Going Beyond - Episode 5 Transcript

Jo: In this episode, we speak to David Gill, founder of Risk and Resilience Training and Consultancy, and Ben Davy [00:01:00], Reset Outreach and Referral Manager at Providence Row Charity. We discuss the complex barriers to treatment services.

The importance of understanding the cycle of change and the role of peer mentors in providing support to people using drugs and alcohol. Hi, David, hi Ben. How are you both today?

Ben: Very well, thank you.

David: Hi, Jo. Yep, fine, thanks.

Jo: So thank you so much for being here today to record 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? David, I'll go to you first.

David: Brilliant. Yes. [00:01:30] Thank you for having me. So my name is David Gill. I started off in this field, working on the frontline, doing a variety of different things, largely for substance services, and in the last five years, I've been doing my own thing, an organization called Risk and Resilience, where we do a lot of support with organizations around drugs, alcohol, trauma, take trauma informed approaches and yeah, just.

Doing whatever we can really so yeah.

Jo: Brilliant thanks so much. Ben. I'll go to you now.

Ben: Thanks Jo, and thanks for having me. Hi, my name is Ben Davy. I [00:02:00] am currently based at the Dellow in East London working for a charity called Providence Row and I manage the drug and alcohol service here, which is called reset outreach and referral service So we go out into the community and we try and meet individuals with drug and alcohol need.

And if and when they are ready, we refer them, um, do a supported assisted referral into treatment. And we also run a harm reduction room having a needle exchange service, which is based on site. We are based at a homeless day center. Where rough sleepers can come in for [00:02:30] breakfast and for lunch, and to access other support programs that we have on offer here, including psychotherapy and housing support and educational support.

I come from a background of using services, both substance use, mental health and homelessness. And I've kind of worked and volunteered around the sector for the last couple of decades in different roles and responsibilities. But yeah, here I am today. Thank you.

Jo: Thank you so much for being here, both of you. So this series of the Going Beyond podcast, it's [00:03:00] 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 explore change resistance and the use of peer mentors in providing support. Now I want to quickly touch on the title of this episode being change resistance, as I think it's important to think about language here. So we're not suggesting that all individuals who are using drugs or alcohol need to change, and rather that change resistance indicates that there are often challenges for [00:03:30] individuals with engagement and support.

And obviously change can mean very different things to different people, and I think we'll speak more on that later. But I want to start by asking you both, what might be the challenges or barriers to someone engaging with drug treatment services?

Ben: I'll kick off on that if you don't mind, David. I think the immediate obvious challenge is the fact that a lot of people either feel like they don't want to make any changes or stop taking drugs and alcohol, and if they do feel ready to make any changes, they may not know.[00:04:00]

What type of support there is out there for them or where to access that support and they might not have any expectations from what that that provider may have to offer, so as opposed to try and finding out all of that information is a bit more difficult than not changing and just

continuing to take drugs and alcohol like you kind of have been in your daily life for so long, so I think that the fact that most people might be quite naive to treatment and it's [00:04:30] quite of an effort, and the whole fear around change, I think just humans don't like change anyway.

We get in our little comfort zone, and we know what we like, and we know how we like it. And if anyone suggests making just the slightest little changes to that, we're immediately quite guarded. So, I understand the change resistant there. And the fact that also If anyone does have motivation to change or feels a motivation to change, it's a kind of short lived thing.

So, you know, it'll soon pass the same as any kind of [00:05:00] craving might soon pass whether you intervene or not. So I think the whole resistance bit is it's something new. People are generally quite naive. And even if they're not naive and it's not new, it's a big challenge to just think about changing yourself and changing your entire lifestyle.

Because I think if ultimately you want to make a long lasting, successful, healthy change to your substance use patterns, it's going to require a lot of effort. And I think most individuals know that, and they probably [00:05:30] don't have a lot of faith in the support that may be offered to them along that journey.

And they might feel that that journey is something that they solely have to do by themselves, so it's quite a lonely journey. And even though there's elements of truth within that, um, trying to make somebody aware that there is a support network that will be with you throughout this journey and it may change.

The people might come and go and some may be helpful and some might not be helpful, but all of [00:06:00] this is going to be new and it's going to be quite scary and the easiest option is to opt out. So I think that's probably the biggest challenge.

David: I guess from my perspective. One of the biggest challenges that we see across the country is, is around the services themselves, the resources and the funding available to them.

This is a, unfortunately, a field that has been chronically underfunded and under resourced for many, many years. And I think it's been highlighted by the fact that we just don't [00:06:30] have enough time. We don't have enough resources for, to support the people that are in need. And all the things that Ben said there, you know, if you're feeling all of that, adding to the fact that you might go into a service for help and be told there's a waiting list for the support you need or treatment, or due to the numbers, the only option is group work rather than one to one work.

These can be barriers to just getting that basic support. And I think again, services have been set up to, to work with specific types of substances, different [00:07:00] specific ways for many, many years. And it's largely based on the fact that they're still. Following the 1971 Misuse of Drugs Act, you know, all services are designed to respond in this, this way, you know, this very old fashioned 52 year old document is driving everything that we do, which, which primarily looks at things from a criminal first perspective, whereas I think what we've all recognized here is that it needs to be a person centered support perspective and therefore it's a huge thing because everything [00:07:30] that goes with drugs there is that element of stigma and shame because of it's an illegal activity and it can be in just a huge amount to push people away and there are a lot of you know, really passionate staff members in services who want to support, want to help, but they just, they just don't have what they would like to support people because again, the systems just aren't there, chronically underfunded, under resourced, and the need for alternative approaches, unfortunately, just aren't, again, aren't prioritized.

You know, we had our new drug [00:08:00] strategy almost two years ago, December 21, and again, despite that promising new funding services, there just hasn't been enough in terms of forward thinking and new approaches. So when you're talking about the challenges just from the very individual walking in service, there are challenges, but there are wider issues as well that just compounds that, that challenge for, for the individual and also the staff to be able to, to get that job satisfaction to be able to help and support people.

Jo: Yeah absolutely. There's a huge, huge amount of sort of challenges and [00:08:30] barriers for kind of engagement. And I think we spoke

before about often treatment services being based on an abstinence model. And like you said, which really criminalizes those that are using.

Drugs. I think we also spoke before a little bit more about kind of, you know, like the safe consumption rooms and things like that. And I wonder if there's, if you could touch on the different kind of approaches to harm reduction that would work, that could work better.

David: Well, I guess the, the bottom line of harm reduction is, is about it's keeping people alive, keeping people safe to [00:09:00] be able to make positive changes and decisions in their life that's right for them.

And sometimes the very nature of harm reduction is at odds with our policy around drug, drug use. And you mentioned there about safe consumption room or overdose prevention centers. They have many names in Glasgow are in the process of piloting one as we speak. And I think the joy of things like that is it's to take away the shame.

The stigma for the individual because you are giving people a safe place and showing we value you. We want you to, to, to [00:09:30] be safe, to, to feel connected, to not feel that you have to go out on the streets and use and feel that shame and stigma of doing it. And I think it's, it's, it's encouraging people to look at things in a different way.

But again, I think harm reduction approaches like that out there for a lot of people, particularly for our policy makers, and they see it as, rather than reducing the harm, which is what these things are about, they see it as promoting or condoning drug use, when it is absolutely not the case.

So when you're talking about harm reduction as well, [00:10:00] you know, one of the best approaches that we have is things like naloxone for the amount of opiate related deaths, so that when someone is overdosed from opiates such as heroin or fentanyl or nitrosines, you can administer naloxone, either injectable or nasal spray, and it keeps people alive, keeps people safe.

The government are backing that, but that is one of the few things they are backing and other things are just unfortunately seen as more of a, uh, a high risk strategy that I guess they just don't want to be taking at this current time.

Jo: [00:10:30] Absolutely. Ben, I didn't know if you wanted to comment on that at all.

Ben: Yeah well I mean. I think, yeah, policies and the law do kind of hinder our work to some extent, but it has been changing slowly. I think public perception has been changing slowly. I think the legal kind of stance on drug users is being a bit more empathic in recent years. It's still got a long way to come, but if we look at the 50 years that [00:11:00] the drug policy has been around, some attitudes towards drug use have changed within those, but it's kind of a little bit at a time.

And I do remember when naloxone kind of first became available, almost like two decades ago, but it was so difficult to get to the client. It needed a prescription from, you know, a prescriber for that particular patient. But to try and get that individual into the setting to be prescribed is one massive hurdle to get [00:11:30] through forward anyway. But us as, as workers and as frontline workers, we weren't able to carry naloxone. We weren't able to have that. It was only prescribed for the individual. And those are the individuals that were in treatment. So I run a needle exchange here for individuals who may or may not be in treatment.

I'm not going to discriminate there, but for most of them, I'm going to say they're not in treatment for whatever reason. And we're probably the only health provider that they have contact with. So we're the ones that see them [00:12:00] regularly and we will be offering them support, not just with trying to get clean injecting equipment, but we will also offer kind of other harm reduction for them, whether that's around wound care or around sexual health, or it's around BBVs, they know that we are supportive. We're nonjudgmental. So they will come, they'll engage and slowly and surely we build a relationship. They engage more and then they're more open to the effect. They did the offers of support that we have without having that these kind of people would not be [00:12:30] coming into contact with services.

So there would be, you know, there'd be an unknown risk. I hate labeling people at unknown risk, but, you know, they would be there. And that poses a risk to themselves and everyone else in the community. And, you know, for me, it's the risk that they will never be able to be empowered to decide whether they want to make any changes or not.

At least the clients that we see on a daily basis, whenever they're ready to make any kind of change, they know they can come in for a conversation. And they'll also, you know, if they don't want to make changes [00:13:00] themselves, they'll have concerns about other people within their, their little peer group or their communities and their families.

And they'll raise those concerns with us because they trust us and they know that we can help and assist. But something like naloxone is a big. Well, we're commissioned to distribute naloxone across the borough to clients and to, and to professionals. And we offer training for that as well, which isn't too long.

It's only an hour in which we sandwich a lot of kind of overdose training in there as well. So we're upskilling and acknowledging people that previously wouldn't. [00:13:30] I've considered that they needed to know this. Now I feel that the professionals I'm working with in the borough are aware that they will come into contact with vulnerable people and people that may be at risk of overdose, maybe not in their place of work, but at least on their way into work.

I mean, it's quite visible, the homeless issue within every borough in London is quite visible and the drug and alcohol issues that surround that are also quite visible. So the fact that now actually we're all taking a bit of responsibility for that and we're responding to that in a [00:14:00] in a positive way, not a punitive way, is, you know, something that wouldn't have happened 10, 15, 20 years ago.

So the fact that it's happening now is positive, but it could, it's still got a lot of room to progress and become a lot more acceptable and part of people's daily lives of acceptance. So I don't think we can afford to live in denial ourselves anymore and turn a blind eye where other humans are suffering and suffering so sort of openly in our lives, in our communities.

So we have a duty, a care and a [00:14:30] responsibility to, to respond appropriately to that.

David: What you, what you said there, Ben, about how you are there for, for people, which is fantastic. And like, when people come to you, they get that help, that support. But I think the problem is, is if an individual

needs support and they go to maybe mental health service first or their GP or a hospital, all it takes is one member of staff who doesn't have that knowledge, who has chosen to not.

Skill themselves up about naloxone and they can provide really unhelpful [00:15:00] advice, you know There is still the amount of places that can just default to drugs are bad. Don't do them You know It's a very condescending tone to take with people and that one message can do a lot of damage For services like yourself because no matter how wonderful you are if someone's gone somewhere else Unfortunately, professionals can be all, all, all be seen the same and it can greatly affect what we do.

So I do agree that things are changing, which is fantastic, but there is still a heck of a long way to go.

Jo: Yeah, absolutely. [00:15:30] So I think we spoke before about this, but a lot of drug use is kind of, it's based on a cycle and it's often for dealing with people's traumas, people's experience and people become kind of stuck in a bit of a pattern and a cycle of this.

So I was wondering. how we might use things like trauma informed care and motivational interviewing to support people who are using drugs and alcohol. How can we use those techniques?

David: So, so I work with a lot of organisations about taking this trauma informed approach and I think [00:16:00] what that helps people to understand is that the behaviours that we see are often the result of a lifetime of adversity and challenges.

And I think again, You know, maybe my own knowledge, my own experience growing up was, you know, often the behaviours that we saw were just treated as what we see. They are a drug user. They are homeless. And I think very unhelpful approaches, and I think what approaches like trauma informed care helpers do is understand that Why?

Why are people there? [00:16:30] Because people don't wake up one day and think I want to be an addiction. I want to be homeless. I want to have mental health problems. They stem from somewhere. And I think

sometimes understanding that the behavior that we see are the sign of something deeper, you know, that that was even that, as you mentioned that the terminology of change resistance, you often hear people say phrases about service users like, Oh, they don't want to be helped.

They don't want our support or they're beyond help really negative phrases that don't help anyone. And we don't always see it from their perspective of [00:17:00] why do they not want to help? Why are they struggling? Why are they struggling to engage with those? And I think what trauma informed care can help us do is to understand the why, which is powerful.

And I see it in staff themselves when they're trained in these skills for them to start to question, not just the work moving forward, but maybe previous stuff they've done and thought, well, is the phrase, you know, the words or phrase I've used in the past, have they been helpful? Have they been supportive?

When you build on things like trauma informed care with appropriate tools and techniques like motivational [00:17:30] interviewing, they can be incredibly powerful. MI has been around for, like, 40 years. It's existed for a long time. And it's like anything, we learn a little bit more about it, we modify, we tweak it in a slight different way.

And there, you know, there are techniques within MI, like the AWES technique, you know, open ended questions, affirmations, reflective listening, summaries. The idea is just reinforcing that the person in front of us is the expert, and we don't need to have all the answers, and asking curious open questions, truly listening, [00:18:00] summarising what that person's saying, allows that person to feel valued and listened to.

So I think trauma informed care, motivational interviewing, all of these things can work in harmony, but we've, I think a lot of services have to see the value of this, have to see the investment and not see it as just ticking the box, but as a, as a, I guess, how do I put it. As an investment in their staff as you know, really seeing that continued professional development as well.

Ben: Yeah. I think motivational interviewing [00:18:30] is probably is the best approach for a clientele group, I'd say for both substance use and, and sort of mental health, particularly where the two meet and you get like the dual diagnosis issues, rather than just sort of taking like a traditional therapeutic stance of any other kind of choice, if you like, because this, it breaks down the, the expert and the patient, the professional, you know, with motivational interviewing, it makes the, the client themselves the expert in their own right.

And it [00:19:00] allows the professional to almost. Form a relationship where both people are, I wouldn't say equals, but they're both together on a journey working towards the client's goals. Whereas it's not the patient trying to please the therapist or the therapist trying to prove their theory over, you know, the patient who's just another, another trauma or another symptom.

So we kind of strip away all of those labels and you are actually looking at the human being in front of you that hopefully you can empathize with and you can understand that what their goals are and you will work [00:19:30] towards those things. Together, you're not going to let somebody wander off aimlessly with a plan that is either going to succeed or not succeed to do by themselves and then let you know how that felt, because that's not that productive and it's not that useful for that individual.

It's much nicer and kinder, I think, to sit there and work through something with someone. And the fact that a, you know, you're going to do that differently with every person that you work with says that, you know, you, you're going to be client centered. And if you're, you know, you're [00:20:00] nonjudgmental and you're, you're, you're displaying all of those things and you, you don't need to have years and years of reading books about other kind of psychotherapists and their approaches and what goes on with the human mind You just need to listen to the person in front of you and and hear what what they're trying to say And I think that's what's missed a lot in treatment in the past is is is the voice of the client the individual So I think you know now the voice of the individual is [00:20:30] is it is at the forefront you know of successful treatment for clients that maybe aren't that routine or that stable to be able to commit to sitting in a room for 50 minutes at the same time on an individual day in the same room from week to week for

months and years to be able to achieve what they need to achieve. They can actually be a bit more sporadic and with every interaction, every interaction counts, whether that is a five minute interaction or [00:21:00] an hour and a half interaction.

You know, and whether that's every day or whether it's every month or just it kind of meets and suits the clients patterns you you you be that flexible and I don't think sort of treatment systems were set up initially to have that Flexibility to allow for the chaos of a lot of the the clients that we say

David: Yeah and I guess your point there about the flexibility again.

This has been for me, one of the biggest challenges for treatment services is that you have systems like ND TMS that records things [00:21:30] and they demand treatment processes and programs and formal assessments and staying in treatment, dropping out of treatment, but which in itself seems counterproductive.

You know, we're, we're dealing with often quite a chaotic user group and, and, you know, to have in our heads that this is going to be a linear process that you come for a formal assessment, as you, as you said, then you sit down comfortably for an hour a week talking about that. It's not going to work for a lot of people.

And I think this is where the danger is, is that a lot of people have tried to get help and support. [00:22:00] And because they can't fit into these really rigid models, they end up dropping out and they end up getting that odd bit of support and help in various different areas. But when you're talking about things like prescribing, opiate substitute prescribing, you have got to often take uh, go through and jump through the hoops and make sure you're able to do X, Y and Z before you can get that medication that you really need.

And I think there's something about our treatment system that really needs to be looking, looked into to understand that that's coming in from our [00:22:30] perspective. The argument is often it's to do with risk management, you know, when providing treatment and particularly clinical treatment. I do think there is an element of flexibility that could be explored that unfortunately perhaps isn't to the level that it should be.

Jo: Yeah I think this kind of goes back to what I said about sort of change meaning, different things for different people and, you know, just because you didn't tick that box in that, you know, that you've, you know, you've taken your, your substitute, you've taken your script, it doesn't mean [00:23:00] that a change hasn't happened in your life.

And, and I think that's really important and that services need to consider that. You know, adopt that flexible approach.

Ben: And whilst you do run the risk of being quite discriminatory really, because you're discriminating against a large number of people who maybe just don't fit your treatment model or your treatment system.

And the easy way to get rid of those is to do the whole, well you've missed an appointment, you didn't answer the phone, I sent you a letter and an email and you didn't respond, so I'll close your case. So, and then to restart that [00:23:30] whole journey, this is the massive barrier that I face with a lot of my kind of people that are on and off script and they're on and off script for lots of different reasons and that's generally the chaos of their lives.

They would be a lot more stabilized if they were on a consistent prescription, but if they are not getting their appointment letters or their appointment text reminders or they're not engaging, they're not fulfilling the engagement requirements of the service, then the service will close their case.

And to start restart that is such a long journey that the clients just may just [00:24:00] give up on the motivation of the thought of it, even though, despite they know they're dead, the the benefits that they would get from engaging with that treatment actually getting that all set up in the first place is too much of a headache for them.

There's too many barriers and too much stress when they've got too much stress already in their lives. So they'll go for the most immediate like stress reliever or coping mechanism that they know, which is going to be drugs and alcohol. So it's just half the time, a lot of, you know, the triggers and the motivation to use might stem from the actual [00:24:30]

frustrations that they have and the barriers that they're facing and just trying to get the right, correct support.

Jo: Yeah. Yeah, very true. I think it was, Ben, we spoke previously about kind of for frontline workers having the importance of having knowledge surrounding the cycle of change. So knowing where that individual is at and then thinking about what's the kind of most appropriate support to give at that moment in time.

So I don't know if you could maybe sort of go through some examples potentially.

Ben: Yeah. Well, I guess, I think Because I spent quite a lot of time working with 16 to 25 [00:25:00] year olds in a previous role and, you know, trying to explain to people that this population aren't really ready for treatment, or if they are, it's still going to take a bit of work and there's only a small amount of them that are going to actually require some kind of substitute prescription because they're drug of choice, there isn't an alternative, a safe one that will be prescribed.

So most 16 to 25 year olds aren't going to be opiate dependent or they're not going to be alcohol dependent as yet. So to try and force them into a treatment system that's not [00:25:30] appropriate is, they're just going to say, they've declined that offer. But if they are, and if they are pre contemplative about their drug use, so their drug use is fine, there's nothing wrong with it, they're not experiencing any issues or any problems, then, they can't see any motivation to change their drug use.

And if there is any, any motivation to change their drug use, it's normally I'll try something new or I want to try other drugs that are probably going to give me a different effect or a better high than what I've already experienced [00:26:00] in. So with that kind of perspective, and you realize that they are pre contemplative, then it's really you know, rather than looking at in changing a behavior or cutting down the amount or the frequencies that they're using, it's more about providing the right advice and information so that they can make the right informed choices when they do decide to experiment with a new substance or try a different high.

And, and, you know, talking to them about the impacts and that they can actually see here and now [00:26:30] rather than the long term like effects that might happen if they continue to use their, their, their substances in that way. Cause, cause they're not really going to see the value in the potential risk of lung cancer 20, 30 years down the line when I'm only 16 years old now, I'll keep smoking now and welcome those kinds of consequences later on.

But it's more important if. If I'm going to then mix with half a dozen friends at a party and then there's a new substance being passed round, rather than going [00:27:00] in blind and taking the, in a full risky situation, it's better that they know a bit more about the differences between types of drugs and what to expect, what the effects are, and what's the safer way of taking those drugs. So, you know, having a little bit first, not using alone, not mixing drugs, like all of these kind of key kind of messages that you get from a harm reduction approach is the things that you should be offering and the things that they're going to listen to a bit more rather than asking if they want to go and see a drug counsellor, or asking if they're ready [00:27:30] to do a reduction plan or get on a prescription, or, you know, even go to a treatment system where there's people with bigger drug problems that may well influence these guys to develop even worse sort of drug issues.

So, yeah. Yeah, I think, I think knowing where somebody is at and somebody won't stay where they are when the cycle of change forever, they'll move around and zip in and out and they'll be on the, on the, on the cycle in different stages for different substances and different behaviors all at the same time.

And if they [00:28:00] have an understanding of that as well, then that also helps them kind of plan things and prepare things and it also helps them be a bit more informed and and knowledgeable about how they can perceive their own drug use and how they can vocalize that and express what's going on for them in their world and maybe have a look at the underlying motivations factors for them to use in the first place and for young people a lot of the time it's, it's, it's, okay, it's not always deep trauma.

A lot of the time it is they just want to have fun. So if they [00:28:30] just want to have fun, let's try and make sure that they're equipped so they

can within their own limits. have some choice and control where it is still fun and they don't end up in some kind of nightmare situation where they either wake up in a hospital themselves or they have to call the ambulance or unfortunately they have to then go and say goodbye to friends at a funeral which does happen and I do find looking at two different treatment models there isn't really scope within an abstinence model to to work with people to minimize the risks of these happening because there's [00:29:00] the kind of ideology of If you don't do it at all, then there's no risk of that happening.

But then it's the kind of attitudes where people don't, don't accept drug use, don't talk about drug use, that there's too much stigma, too much taboo, that then they go off and do things without telling people, without having the knowledge and the skills or the awareness. And in the fear, they will do it out of sight and out of mind, which is increasing the risks for that individual tenfold.

And unfortunately, there's no real, no. way of knowing how that [00:29:30] pans out until it, until it goes wrong. And for those individuals, if they were still going to come into an abstinence based model, they're going to be judged for coming in and saying what they've done. So that fear of persecution will often stop people going in and reaching out for help too.

David: I was just going to say then, you know, when we're talking about the cycle of change, I completely agree, you know, understanding that from both sides is absolutely vital. And for me, there's, there's one element within that, that I think is, is really powerful from a staff perspective, which is understanding the maintenance stage.

[00:30:00] Cause a lot of people assume that once you are drug free or you've reduced your substance to a level that you find manageable, then suddenly everything's all right. And I think when you start to apply a trauma informed model, or maybe understand that what they use might be doing is masking. something or covering it up or self medicating, what we have sometimes done is take away that person's coping mechanism.

So sometimes the most dangerous place for someone to be at is a reduced level or in a maintenance level, [00:30:30] because they suddenly maybe are dealing with things that they've suppressed or

they've lost that coping mechanism. And I think that that can sometimes be the danger of support and treatment services.

We go, oh, job done. And we walk away. And that's usually the time when that person is, is the most most vulnerable, the most in need of support. And I guess, Ben, as you're saying as well, abstinence based models can sometimes not always benefit that approach. You know, again, I, I don't want to seem like I'm saying one is better than the other, because I know for a lot of [00:31:00] people, abstinence based models work for them and they've stuck with it.

For example, the 12 step program, it works wonderfully for a lot of people, but for others, it just doesn't work. And I think we've got to, to recognize this. There has to be a range of different techniques out there. And for some people, it's understanding that part of their maintenance will be their youth will go up and down in periods.

You know, they, they might just cause they return to what we often describe it as a lapse or relapse. Whereas for that person that just might be, that's just that. part of that life. [00:31:30] That's part of what they're going through. And as Ben says, you know, that's the time when we need to step up and show that human support and help that person understand what they're doing and use it as safely as possible.

Ben: Yeah. And I think for the individuals on both models, you know, yeah, I totally agree with you, David, when you're in a maintenance stage, it's probably the, you're the most vulnerable and it's probably the most risky. And actually it's where the hardest work comes in. And I do think most individuals believe that actually sort of stopping using drugs.

It's the hard bit, it's [00:32:00] the living life after you've stopped using drugs without your main coping mechanism is that how do you deal with life then? That's a big question and you're only really going to find out the hard way by living it without the use of drugs and alcohol. Which means, you know, this is the key bit where you really want to be offering a lot more support and you want to be engaging whether that be your, 12 step group, your, your fellowship or whether that's with your, You're a one to one worker doing your psychosocial work, or you're, you know, whether that's just your, your peers, [00:32:30] you're going back to

work, you're seeing your friends and your family, sober for the first time in God knows how long, like, this is all quite alien, quite scary.

So it's very difficult and very hard work. And you are extremely vulnerable because the most tempting thing will be the next stage, which is the relapse stage, which for me is probably the most important part of the stage, because it's where you are going to learn the most about you. and your drug using behavior, and you will understand what your triggers are, and you will understand what your coping mechanisms could be, or maybe, you know, you'll, you'll, [00:33:00] you'll realize that your tolerance levels have dropped, and when you go back to using how you used to do, it doesn't have the same effect anymore, your whole relationship with drugs has changed, your relationship with everyone else has changed, and to try and learn how to, you know, spend the shortest amount of time in the relapse phase, then the quickest time cycling back around to the maintenance stages, where you're going to need the best part of support. And a lot of people in traditional treatment systems, once they've given up drugs, success, then we'll see you later, you know, hopefully don't see you later. And with [00:33:30] abstinence based, it's quite difficult to encourage somebody to come back when they've been clean for a length of time that is dictated by, you know, the color of their, their, their keyring to then sort of come back and change that color of keyring and go back to day one is, is very demotivating and it's quite judgmental.

And I know for a lot of people who have been through the fellowship for that reason, it's kind of if you have been there and been clean for years and then the experience of relapse, it's very, very difficult to come back [00:34:00] in. And, and, and start again at the beginning, um, whereas this is really where the stage where the most praise and the most acknowledgement and the most encouragement should be given.

And also for the individual, it's key to look back and reflect on what happened there because that's, that's your key opportunity to learn more about you and, and your, and your path and your recovery pathway. So yeah, it's very good, very important to learn about the cycle of change and apply it to where you're at each day.

David: I think One of the things you can [00:34:30] do as well is help people understand it because sometimes people can, you can talk it through and we can talk about it from a drug alcohol perspective, but I think sometimes from a staff perspective is helping them to relate it to themselves. I often say about, has anyone given up smoking before?

Or has anyone maybe tried a healthy eating plan? And they're like, yeah, yeah, yeah, the first few days are relatively easy. And then what about when you want to celebrate and have fun or when things are tough, things are hard. Even if you don't do it, the first thing your brain says is, I need [00:35:00] a cigarette.

Or if I've given up not so healthy food, your first thing your brain says is, I want cake. You know, the idea is that that's just how our human brain works. And it's just helping people to understand that all of these things are natural responses. And, and to try and reduce that fear, that stigma, because it's, you know, that as, as Ben says, that just holds people back.

Jo: I'm aware of time, but I do just want to kind of ask just one more, one more question and just think about sort of why you think it could be beneficial, beneficial to have peer mentors in [00:35:30] providing support to people who are using sort of drugs and alcohol.

Ben: Okay. Yeah, no worries. I think firstly, it's easier for an individual coming into treatment to relate to a peer because somebody with lived experience at least has, you can assume experience something similar, even if they haven't, they're definitely going to be using a more familiar language than, say, a lot of medicalized people that might be in, as well, in the same service as you.[00:36:00]

I would rather have a peer explain to me what treatment is and what to expect and how it's going to work or maybe not for me than listen to a consultant psychiatrist tell me how this is going to be because, yeah, there's more layman terms with a peer and I think there's a little bit more empathy with a peer, um, and also I think there's a bit more flexibility with peers in the sense of [00:36:30] they're not too restricted to actually just see you in that room for that amount of time. They haven't got the pressures of the appointments and everybody else that's on their caseload and everything else to remember and all of those other

reasons why you might be a little dehumanized and just be another number running through the treatment system.

Peers can actually, they are another human, they have a name and they can probably empathize best with you because they have gone through the journey that you are about to embark on. So they've [00:37:00] probably learned a little bit about that and they could share that with you and they're probably best placed to answer a lot of the questions that you might have to sort of ease any anxieties about what to expect and how it's gonna, how it's gonna pan out.

And I think also what's, what's really good with peers is the fact that they probably look a bit more. holistically at you, they're not going to look at you about and think about Label you with the drug that you use, or the crimes that you commit, or your relationship, or your [00:37:30] housing status, or your BBV status, they're going to look at you as a person, see what your needs are, and understand that if you're going to be giving up things in your life around drugs and alcohol, that you probably want to increase other things within your life, like hobbies and interests. And, and you're probably going to have to change your peer group and spend less time with people that use drugs and alcohol and more time with people that don't use drugs and alcohol.

And that's quite a challenging thing to do on your own. So to have someone to guide you through there or introduce you to some other [00:38:00] bits and pieces within your social network, within your communities and go, you know, this cafe does this or that group does that. And this is kind of free and that's, you know, and I'll come along with you.

You know that having that companionship that that bit of support that maybe other professionals can't do, it's kind of maybe bit of a boundary crosser to go out in a one to one setting of an evening with a with a client and just sit and talk to them in a different setting. I think you've managed to get a bit more closer on a trusting kind of [00:38:30] relationship and if you have any kind of faith in your peer mentor that you're going to be successful on this this pathway then then that that's kind of going to be key to your recovery and there's much.

And how good a lot of the professionals are, most professionals are still going to be working within a time frame of nine to five, and they're only going to be able, their capacity to support you is going to be very limited. Whereas I do feel within the peer mentors, they still have an expertise, they've experienced training, [00:39:00] as well as their own journey, so that they are equipped with the right kind of skills and knowledge to be able to support you, but they're still not a professional, they are still just a peer and just a person.

So with that. I think they're more likely to engage with you when you need them and when and they'll be able to notice when your motivation is high and you can just be left to soar a little bit and watched and observed and when your motivation is low and it needs to be built up a bit and they'll probably know how best to do that,[00:39:30] and I do, I'm going to go out on a whim and say they're probably going to be able to. Do all of that without focusing on drugs and alcohol, which a lot of treatment systems will want you to talk about drugs and alcohol and focus on the drugs and alcohol and tell me what drugs and alcohol you've been taking today and the whole emphasis is on around the drugs and the substance itself and that takes it away from the person and the other individual needs and I think the peers are sensitive to that fact and will be able to support you in reducing your drugs and alcohol, ironically, by [00:40:00] increasing other things in and around your life without actually talking to you about drugs or alcohol.

David: I guess one of the things I would say with, from an organization's perspective, if you are listening to this who, you know, who supports peer mentors and volunteers, I think, all of what Ben said is absolutely accurate. But I think there is a duty of care that organizations have because again, peer mentors and volunteers have gone through so much themselves.

And when they're having, when they're doing this work, they are potentially bringing [00:40:30] up their own stuff. Um, you know, we often, we, we need to talk about things like empathy, fatigue, compassion, fatigue, vicarious trauma, and understand that counter transference, that fact that you're absorbing other people's stuff.

And I, I've seen some not so good practice. I show. Not mention names from organizations where they haven't effectively supported pay mentors

and volunteers, and then the pay mentors are doing everything to help other people, and then they are struggling with their own journey. And then they suddenly absorbing other people's stuff as well.

So I think [00:41:00] absolutely everything that Ben said is 100 percent accurate. But I think if any organizations I have supporting peer mentors and, uh, you know, whether it's supervising them, offering them training support, there has to be that emphasis on their wellbeing and their safety and that check in and how are you doing and not accepting I'm fine as a response, because that that's, that's our, that's our defense mechanism and I think sometimes we need people who go.

Yeah, let's have a, let's go for a coffee or a walk and talk about that stuff. Cause you know, you're doing good work, but [00:41:30] are you looking after yourself?

Jo: Yeah, completely agree. Unfortunately, I think that's all we've got time for, but thank you so much David and Ben for speaking with me today. I know we could have spoken for longer on this and I'm sorry, but it's been so useful to kind of understand some of those barriers and challenges to engagement and kind of like we've just spoken about the role of peer mentors in providing support.

But yes, thank you so much both for your time.