

Podcast Transcript

Host (00:01):

Welcome to Mental Health in Practise, a podcast by MHPN, bringing you insights and experiences from professionals across Australia's health and mental health sector.

Lisa Fyfield (00:18):

Welcome to Mental Health in Practise, a podcast from the Mental Health Professionals Network. In this episode, we're focusing on how being aware of and challenging stigma towards those with co-occurring substance and mental health challenges, both within and outside of individual practitioners, supports a more effective and integrated care system. My name is Lisa. I'm the quality improvement lead at the Hamilton Centre, and I'm joined today by Leanne, who works as a peer worker and peer educator. The Hamilton Centre is Victoria's statewide service for co-occurring mental health and addiction, and we provide a consultative service across Victorian public health services. So Leanne, why is this an important conversation to be having right now?

Lee Ann Jemson (00:55):

Thanks for that, Lisa. So I think it's a really important conversation to be having because there is stigma against those who use substances and those who experience mental health challenges, and even more so for those that have co-occurring needs that experience those simultaneously. And this creates barriers to care at every stage. Having lived experience of mental health issues and alcohol use disorder myself, I can say this from the perspective of being a past client and also can see it with the clients that are accessing our services as well. Due to this stigma, opportunities to engage clients might be missed. Negative experiences do harm, which can put people off accessing the service again and the system becomes more ineffective. So we acknowledge that challenging stigma takes internal work and collaboration throughout the system. I think we are getting better at raising awareness and understanding when it comes to mental health.

(01:54):

And we're also getting a lot better in raising awareness for substance use disorder and understanding that it's a disease which needs to be treated just like any other disease. However, we still have a really long way to go. And by working together and utilising a full skillset of a multidisciplinary care team, we can collectively move towards integrated care and hopefully move away from stigmatising experiences.

Lisa Fyfield (02:18):

It's really great to hear that from that personal point of view because we know that the Victorian Alcohol and Drug Association, OVADA, they found that over 80% of people presenting to Victorian AOD services also described symptoms of mental health conditions and that they actually spend more than 70% of their time on mental health interventions, which is a pretty big percentage. So we're looking at almost a universal treatment of co-occurring conditions in the AOD sector. So when you're talking about that impact on the humans involved, we're not just talking about one or two per service. We're actually looking at a fairly substantial proportion of the service users. So we know that this is a real issue in our services that we should be delivering integrated care to people with co-occurring conditions. It's the norm, as you said. As somebody has used these services, what are some of the really overt experiences of stigma you've seen?

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Lee Ann Jemson (03:09):

Recently I was going to a integrated care clinic and I actually saw a sign on the door that said, "Do not enter drug testing in progress." And this was all in bold letters. And I just thought to myself, that's a real breach of privacy of the person who is in there actually undergoing that test. Also, not to mention the fact that if they are doing it, they're complying with the situation that they're finding themselves in. And thinking also of the looks that that person's going to get when they walk out of that stall, I don't know if they're aware of that and how stigmatising that is. And then I thought, what could be other reasons for that sign? And then I was thinking maybe urine drug screens are supervised. I think it could be because there might be embarrassment or judgement if two people come out of the toilet at the same time.

(04:05):

So it's kind of almost thinking that it's prioritising a little bit of embarrassment of the worker over the rights and privacy of the client. And I just thought that was a bit questionable. So I actually sent them an email and said to them, "This is quite stigmatising. Did you think that it may be a privacy and confidentiality issue? And also the looks that that person might get due to that sign." The word stigma comes to mind. I don't know how you feel about how you may be contributing to that.

Lisa Fyfield (04:39):

And the next time you went back there?

Lee Ann Jemson (04:40):

Yeah, the next time I went back there, the sign was still there. And then another couple of weeks or a couple of months later, the sign was up again. I've sort of decided next time I see that sign, I might steal it.

Lisa Fyfield (04:54):

Yeah. It's a hard thing to do, especially as someone with lived experience, you're going to be the person who notices that stigma. And I think that's where, as a health professional, the onus has to be on us. We can't expect people experiencing stigma to always be the ones who have to raise it and advocate for themselves and for other people within the sector. I just don't think that's fair. I think it's really incumbent on us as health professionals to take ownership of looking at our environment for stigmatising situations. There should be a staff member in that service who says, "Hey, wait, how's this going to affect people coming in for a urine drug screen? How is this going to make them feel?" But clearly no one had. And I think it's equally as important as health professionals that we catch it in ourself and that we sit and we think, "What's my internalised stigma?" So we know that there's lots of parts to stigmatisation.

(05:45):

Part of internalised stigma is the thoughts and feelings we have in ourselves about the world around us, how we respond, our automatic thoughts. And automatic thoughts themselves, they might be stigmatising, but the most important thing is how do we respond and act on those automatic thoughts? A colleague who was happy for me to share this story shared a story about when they were an AOD

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counsellor and they had a new client coming in who was pregnant and using drugs and they were coming in for co-occurring mental health and addiction needs. This was somebody who already had children who were not living with them. And my colleague had feelings as a new mom herself about using drugs while pregnant and potentially putting children at risk and had to work on that themselves. To this person's eternal credit, they noticed these feelings they were having and these negative feelings about not sure I can work with this person.

(06:35):

I'm feeling really angry about it. And instead of saying, I can't do this, it's too hard, this person's too hard to work with. They said, I need to take this to supervision. And so went to supervision and worked on those internal thoughts and worked their way through and did some amazing work with that person who was then able to work through their pregnancy, maintain a contact with that baby. The baby stayed with them and they actually got custody back of the other children as well, got themselves out of an unhelpful relationship and developed some really helpful support systems. So what came from noticing internalised stigma was an incredible outcome both for the client and also for the clinician. And that was a really empowering way of responding to internalised stigma. And we have that responsibility to challenge stigma both within ourselves and in our organisations and respond to the human person in front of us.

Lee Ann Jemson (07:25):

Yeah, what a great outcome that was. When you are experiencing those negative impacts of your mental health and your substance use, you do have a lot of guilt and shame and you have all that internalised stigma as well. So I think it's really important when you are particularly struggling with your substance use in terms of seeking help. A metaphor I like to use is it's kind of like the Macca's window opening and closing. Sometimes when you want help, the window opens, but it can be for the bravest of moments. So while that window's open, it really does depend on the treatment that they're receiving at that time. If they're met with welcoming therapeutic language, a welcoming environment, a smile, non-judgmental behaviour and everything, even if they don't choose to access a service at that time, they're going to remember that. And when they are ready to change, that's going to make them more willing to seek help at that service.

(08:31):

Everyone has unconscious bias. I remember at one stage something came up for me when I was introduced to a new role of a worker and I noticed in my stomach something didn't feel right for me. And I acknowledged that and I was like, "I don't want to feel like that." So I took that to supervision and unpacked it with curiosity and I was able to process that and see it as a positive. And so I think it's normal for us to have unconscious bias, things that we don't have education about, things that we get certain types of education about. We don't necessarily get two sides or things we're exposed to, things that we're not exposed to. And when things come up for us, that's totally natural. But the thing is, it's a really good idea to question it. And if we do have those biases, trying to acknowledge it and then find a way that we can work around it or work with it.

(09:33):

And that might take a bit of reflection or a bit of workshoping, but it's natural to have these concerns, but it's really important to find a way through it and to actually acknowledge it, but still work with it.

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Lisa Fyfield (09:47):

Yeah, absolutely. I think we're all a product of our experience and that experience starts from our family of origin and our education and then our experience in our service systems as well. I mean, our system is stigmatising. We know this. Stigma affects every stage of navigating through this system. So as you were saying before, when we know that people with co-occurring mental health and addiction concerns that don't just present to services once, have a great experience, leave and live forever in recovery. We know that that is not a normal pathway through services. For some people it isn't fantastic, that's great. But the majority of people come in and out of services over a long period of time. But somebody with co-occurring conditions finds it much more difficult to access services. So someone who uses drugs is less likely to stay in a mental health service, but they're also less likely to be admitted to a mental health service.

(10:36):

We've heard time and time again how many people are not even put on a waiting list because they have a history of substance use disorder or they're currently using drugs. They're not able to go into a mental health service. They're deemed to be too complicated. Every time we reject someone from a service, we're telling them, "You're too hard for us. You're too complicated." We're labelling that person rather than accepting them as a human being and looking at how can we help this person? Even if our service is not right, how can we bridge across to another service? How can we try and create care systems that are sufficiently integrated to manage the care needs of this human being in front of me? Even if my service is not the right one, how can I make sure you're not feeling rejected and too hard? Because that does not make somebody likely to come back the next time and that's what we need to live for.

Lee Ann Jemson (11:27):

I think that's the beauty of integrated care because it's always been mental health and AOD being siloed and to treat them both simultaneously is really amazing, but it still creates barriers. I hear the term people being too complex when referring to their mental health and also history of incidents when they've been at their very worst and that stays on their record. And then everything is so risk adverse that they don't get accepted to services such as detox or rehab because they're worried that that mental health condition could present symptoms that are the worst case scenario. But because of that, their referral won't even get accepted. So that's a huge barrier for them receiving treatment for their substance use, which is probably part of the reason that resulted in that acute presentation at the time that has followed them around on their record, which is again, preventing them from accessing care.

Lisa Fyfield (12:29):

So we're talking a lot about integrated care today, and I don't think we've actually said what integrated care is. Integrated care is one of those terms that's relatively new and it gets bandied around, but often there isn't a common understanding of what integrated care actually really is. And in our world at the Hamilton Centre working in an integrated care space, it's about receiving seamless care. So we often hear go and deal with your addiction issues first and then we can do your mental health or go and stabilise your mental health symptoms, then come and do a detox. But what we find, as you said, side by side simultaneous treatment works better, but integrated treatment works better still. So integrated

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care being all of the care needs that a person needs under the same roof or what feels like under the same roof. And the what feels like under the same roof doesn't even have to be in the same city.

(13:18):

So it could be a rural person accessing telehealth services for one issue, but the practitioners get together and have one care plan that is led by the consumer. They are centred in the care and defining their own goals supported by all of the different services that are involved in their care. I like to liken it to the duck. So the duck working really hard with their legs below the surface, trying to make sure that they're keeping on moving in the right direction, but the experience of the service user should be sitting on the back of that duck, nice and smooth, moving across the surface and wear those legs, working really hard to make sure that that journey stays smooth. And as a part of that, I know I'm preaching to the converter talking to you today, Leanne, but the peer workforce is vital and really underutilised.

Lee Ann Jemson (14:03):

I am very fortunate and grateful to be part of a team where we have a lot of clinicians that really champion lived experience. I remember when I first started on the team, this is my first lived experience role and my role is at the Hamilton Centre as part of a multidisciplinary team delivering integrated care. So I felt way out of my elephant. I had imposter syndrome. I didn't feel confident to speak up, but now I know I'm in a place that actually really values my lived experience and I'm not only feel comfortable enough to speak up, but I'm encouraged to do so. And sometimes the clinicians on our team will actually seek me out and be like, "Oh, I think you'll be really good to support this person or this person's experiencing these issues. What do you think will help them?" And when we are delivering care to a person, we have the clinicians that can speak to medication diagnosis, interactions, things like that.

(15:10):

Whereas we can talk about, okay, so the person's feeling a bit isolated. We could suggest some groups that they might want to go to, or we can just validate that fact that yeah, when you are experiencing co-occurring needs, it can feel quite isolating, you can feel quite othered, and sometimes small steps like joining a smart recovery group online, something like that, or detox for the first time. And then you can also have that feeling of, gee, I'm not the only one. I know when you're in sort of the worst parts of substance use disorder, you become the worst version of yourself. That's where that internalised stigma comes from, that guilt and shame because you're not really the person that you are truly. And I think that's why sometimes a little bit of unconditional positive regard can go a long way. I know when I was in and out of services, I was quite known to many services.

(16:09):

I had a few clinicians that really stood out to me. I remember there was one nurse and he took the time to actually just chat to me as a person, ask me about my hobbies. If I was watching a movie or something, he'd ask me what other TV shows I like, what movies I like, what kind of music, whereas everyone else was like, "Oh yeah, we have to do your obs, we have to do a blood test." But he spoke to me and made me feel like a human, which is really important. Also, I had a really, really good doctor that supported me through my substance use and I had a really, really good therapeutic alliance with him. I remember one of the things he did for me was he really reframed things for me. And I guess now that I'm a bit more educated, I see it as a strength-based and person-centered approach.

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(17:03):

One time I came in after yet another lapse and he said to me, "How long was your relapse for?" And I told him and he said, "That's a lot shorter than your last couple of relapses. They're actually all getting shorter. So I think your pharmacotherapy is working. What else have you been doing that's positive? Okay, look, you're on the right track. What else can we add to that?" And I went in there thinking like, "Oh, I've got to tell him I had another relapse." Whereas I came out thinking, "Okay, that's positive. I'm making progress." And so having him point that out and reframe it for me was really, really cool.

Lisa Fyfield (17:37):

Yeah. I think taking it back to that strengths and skills like, "Wow, look at how much you've learned." And also then you're more likely to go back if it all goes... I was about to swear then. Pear shaped. If it all goes pear-shaped, you know that you've got a safe place to go back to and that he's going to have your back and he's going to welcome you back in his office as well as having your back and tell you how amazing you are. Because I think that your strength really does come out when you talk about your experiences. And I feel privileged as a clinician to work with amazing peer workers, amazing people with lived experience and living experience. I was reminded while you were speaking that I think it's really important that we do address the fact that in working in this space and working in particularly tertiary mental health and addiction services, we're working with the pointy end of people.

(18:21):

There are a lot of people who use drugs that don't necessarily have a substance use disorder. There are people who regularly use drugs for whom it is just part of their lifestyle and part of their life. Choosing to give up taking drugs is a decision. Everyone has a right to make decisions about their own health. So there will be people who come into our services who aren't interested in being abstinent and for whom as part of their recovery, abstinence is not part of their recovery. And I think that that's really important and we need to validate the choices that people make about their own health. As people who use drugs get older, their physical complications also can get more so and we need to work closely with the humans in front of us to find the goals and to look at those goals, reorientate to strengths, making sure that the person using our service is the centre of their goal setting and we're not telling them what to do.

(19:09):

And if they're not doing the things that we think they should be doing as healthcare workers, then we need to take ourselves out of that equation. It's not about me when I'm talking to somebody. It's not my life, but it's their life. So I think that's really important. And I think finding the person at the centre of it all also helps us. You talked about the Macker's window

Host (19:29):

Earlier,

Lisa Fyfield (19:30):

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Helps us find those little windows of change, those little glimmers, those moments where somebody is ready to take on a challenge, they're ready to take on something new. And that's really exciting time when you get to see those little glimmers and people are ready to take the next step.

Lee Ann Jemson (19:43):

Yeah. I can totally speak to those little glimmers because I know sometimes when you're in that stage where your mental health isn't great, like I really struggled with anxiety and depression. A lot of people don't understand how heavy those conditions are and really how debilitating they are and how they can impact your life in so many different ways and adding substance use on top of that. One of the biggest problems is people see or want to treat the substance use and the mental health issues, but the thing is they're both symptoms of a larger problem. So what is actually going on for the person that is causing these things? A lot of the time people have trauma, they're using it to cope with something, whether that being a loss or it could be a loss of a relationship, a loss of a job, intersectionality. There are so many things that people experience that are really, really hard.

(20:43):

And sometimes the way that people choose to deal with that is by using a substance. And it might be the first time, but then tolerance comes and then dependence. And then before you know, you go to survival mechanism. But also I think it's really, really important to normalise lapse and relapse because it's like my doctor said, if you can reframe it, you can actually use it as a learning opportunity rather than see it as a failure. I know for a fact that my last relapse, I just acted, I didn't think. And thankfully I was able to get through that because a loved one actually threw me an olive branch. I feel like I was drowning in water and they threw me a rope and I actually gave in and agreed to grab the other end of that rope. But then next time that things were getting a bit pear shaped for me, I was able to notice those early warning signs.

(21:39):

So I actually called out for help. I got onto my AOD counsellor, read my NA book, I had my relapse prevention kit and I asked for help. And then that way I was actually able to get through that without turning to the alcohol. So I can honestly say my last relapse really set me up to survive my next one.

Lisa Fyfield (22:03):

I think that's amazing. And I think it's a fantastic example of the fact that we expect you to be building up skills as somebody using the system, as somebody experiencing co-occurring conditions, managing when your mental health gets poor, when you're experiencing challenging experiences in your mental health to not go back to substance use. We expect you to be developing skills, but I'd like to challenge health professionals to do the same thing. The system isn't set up well to facilitate integrated care for people with complex issues, people who are experiencing complex things, but there are a lot of things within our capacity as health professionals to do this better. So what we can do when people come into our care is to check ourselves, look internally. Are you feeling that uncomfortable feeling? Do you read somebody's referral and have a picture in your mind of what you think that person's going to look like?

(22:52):

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That's a preconceived notion. That's stigma. If you read somebody's coming in with schizophrenia and heroin use disorder and you have a particular image of what you think that person might look like before they walk in your doors, that's your internal stigma. Recognising that and challenging it, you might be right. They might walk in and look the way your internal picture says, but they might be completely different. And I think every time we challenge ourselves, we grow. So we expect people using our services to develop skills, embrace introspection, but sometimes we don't do that for ourselves as health professionals. So what we should be doing is thinking to ourselves, well, okay, that was an interesting automatic thought. You can almost use something like CBT, CBT yourself. So pick up that thought and go, "Hello, old thought. That's an interesting thing you've put in front of yourself.

(23:42):

How can I challenge that today because that doesn't feel quite right to me. I don't like the way that makes me feel." And go take it to supervision. If you're not lucky enough to have supervision in your workplace, talk about it with your colleagues. Use peers that are happy to bounce ideas off each other and go, "I just had this experience that made me feel sick that that's how I felt and thought." As I sort of alluded to earlier, the thoughts themselves aren't wrong. The way we respond to the thoughts is the most important thing. So allow yourself to challenge those internal thoughts and act with compassion, act with kindness, be that soft place to fall and ask the questions. It can be really scary, particularly in mental health services, to ask questions about substance use. If I ask you that question and you give me that information, I have to do something with that now.

(24:26):

And while we said before the expectation is that you should be able to deliver integrated care, we know that many people working in mental health don't feel they have the skills to manage substance use, but what you do have the skills to do is manage distress. Mental healthcare workers are experts in managing distress and sitting with discomfort. We're very good at the challenge, so we're very good at challenging people. And also you can work with someone to develop those skills. So even taking substance use out of the picture, you actually have some really great transferable skills that work well with integrated care. You can sit with that person's distress and help them work with a harm reduction approach towards substance use, even if you're not set up to help them directly with substance use, prescribe pharmacotherapy and actively act on that. While you're linking them into appropriate services, you can still work with them on harm reduction.

(25:15):

So harm reduction means if somebody's injecting drugs, do they have access to fresh injecting materials? Are they reusing needles? Do they have access to pill testing services, which are available in some spots in the country? We're lucky enough to have a pill testing service here in Victoria now, but do they have access to an injecting room? So is there somewhere they can go to be safe? Do they always have somebody else with them when they're injecting? So there are things that you can do. And if they're not strategies that you're aware of, then it's time to go and have a look about what's best practise. Think about what you can do in this setting rather than what you can't do. And ask the questions. And if you're not sure, ask some more questions.

Lee Ann Jemson (25:54):

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And I think also from a consumer lens and being a service user client, if the first time you access a service and people ask, "What's your stage of change? Are you using substances?" Yes. "Can I ask what substances you're using?" "This is what I'm using. ""Oh, so where are you at with your substances at the moment? Are you looking to keep using? Are you looking at cutting down? Where are you at with that?" And again, be non-judgmental, just asking the questions, be wary of your body language and things like that. And they say, "Oh, I'm happy to keep using." Okay, great. So you told me you were using heroin. Like you said, make sure they know about needle syringe programmes, medically supervised injecting rooms, things like that. Make sure you've got some take home naloxone. I can look up some chemists that you can get it for free.

(26:46):

It's your choice. I'm not going to try to change what you want to do about your substances, but I do want to make sure you've got the education and information so you can use as safely as possible. And then that might be a real aha moment or a real wow for that service user because it might be the first time they've gone to a service where A, someone hasn't been judgmental and B, hasn't given them all the negatives like what if you overdose? What if you get one of the bad batches that's laced with this and do you think about what it's doing to your health? The service user might be like, wow, that's the first time a service has just accepted that I don't want to stop and has been okay with it.

Lisa Fyfield (27:31):

And it's okay to check in about, do you know how that interacts with your current medication? And I've got a few concerns. Is it all right if I talk you through my concerns? And I'm reminded that it's also very important to have these conversations with colleagues. So to look at the way the language that we're using in the clinical setting isn't stigmatising. So you mentioned earlier about known to a service is a great alternative to a frequent flyer. So if somebody has been to your service more than once, describing them as a frequent flyer is incredibly stigmatising, but say if they're known to the service is a very different way of approaching it. There are some great language guides out there. The Matilda Centre, which specialises in this space, they wrote the comorbidity guidelines. They literally wrote the book on this and there's a fantastic guideline for language in there.

(28:20):

The Alcohol and Drug Foundation's language matters.

Lee Ann Jemson (28:23):

It's really good. It just all fits on an A4. You can put it on your office wall or on your desk and it's like, this is the stigmatising term. This is non-stigmatizing. But the words we say that can really change how a service user is perceived just in an initial conversation. And further to what I said before with the person saying, "Oh wow, that's the first time I didn't feel judged or didn't feel that stigma," they'll remember that. And when they are ready to change or when they want help with something else, they're more likely to return to your service. Further to earlier when I was saying about the Macca's window opening and stuff, I think every positive interaction really stacks up. The words we say when we use unconditional positive regard, it does matter. It does stay with us. I remember another clinician that I encountered on one of my hospital admissions, he said to me, "Oh, you're back again." And I'm like, "Yeah, I am." And he's like, "Oh, I was telling one of the other patients about you." And I'm like, "Why

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would you do that?" And he goes, "Oh, because you're going to make it." And I'm like, "I'm here again because of my drinking." He's like, "No, there's something about you."

(29:34):

You're going to do good." I was like, "Okay." But it's really important to have people that believe in you when you don't believe in yourself, because now I've encountered people that have supported me along the way and they're just like, "Oh my God, look at you now."

Lisa Fyfield (29:50):

Absolutely. He may not even remember saying that. And I think as clinicians, we underestimate the power of things that we can say as well, the power of those words. And he might not remember, but he might not. But what we can say has an opportunity to stick with someone. So for example, if you do work in a mental health service and you haven't previously routinely had conversations about substance use, it's okay to say to the person in front of you, "Hey, I haven't had this conversation before, so walk me through it. Let's do this together. We'll learn together." It's okay to be a novice at something and it's okay to do something for the first time, even if you've been a health professional for decades. I'm approaching a pretty reasonable milestone in my healthcare career. It's too many decades to admit to, but I learn something every day.

(30:36):

And if you'd said to me 30 years ago that you'll be working in drug and alcohol one day, I would've probably laughed and said, "No way. I never want to work in that area. I have no interest in working with people who use drugs." And I admit now that that was my internalised stigma speaking. I grew up in a pretty open-minded setting, yet I still had that internalised stigma that I've had to, over the years, work on and combat and recognise. And working on that internalised stigma is a real strength because you're acknowledging your own weaknesses, your own learning opportunities. And the more we learn about ourselves, the stronger we are as individuals, as clinicians, as people who use services. And it enables us to work with someone on a more genuine level. And I'm very well abled, even as somebody with decades under their belt, to say to someone, "Oh, I haven't done this before either." Or if I'm asked for what is the right service, if a clinician comes to me now in the Hamilton Centre and says, "What's the right service for this person?" And tells me about the person in their care, and we start to work on some service linkage work, because it can be a bit tricky to match the right service for the needs of the person in front of us.

(31:44):

It's the, "Oh, well, I haven't actually found a service that meets those criteria. Let me do the legwork." And so we go and we have a look and let's find the right service for this person. I know that that can be really hard. We're in time pressured situations. Doing any sort of additional work can be really tricky, but being able to do it makes the world of difference to that service user. Sometimes integrated care means thinking outside the box, and sometimes it means working with the receiving service to make sure that we have that seamless care. Combating stigma though, if we go back to stigma, I think it's a really active and ongoing process. It's really hard. And even now working in this space, working in integrated care, working in mental health and addiction, it still can feel a little bit sick in the stomach to openly combat stigma.

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(32:28):

I'd encourage everyone to challenge yourself to go to your pharmacy that might provide Naloxone and actually ask them for Naloxone. How does that make you feel? Can you do it? Does it take you 10 times walking in the pharmacy to be able to have that conversation? Because it can be really confronting even if you're not someone who uses drugs.

Lee Ann Jemson (32:45):

It's funny. I've actually done that myself because I have a little harm reduction kit for when I'm giving education in services and workshops. And also I like to have some to give to clients or anyone who may need it. I find that every time I go into the chemist, I get a different reaction from the person supplying it. A couple of times I've just had a big smile, "Yes, how many would you like?" A couple. Not even can I ask what you're using, just what medication are you on? So it's a really good way to challenge how you feel asking about it, but also the response you get. And then again, be curious about what's the experience of someone who is actually on opioid medication or actively using some kind of opioid and actually asking for that, particularly when they may present substance affected or not look like a professional, think and be curious about what their experience is.

(33:44):

And hopefully the chemist giving it to them will treat them with respect and be non-judgmental and just supply it for them, no questions asked. So question for you, Lisa. Thinking about everything we've discussed, what has changed or become clearer in the way you approach this now in your practise?

Lisa Fyfield (34:03):

Well, I think talked about the internalised stigma that I carried and well, we all still carry it and it's our responsibility to challenge ourselves to think outside our comfortable thoughts and to grow in discomfort. And we grow in uncomfortable places. So if you're always comfortable in your practise and you're probably not growing very much, I'm much more comfortable pushing myself into discomfort and admitting what I don't know. I don't like not knowing things. It's not a comfortable place to be for me. So that's been really interesting. I'm always looking to learn something new, whether it's from the people I work with, whether it's from journal articles, attending webinars, workshops, running workshops. You learn just as much putting a workshop together as you do by attending one. If I was thinking about my professional journey, I would tell my student or early career self to always be curious, to keep being curious, to ask the questions when you're not sure.

(34:56):

It's okay to not know. And it's okay to tell the person you're working with that you don't know and to come back to them. In fact, I've found that honesty is so much more important than knowing everything, and that's been a really key learning. So isn't it funny, the longer you go in your career, the more okay it is to not know stuff, and I think that's been really powerful.

Lee Ann Jemson (35:13):

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Host (35:38):

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