerance doesn't equal chaos.

And so, a lot of the time it's a more honest organization. It's an organization which has greater levels of transparency, hopefully works towards greater levels of trust between people who use the service and people providing the service. But, being able to see that in the real world for an organization, so someone being able to visit, a person who's contemplating that change.

for someone like myself working as [00:26:30] a trainer and consultant being able to say go and visit this project have a look at them chat to the organization and then coming back and going i can see how it works there we might not do it exactly the same because that was tailored for that specific situation but i can see how we do that journey but i don't expect the journey to be fast.

Jo: Yeah that's really interesting thank you Kevin we have a couple of minutes left so i wonder if um It'd be interesting to hear about how we can support individuals who are using drugs in their accommodation, especially sort of [00:27:00] when there's others using around them as well, and thinking about sort of those good practice approaches like trauma informed care.So I wonder if you wanted to comment on that, either of you.

Ellie: I mean, I think, I think that the most important thing is that, uh, is that we have hope for every person that we, that we work alongside. And that hope comes in, in many different forms, but I think that, that visible recovery is really important.

And, and so we employ a lot of people [00:27:30] with lived experience in our services, but we also have pathways into recovery services for people. So I spoke about having kind of our prescribing teams on site, but we also have a service called Rise Recovery, which is our rehab service. We, we recognize that that's been going for about five years, but what we found was that the transition from, um, kind of high tolerance homeless host into, uh, detox and then into rehab felt like a really large transition for people, and so we [00:28:00] work to create a service that we call prehab that's, that opens this week, actually. And it's a stepping stone between high tolerance, high drug use, um, services. and, and rehab. And so that will be an eight week residential offer for people and to kind of step in between. We're really fortunate that we've been able to do that.

And I recognize that in lots of areas, particularly with the kind of chronic underfunding of services and the. And the under, you know, not just underfunding, but under resourcing as well [00:28:30] of services and systems that that isn't possible everywhere. But I do think there are ways of kind of tiering your services and offering people, um, different, you know, kind of levels in the service of, of, of, of kind of what they're

working towards, but I do, but I think that the presence of people who are in recovery and the acknowledgement that harm, harm reduction and recovery. are, are, are a spectrum of support for people and that they should go hand in glove. They shouldn't be two [00:29:00] different philosophies, I think are really important in, in, in, in kind of helping people to, to see a different future for themselves and moving through.

And then I think the other, the other part of that is that, is that. Psychological understanding for people as well. And that actually over time that if we do things differently as services, if we work in a different way, that over time, there's a drip, drip, drip approach of change in the people that we work alongside.

And, and more and more over time, what they can do is that [00:29:30] they can start to do that change for themselves. And that kind of development of self efficacy and, uh, and belief in themselves are really, really important for that.

Kevin: Completely agree with everything that Ellie's. I've just been saying, especially the, the implication of resources and the idea, one of the challenges, not everyone has that spectrum of different housing provision.

The risk is that people get locked into a service, it becomes comfortable and change becomes less and less easy to achieve. The other thing I just really want to stress at this point, because it's the [00:30:00] key message that's going, I'm delivering to all the training that's happening to housing providers at the moment, is the need for keeping the game on harm reduction at the moment because of the critical shortage of heroin in the UK, and the contamination of heroin streams with super strong opiates and the role of housing providers and the need for housing providers to be absolutely on their game at the moment in terms of overdose awareness, overdose response and supporting residents. It's, this is probably the most important period in [00:30:30] terms of death reduction.

Obviously want people to work towards achieving recovery however they experience that, but in this window now. It's prevention of death because of the huge seismic changes in the street heroin and the street benzo market and the, the, the spectrum of use that Ellie's talking about

absolutely, and we're starting right at the start of that spectrum, we're going to see absolute skyrocketing death rates and housing [00:31:00] providers, especially high tolerance housing providers are absolutely going to be at the cutting edge of that, unfortunately. So their role and the importance of that role cannot be understated.

Ellie: Yeah. Thank you. So important, Kevin. I think that that is, is so important to know, um, regardless of, of your levels of tolerance in your service.

that your staff are trained in harm reduction, that they carry naloxone, that they know how to, how to use that, because that, you know, whether you condemn or condone, um, drug use, um, that [00:31:30] will, that, that has the potential to save someone's life, doesn't it? And I think that that is the most important thing that if, if anything is taken, kind of taken away from this podcast, regardless of your levels of, of tolerance, is that, is that staff are trained well and that they have that ability to administer naloxone where they need to.

Jo: Yeah, completely agree. Unfortunately I think that's all we've got time for, but thank you so much Ellie and Kevin for speaking with me today. It's been really useful to understand more about drugs policies for support and accommodation, and what this looks like in [00:32:00] practice. But yes, thank you both for your time.