COORDINATE.....CA

Two views of the priorities for dr agencies once they stop working wi clients and start addressing 'the communi

Robin Burgess

Robin Burgess's vision of change from the bottom up, by mobilising and coordinating local community resources. In many ways, he argues, it's more realistic and more appropriate for community groups to deal with the drug problems in their midst — supported but not replaced by the specialists.

SERVICES FOR DRUG misusers have accepted that community involvement is a key to successful prevention, awareness-raising and treatment. Despite this ambition, and despite the proliferation of services with a 'community' prefix to their name, practice is often lacking. Key staff either do not have the time, or community liaison is tacked on to the job descriptions of already busy workers. The result is that the 'mobilisation of the community' is piecemeal or ineffective, leading to confusion, low morale, and a poorer service.[1]

The purpose of this article is to critically examine the fears behind this reticence to put the rhetoric about community work into practice, and to catalogue the benefits of active community liaison for both clients and services.

What do we mean by 'community initiatives'? Moving a drug unit from a hospital to other NHS premises? Relaxing medical viewpoints and blurring professional status? Recruiting volunteers to fill gaps in service provision? Or do we mean listening to community groups, taking the debate to them, mobilising community voices, and involving consumers in the direction of services?

Some of these aims have been taken on board. Most community drug services are theoretically multidisciplinary, employing social as well as medical and psychological therapies, and in many volunteers take on the lowest status tasks. But few do joint-working with parents' groups, tenants' associations or trade unions. Where they do, they do so reactively rather than courting a relationship with such groups.

Overcoming resistance

There are several reasons why community liaison remains a science in its infancy. Often the powerful barriers to developing community work (see panel) arise from professional fears about status, role and identity. Some types of community activity — parents' or tenants' groups, for example — are viewed with distaste and there is suspicion about their motives, which are seen as unhelpful and uneducated.[2] Any independence acquired by such groups is interpreted as a threat to professional status and their work is seen as of lesser value than professional 'therapy'.

Two stages of potential liaison with outside agencies and community groups can be identified. The first is simply letting people know who you are, where you are, and what you offer. While there are agencies that don't even do this, it is a prerequisite of community credibility and good referral channels.

It is when we move to stage two — actively working with the community — that we have to address professional fears by giving examples of the benefits to the customer from improved liaison, while acknowledging the practical limits on resources and on the contribution each partner can make. For example, in a residential social work setting a range of joint prevention and education work could be undertaken with the workers and with the young residents — from offering the workers training on counselling/advising a young person with a solvent or drug problem, to identifying the specialist drugs worker as the 'key worker' at a case conference.

The process of development and liaison is to identify and establish at least the practicalities of how such joint working might be enacted. Joint case-working can be prepared for by stressing availability in advance. So that, for example, a probation department can plan and liaise with a specialist worker, knowing that the worker's agency is likely to respond to a request for a court report on an offender being sentenced for a drug-related crime.

Objections to this kind of liaison over court reports may be raised by both sides. Nonetheless, the experience of many drugs workers is that such reports do help clients get a good outcome at court. There are fears about 'labelling' juveniles as 'sick' or 'addicts' by involving them with a clinical service, but the type of service now being offered by many community drug teams no longer constitutes a labelling process.

> "From our observations there is today insufficient involvement of the local community ... in dealing with drug abuse. This is largely due to there being very limited opportunities given for the participation of the community in helping with a drug prevention strategy and consequent local initiatives."
>
> *— European Parliament Committee of Inquiry, 1986*[3]

Barriers to community liaison

- The belief that any other activity is of less value than direct work with clients combined with pressure of time means priority is always given to face-to-face work.
- A deep suspicion of the potential consequences of working with community groups with 'conservative' views on dealing with drug problems.
- Lack of a clear identity in terms of the service's objectives as a basis for raising its profile in the community and/or failure to achieve cooperation with other agencies about these objectives.
- Concern over advertising services before being sure the agency can deliver.
- Community initiatives seem to lack appeal for the media and funding agencies.

The benefits of liaison

To get such referrals, a drug service needs to 'sell' itself to the agency concerned, not just advertise its existence and wait for the phone calls to come. The result can often be directly client-empowering. But if lack of liaison leaves other agencies in the dark about the drug service, then the referrals will not be made in the first place.

There is greater scope for proactive work with voluntary projects. Tranquilliser problems in particular present major challenges to drug-specific agencies in terms of the need to carefully sift referrals coupled with a very extensive need for the dissemination of information. Liaison with community groups already actively concerned with mental health creates opportunities to disseminate information and to prevent inappropriate and time-consuming individual enquiries.

The aim would not be to discriminate against tranquilliser users as a client group, but rather give them the information they need to enact their own self-help coping strategies. Participation in local mental health support groups can be an assertive piece of self-therapy. Drug agencies can feed into the work of these groups, helping them to identify their members' needs for prescribed medication and to support those members in achieving their aims. In this way the agency facilitates an informative piece of consumer direction of services — an appropriate use of worker time.

continued on page 12 ▶

The author is County Development Worker with Leicestershire Community Drug Services

1. Parker H. *et al. Living with heroin.* Open University, 1988.
2. Pearson G. *et al. Young people and heroin: an examination of heroin use in the north of England.* Gower, 1987.
3. European Parliament. *Committee of Inquiry into the Drugs Problem in the Member States of the Community: report on the results of the enquiry.* EEC, 1986.

MPAIGN

Ian Wardle and Colin Cripps

Two Newham drugs workers respond to Robin Burgess's arguments. The priority now, they say, is not to coordinate what little we have. To get the resources they need, and to be allowed to take effective local action, drug agencies must band together to achieve a radical top-down shift in the national climate of opinion on drugs.

ADVOCACY OF decentralised, inter-agency community drugs work is a well-established orthodoxy, so well established that it is difficult to know how to argue against it. The word 'community' is an almost obligatory designation of the 'correct' approach. We have been subjected to an ever-growing number of variants on the community theme, each with its own novel features. The importance of this work cannot be underrated. But in terms of the current priorities of the national debate on drugs policy, we think this particular seam is exhausted.

In our London borough there are 213,000 people; 14 different languages and cultures; millions of pounds of speculative property development which has shifted whole masses of people (less than nine per cent of Newham residents can afford to buy a home in the borough because of the explosion of the property market); structural inequalities between the sexes which economic recession has exacerbated; and shortages of all kinds of skilled employment.

All these factors divide rather than unite people. In the face of these divisions, and many more besides, too much talk of 'the community' is at best misleading, and at worst, dangerous. Giving the impression that everything would be OK if only the full resources of the community could be tapped is unrealistic. The fact is that the required resources just aren't there and one priority is to dramatically increase community resources across both statutory and voluntary sectors, not just to discuss how to exploit current provision.

We've learnt to accept shrinking statutory services, yearly paring of budgets, ever-widening gaps in provision, without even affording it prominence in our own house journals. For at least six months of every year, statutory services are largely concerned with deciding upon and administering the next round of cuts in provision. The voluntary sector likewise spends more and more time chasing less and less funding. Policy recommendations for drugs and HIV training and services, with or without funding implications, are stacked up because managing shrinkage is a full-time job.

The situation is exacerbated by the intrinsically controversial nature of much drugs policy. Sensible, realistic, factually-based initiatives can founder on public/media reactions stemming from the thinking that if you're not blindly 'against' drugs, then you must be irresponsibly 'for' them and thereby 'promoting' drug abuse. More likely, fear of the repercussions on funding and public acceptability will mean the initiative is not taken in the first place. Add this to the funding crisis and you are left with a recipe for widespread inertia.

Drugs workers have cosy debates about the merits of different needle exchange schemes and educational approaches, but the whole cake of which these are slices is disappearing fast, and we remain silent. In our borough there are a total of three full-time workers for drugs training, counselling, advice, support, policy formulation and networking. This barely constitutes a finger in the dyke. No matter how good our neighbourhood philosophy there's no point in us pretending that our impact alone will make one iota of difference to a worsening situation.

The national drugs network — SCODA, ISDD, TACADE, community drug teams, drug dependency units, independent training agencies, drug education coordinators, university departments, voluntary agencies — is now extensive enough and well enough established to be speaking with one loud, unequivocal voice. If the price to be paid for respectability and 'influence' is merely to respond to a succession of tabloid-led drug panics, then it is much too high. There is seemingly a cottage-industry of drug experts content to exist on a drip-feed of piecemeal funding — possible itself only because there is no widely heard voice at national level proposing a more sensible, coherent policy than moralistic crusades and an ever more repressive 'war on drugs'.

Lobby the politicians

The whole drugs issue, from global production through to street-level response, has always been governed by politics in every sense of the word. Yet the political messages we allow ourselves are so heavily encoded that they can easily be assimilated by politicians of almost any persuasion. Politicians might shy away from arguing against the erosion of civil liberties in a punitive drug war that cannot be won — but who can blame them when they are not actively lobbied by the one group of people in the best position to advise them?

If the war on drugs is not to be simply a war on drugtakers, then we need a coherent policy on production, manufacture, distribution and consumption which addresses global and domestic inequalities; a systematic review of drug laws; a clear recognition that by 'drugs' we mean more than just controlled substances; and the ability to understand the implications in terms of service provision and education, as well as control. A change in the messages from political leaders can change the national climate of opinion so as to allow effective local action and free up the resources to carry it through.

WE NEED TO ORGANISE nationally to influence the detailed policy and manifesto commitments of those political organisations capable of bringing about change. We need to make our voice heard. If drug workers could become half as effective as the political lobbies representing tobacco and alcohol, then at the very least we would be addressing the sense of being beleaguered which currently divides us. We must not be afraid of being radical.

A national voice needs national organisation. It will need servicing by an efficient secretariat and will need to be accountable to all its constituent parts; an enormous task, but a necessary one. We suggest that one way forward is for SCODA to bring together other interested organisations with a view to holding an initial conference to establish an effective campaigning lobby. Comrades, we have nothing to lose but our funding! ■

Barry Lewis, Network

The first author is the coordinator and the second author the secretary of the London Borough of Newham's Drugs Advice Project.

▶ *continued from page 10*

Tranquilliser groups set up by therapists within a drugs service can perpetuate therapist/client barriers, but a consultant role to a self-directed voluntary group helps erode those barriers. Making the problem of anxiety rather than withdrawal effects and pharmacology the focus for group work also helps counter the hysteria associated with tranquilliser dependence. A mental health group can do this far better than a community drug team's 'tranquilliser reduction group'.

In this way effective liaison and information-provision can tone down the extreme community responses some professionals fear. This is no less true of parents' or tenants' groups than of tranquilliser users. If we are frightened that they will represent views more conservative than our own, then the option usually adopted — to ignore them — is a cop-out. Working with them on their terms at least widens the range of community provision open to our customers. A third option is to seek to work with them on a joint basis and to inform them a bit more about our viewpoint.

We may fear their conservative views but ignoring community groups is a cop-out.

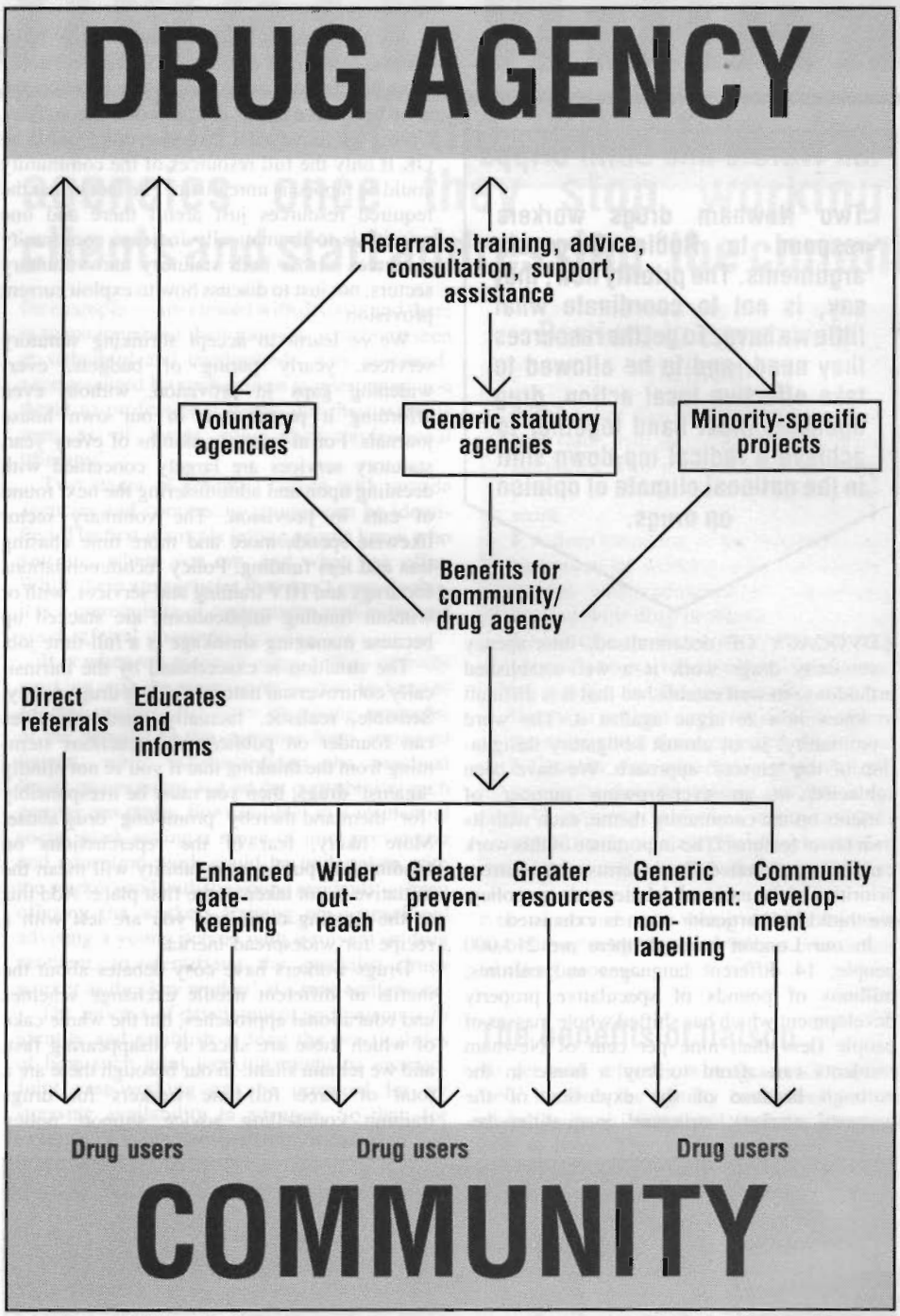
A good parents' support group has real value in meeting the service needs of our 'relative' clients: the parents, spouses and friends who usually make one telephone call and are never seen again. The professional drugs field cannot hope to educate the entire community to a common level of informed awareness — its own house is already in too much disorder on issues like maintenance — so it has to be part of a broad spectrum with Narcotics Anonymous at one end and groups for injecting drug users at the other. Professionals who have the power to direct services cannot ignore either side if they are really seeking community support. 'The community' is just shorthand for a diversity of neighbourhood and family groups.

Community liaison means extra work with different skills, and is at one remove from directly 'helping' individuals. However, drug services do not work simply at the level of casework but also spend much of their time in 'prevention'. Networking and liaison are vital not only in terms of prevention but in creating the local groundwork to support the development of services.

While a European Parliament report[3] has cited the Wirral as a paradigm of community action, researchers in the area tell a different story — one of political infighting based on lack of aims and knowledge. Many workers would argue that to avoid this it is better not to involve the local community for fear of uninformed opinion hindering the development of user-friendly services. This is a dilemma that drug services will have to work very hard to resolve. More initiatives involving the wider community and thus more practical examples might enable agencies to look beyond their user population to other groups.

One other factor may encourage this process. Community drug teams are often based at a central location yet cover a huge population and area. Detached work is often highlighted as a way to reach the large untapped mass of drug users, yet the sheer scale of the catchment area will always defeat the most ardent outreach worker.

Expanding outreach through community agencies



However, teams covering large areas and rural settings can augment their service by judicious use of existing generic detached workers — youth workers, women's workers, etc. With proper training and support, harm-minimisation advice can be given by any detached youth worker, or they could be the main care worker for a young person, acting as a buffer to keep what might be a recreational user out of the hands of a clinical agency. A generic worker can be both gatekeeper and referral agent, expanding the scale of an agency's outreach. The diagram above is an attempt to illustrate the main links in the process.

To some extent this is an acknowledged process that has always gone on. But making it a stated aim and offering the training to enhance confidence can help defuse criticism from both sides that 'drugs' are a specialist matter.

IT IS HIGH TIME that development work by community drug services was given the priority it deserves. It enables workers to keep in touch with users' feelings and tensions regarding drug use, and also with those of society at large, whose views are too often presumed at the same time as being discarded.

Contrary to common opinion, community liaison is client-focused and ultimately client-empowering. It expands the range and diversity of provision and increases the appeal of the service to a wider range of clients. It harnesses the goodwill, time and money of volunteer groups and improves the extent and quality of outreach. In particular, it might improve service delivery to those groups in the black community to whom, at present, drug services are comparatively unknown. And it goes some way to meet the need for a coherent and coordinated response to drug misuse. ■