In her third article for *Druglink*, drug worker 'Beth' describes her move over 'to the Dark Side' from a drug agency in a small northern town to a 12 Step private rehab. Is she feeling the Force?

BETH VADER

Those of you who read my last two articles will be aware of my frustrations with the NTA, DAAT's, TOPs, Models of Care and the like.

I must thank all those who responded to my articles: in particular those concerned people who suggested that I should stop whinging and that I was burnt out and should do something else. I heeded your comments.

But I must tell you that I have gone over to the Dark Side. Others would say I have embraced the Force and become a Jedi. Which, depends on your point of view. I now work in an abstinence-based private residential rehab. Right, saying that felt okay. Now let me try being totally honest. The therapy works with the 12 Step programme. There now, I have said it.

I'm not earning any more than I did in my last job and the place is not full of celebrities and the 'worried well'. Members of staff are not all 'in recovery' and exchanging the secret AA handshake. I joined the place with an acknowledgment that this was a different approach, but that there was nothing here that would be at odds with my understanding of drug and alcohol dependence (a lack of control) and the essentials of treatment (a need to admit the dependence and to seek help). Those two statements in brackets, in a very simplified form, echo the first three steps of the 12 Step programme. What I have learnt is that, like Luke Skywalker and Darth Vader, the disease model and the psycho-social behavioural model are closely related, but find it very hard to see eye to eye.

I was mentored in my last job, up until her retirement, by a well-trained and thoughtful drug and alcohol therapist who taught me that 'addiction' and 'alcoholic' were dirty words. I was at an Alcohol Concern study group with her (developing yet another tool which was never used) some years ago.

We struck up a conversation with a very smart man who was in a fairly high position at one of the most reputable residential rehabs, working with the 12 Step programme. In the conversation he used the forbidden word, addiction. My colleague smiled at him sweetly and said: "Now, we are not allowed to say that, are we?" He looked at her as though she were completely mad. At that point they stopped speaking the same language.

I HAVE TRIED TO FIND OUT WHAT IS THE MOST EFFECTIVE TREATMENT. IN ALL THAT I HAVE READ AND EXPERIENCED, THERE SEEM TO BE ONLY TWO USEFUL INSIGHTS

In my present job I had a conversation with a colleague for whom the words 'harm reduction' and 'controlled drinking' are equally obscene. She related with horror the tale of a client in the rehab who had attempted controlled drinking with the support of a drug and alcohol agency.

"It is dangerous and irresponsible," she said with fervour. "Perhaps he wasn't willing to stop at that stage," I offered tentatively. She looked at me with a mixture of bemusement and frustration. "He has to understand that he is an alcoholic," she replied. I made one last attempt to bridge the gap in understanding: "Perhaps he didn't understand that." With one last flash of the light sabre, my colleague replied: "There are tests!"

I am learning to speak a new language and hardly wince at all when I say 'alcoholic' now. I understand that the 12 Steps make up a philosophy, a life-long programme of self-development. I was not expected to offer that in my last job. It doesn't fit easily into Tier 2 or Tier 3, or the expected 12 weeks of treatment. I still see clearly that it is not right or appropriate for everyone, any more than is CBT, MET, NLP, REBT, DBT or any other flavour of the month. I have over the years, like most workers in this business, watched clients try and fail, sometimes fatally, to move on from their destructive drug and alcohol use. I have also, like many researchers, workers and government bodies, tried to find out what is the most effective treatment. In all that I have read and experienced,

there seem to be only two useful insights.

One is expressed in the old joke: How many therapists does it take to change a light bulb? One, but only if it really wants to change. People will only change if they want to, and a lot of government-sponsored interventions seem to work from the basis that if people are identified as 'needing' to change, for social or forensic reasons, they can be changed. Of course this can be addressed, to some extent, with motivational work, but I do think this is more limited than is generally acknowledged.

The second is most informative to me as a worker and is the message that 'it ain't what you do, it's the way that you do it.' Whatever model of therapy is used the most significant factor is the nature of the relationship with the worker. If a client experiences understanding, interest, congruence, reliability in the worker they are more likely to make changes. Therapeutic alliance, core conditions, or simply an honest human relationship – whatever you call it – this seems to be what works.

I puzzle over the debate over abstinence-based or harm reduction-based treatment. Is there any one out there who would greet a client's request to stop using drugs or alcohol with a suggestion that they should carry on with it indefinitely? Isn't harm reduction simply what it says on the tin: that someone is doing something dangerous and damaging but they are not willing, or able, to stop, so let's try to make it less dangerous or damaging?

One risk associated with this is that, in practice, people get slotted into harm reduction treatment and stuck there. Reviews of treatment can become answers to 'Is this still reducing harm?' rather than 'Is this still the only option for this person?' The disease model view is generally that people will only stop using when they reach rock bottom and give up any hope of being able to manage their drug or alcohol use. It follows that nothing much can be done before that, or even that nothing should be done to stop them going down hill to that point. The risk with that view is simply that people can, and do, die before obtaining that realisation.

We do get caught up with words. I support Professor David Clark, director of the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital, in his view, expressed in Drink and Drug News in April last year, that whether we call it a disease, a disorder, a habit or whatever, dependant drug or alcohol use would seem to be a chronic condition. What we tend to offer, apart from 12 Step programmes, is treatment for an acute condition.

The implicit belief underlying the treatment structures expressed in NTA documents and as funded by DAATs or PCTs, is that a client enters treatment, is assessed, treated and then discharged. Discharge happens when someone is 'better' or alternatively, 'given up on'. AA, NA, CA are able to offer lifelong support. The other powerful message that comes from 12 Steps is you don't have to do this alone. The answer to 'I can't' is 'you don't have to'. Feel the force Luke!

Not everyone is comfortable with the AA, 12 Step approach. I know full well that group work and ideas of 'higher powers' just feels weird to some people. I reckon that there is a lot of good work being done to help a lot of people in a lot of different settings using a lot of different approaches. What is missing is enough open dialogue, flexibility of treatment and a willingness to accept that there is not one right way but many effective routes to saving people's lives.

As for me...Well I shall slip my light sabre into my belt, pull my cloak around me and feel the Force ...for now anyway.