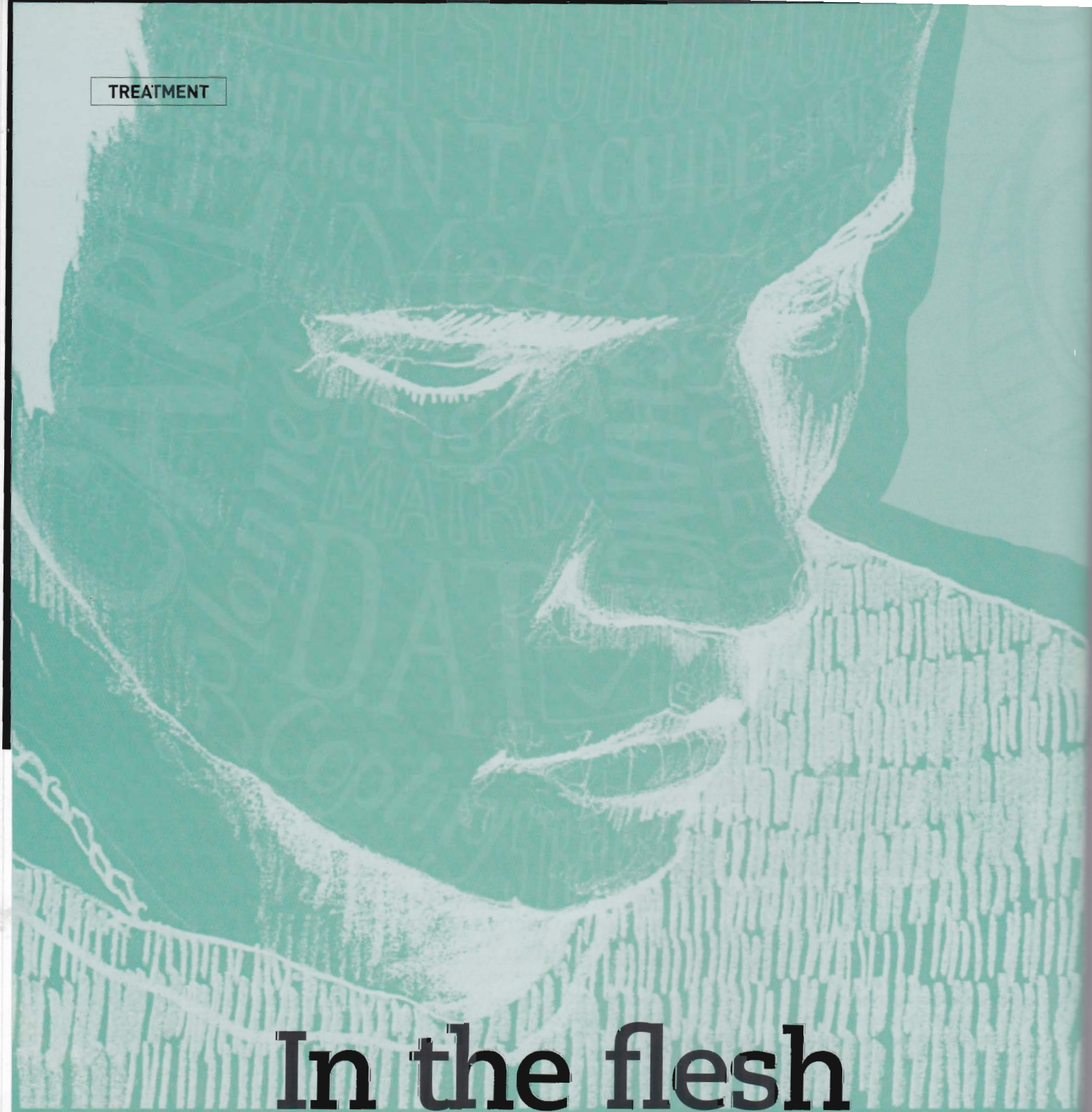

In the flesh

In the wake of the launch of the new drug strategy, the daily grind of dealing face-to-face with some of the UK's most damaged people carries on regardless. In this frank and revealing piece, drug worker **'Beth'** describes the two conflicting worlds of order and chaos which dominate her job

I work in the real world of drug and alcohol treatment. I wouldn't say it is totally unrecognisable from the interventions, policies, procedures and guidelines published in *Models of Care*, NTA guidelines and DAAT policies, but it has to be translated to fit. Perhaps at best the guidelines and the reality are as similar to one another as classical Latin is to Italian slang in the slums of Naples. They're clearly connected but they need a lot of interpretation.

I work in a smallish combined statutory and non-statutory agency in a smallish northern town. The service offers structured, care-planned, psychosocial, one-to-one interventions for drug and alcohol users with complex needs (Models-of-Care-speak). In other words I sit down with people so lost, confused and generally f****d up that most of the other workers in the agency don't know what to do with them. Either that, or they've tried and feel they aren't getting anywhere.

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Of course, I can speak the 'classical Latin' of the people who have the power to give us more (or more likely, *less*) funding, those who give us our targets and then threaten us with being put out to tender if we don't achieve them. I can 'strut my stuff' when needed and present the work of the agency at meetings in the way that I know people want to hear. I can talk about tier two and tier three, behavioural focus, cycle of change, relapse prevention, coping strategies, self-efficacy and (lets throw in a name to impress here) Zinberg. If pushed, I can talk about Rogers, Freud, CBT, cognitive dissonance, constructivism, node mapping and I can even suggest I have a fair idea about DBT and personality disorders. So gosh, what a lovely 'toolbox' I have and how well supported I am by the agreed assessment and monitoring tools provided by my local DAAT!

Right. Back to reality. Here is a day at the sharp end...

I have seven clients booked in to see me today. In order to satisfy the target set by the DAAT for our tier three caseload, I should make sure that I see five in a day, so I must allow for DNA's (Did Not Arrive). I have challenged the powers that be over these unrealistic targets by reminding them of the FDAP guidelines for supervision, the time I need to liaise with other services, the time needed to put notes on the frustrating and complex database that churns out the stats to prove our worth. However, and here comes the stick yet again, I have been told that jobs will be cut if targets aren't met.

So it is fair to say that I am ambivalent about the attendance of these clients. I want them to attend because I want to carry on helping them as best I can. There may also be clients here who have not attended for the magic 12 weeks, which apparently ensures that treatment will be effective. I know that retention rates are another target that we must satisfy to get our funding.

I look at the seven names and see seven complicated and struggling people who need my total concentration in these sessions. If they do all attend I will be exhausted at the end of the day and may struggle to find time for a lunch break. So, hand on heart, I hope they don't all come.

The first one does come – highly anxious, low self-esteem, continued drinking, peculiar thinking patterns, strange and possibly abusive relationship with her husband. I guess she could be labelled dual-diagnosis, but as the only dual-diagnosis worker has an 18-month waiting list and doesn't accept anyone who might be labelled personality disordered (as this client might) the dual-diagnosis label has no value anyway. She has been coming to see me for about six months and has had a dysfunctional life involving heavy drinking for about 30 years. I know that change will be slow, but I don't know at what point the guidelines will decree that she should be better.

We revisit two of our regular topics – her relationship and her fear of not drinking. I get out a bit of paper and draw diagrams on the basis of what she tells me. "It's a vicious circle isn't it?" she says. I smile and nod. Week by week I try to nibble away at her irrational thoughts and dysfunctional behaviour by offering her a safe place and a safe person to question what's going on in her life. She would benefit from some community support, but our community support worker post was axed about a year ago.

I get a break at this point, as the next client doesn't appear to be coming today. I know that he is still drinking, waiting for a detox (let's hope we are within our waiting time targets). He suffers from mood swings and serious depression. Mental health services have passed him on to us because he drinks heavily – not because he doesn't have a mental health problem. He is on a scary mix of prescribed medication, about which his GP seems to be far less concerned than I. The client denies any suicidal intentions, but I suspect this is to ensure his medication is not challenged. His life is made particularly difficult by living alone in the roughest part of town, but with the housing problems we have here he is lucky, frankly, not to be on the streets. By the way, our housing support worker post has also been axed. Anyway, last week this client turned up a day late, so maybe that will happen this week.

Client three arrives. My first challenge is to consider how much of my horror about her appearance I reveal. She has been beaten-up by her ex-partner. She sits and shakes and tries to pull her hair over the dent in her forehead. Her hair covers some of the bruising but her face is black and blue and swollen all down one side. He has held her by the hair and punched her repeatedly in the face. She is frightened he is going to kill her. So am I.

I sit and listen. No tools, no techniques, just genuine human compassion and concern. I want her to be safe and ask if I can contact Women's Aid to ask about a refuge. She agrees. "I'm still not drinking and I've only had one spliff", she says with a somewhat bent smile. Am I doing relapse prevention? I want to capture the perpetrator and lock him away for a long time. I want to send her out with a bodyguard. When she has gone I fill out a risk assessment, ticking a lot of boxes.

Another session follows immediately with another client with a black eye. He is quite cheery and gives me a big smile. As he talks I notice the scrapes and bruises on his knuckles. He has been in a fight, but it was just "male bonding". He also tells me about another violent incident which he feels was justified, but nonetheless has some concerns about. This acceptance of violence as a way of managing life is hard to hear after the last client. I become far more directive and challenge him to think about the implications of this. We're like Pinocchio and Jiminy Cricket – I am his conscience. I wonder if this is what he is looking for, and I wonder if this helps him to take responsibility for his actions. Remarkably he goes on to tell me he has reduced his drinking and has not used cocaine for six days. I wonder what intervention accounted for that.

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The next client is a woman I worked with through her child protection proceedings. Despite having had one of the worst histories I have ever heard, including violence, abuse and the murder of a close relative, she managed to stop drinking and using drugs during the proceedings. Her daughter was "the only good thing that had ever happened". Despite this, her child was removed and put up for adoption.

Her GP has now referred her back in again. I have never seen such despair. At several points in the session, tears flow silently down her cheeks. She is pale and thin and has lost a tooth since I last saw her. I should be doing a health care assessment which asks if the client has a dentist, but there are no dentists in town willing to pick up NHS clients. It would be an insult to ask her. She sees nothing of any value in her life. My impression is that she is only still alive because she does not have the energy to kill herself. I put my forms to one side and ask questions to try to find some glimmer of hope.

She is coping with life by using alcohol and crack cocaine. She is most definitely pre-contemplative in the cycle of change. What would be on her decision matrix? Reasons to change: 'I might die', reasons to continue: 'I might die'. The only hope I can see is that she has attended her appointment.

I want her to know that I care about what happens to her even if she doesn't. I want to form a therapeutic relationship with her but I don't know what to offer. What therapy label would make her feel that life was worth living? The best I can do is to say I am here and I want to offer whatever support I can. She makes another appointment, but in my heart I don't know if I will see her again. Another risk assessment to complete and a letter to the GP spelling out my concerns – will those things help? I suppose I feel I have done what I can but it is nowhere near enough. Oh – and I failed to complete a TOP (Treatment Outcome Profile) form.

Four clients. Great, almost up to target and at last the chance for a lunch break. I chat briefly to some of my colleagues. There is always a lot of humour here. I suspect it is part of our coping strategy. It fits with the resilience model I learnt about recently – another tool to hone. Walking through the town centre in my break I think about the model of how we should work. Assessment, health care assessment, risk assessment, care plans, shared care meetings, treatment outcome profile, sessions x 12, client better, discharge. Have any of the people who compile the theory experienced the sense of powerlessness that I feel right now?

Back in the office the next client arrives, not bruised or crying or in crisis. Great. Actually, he was unlikely to DNA as I have a prescription for methadone to give him. I definitely have something to offer here. I have picked this client up from another worker who is off at the moment so before he gets his prescription I ask him to tell me a bit about himself. I am a bit surprised to hear that he has been on methadone for eight years and is still using street heroin on top. Am I just a legal drug dealer? I can't honestly say if it is my ego (wanting to show the other worker I can do better) or a concern for the client, but I slip into motivational mode. "So is the heroin use working quite well for you then?" By the end of the session he is saying he wants to "knock it on the head". Sounds good, but I have been in this business long enough to know that one hour in a weekly session has 167 hours elsewhere to compete with. However, I come out of the session feeling quite up-beat.

The last one is here. It is my first meeting with this guy. Referred to me with problems controlling his anger and cocaine use, he has mentioned briefly to another worker about being beaten by his drunken parents as a child. He is leaning forward in his chair. He looks anxious, smiling with an almost childlike desire to please. I have on my lap a 27-page assessment form, a risk assessment and a TOP form.

I introduce myself and he tells me, nervously wringing his hands, that he has never really talked to anyone before about the difficult things in his life. I put the forms on the floor and say: "Would you like to tell me about yourself?"