feature

Tony Herbert

Singing from the same hymn sheet

Still struggling with Multi-Disciplinary Teams

At the end of 1997, *Druglink* carried an article examining the theory of Multi-Disciplinary Teams. A year on, we have to ask ourselves whether Community Psychiatric Nurses and social workers alone constitute a multi-disciplinary team or are Community Drug Teams missing out on a better deal?

It's all very well in theory, but in practice, what exactly *does* 'multi-disciplinary' mean? Because, to be honest, the disciplines involved are more often than not just psychiatry and social work – bi-disciplinary, in fact. This is hardly surprising given that most statutory Community Drug Teams (CDTs) were created at the turn of the sixties as bolt-ons to psychiatric services. Set up so long ago with virtually no competition at the time, these teams (not forgetting their treatment beds) still hold the lion's share of treatment funds today.

As psychiatric 'add-ons', these teams have largely retained the 'mental health model' of service delivery. A consultant psychiatrist heads it up, the core staff are qualified psychiatric nurses, there are usually a few social workers and sometimes there is a clinical psychologist or occupational therapist thrown in. All very 'Mental Health' and not necessarily the best configuration to work with today's drug users, unless they are candidates for a dual diagnosis assessment.

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Common ground

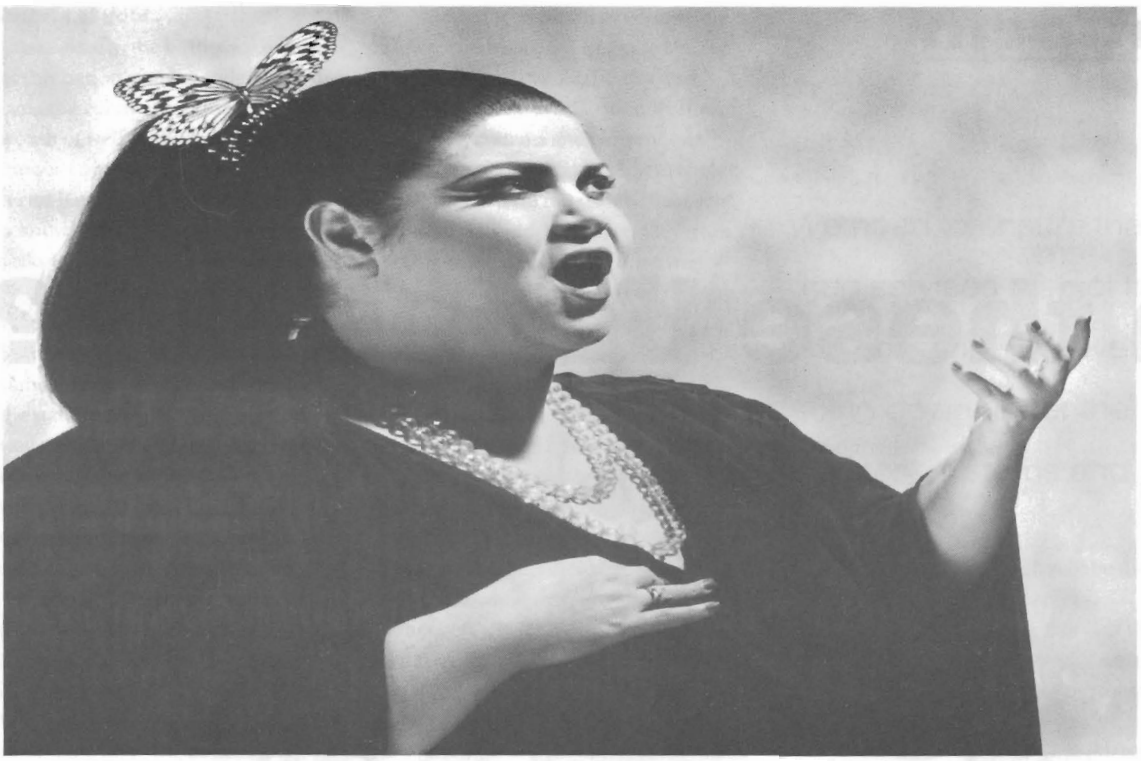
One of the factors that makes multi-disciplinary partnership hard to address is the lack of attitudinal common ground, a difficulty that arises from the differing theoretical and experiential bases of the myriad services on offer. And the multi-disciplinary CDT is often seen as the worst culprit, apparently promoting 'sharing and caring' but actually reinforcing professional jealousies and barriers.

The street agency worker, trained in humanistic or person-centred counselling, may well have a negative attitude towards statutory prescribing CDTs, which are perceived as having too many motivation- and compliance-related hoops for the chaotic user to leap through. "Why don't you accept them where they are and treat them anyway?" is the empathetic cry. This same hypothetical worker may well have problems with 12 step-oriented total abstinence programmes – "it's only cannabis and alcohol they want to keep on using, they want to stop the CrackSmackSpeed, what's the problem?".

The Community Psychiatric Nurse at the CDT replies, "There's little point in us seeing people who aren't motivated enough to keep appointments, never mind change. If you keep pandering to their every drug-induced housing, benefit and legal need they'll be a long time developing the motivation to comply and get better. And while we're on the subject, it's not a disease or even a *dis-ease* – that's a cop-out for accepting personal responsibility, and of course they can smoke dope and drink occasionally".

The 12 step worker (in recovery themselves) says, "You're both missing the point. One of you is enabling the perpetuation of addiction, the other is rejecting the addict. Personal responsibility can only truly follow awareness of the addictive condition (which none of you teach them) and anyway, how many addicts do you know who stop the CrackSmackSpeed and go on to use drink and dope occasionally rather than compulsively? Check out that 'occasional use' against ICD 10 or DSM IV dependency criteria, and then we'll speak again".

Sounds familiar? My guess is that if these arguments aren't then you work in a 'one agency/one view' locality which is ultimately much more unhealthy than the competitive to-and-fro caricatured here. The problem is not that any of these workers' views are all 'right' or that any of them are all 'wrong', but that each of them are right sometimes in relation to individual clients. The onus should be to fit this



'whatever works for you' theoretical and experiential base to the individual, rather than try to make *them* fit the theory.

The worker mix

Which brings me to the organisational survival instinct. Though the organisational drive to look after itself is rarely about a specific individual's pathology (though we all know autocrats who sometimes make it so), it usually takes its staff's energy and redirects some of it away from clients towards inter-agency competition and self-perpetuation. It does not lend itself to the facilitation of practice-based, multi-disciplinary discussions and compromise.

Looking for a solution to this difficulty, the key theme is 'balance'. There is no reason why multi-disciplinary CDTs, whether statutory or independent, can't employ a balanced mixture of psychiatrists, nurses and social workers, youth and community workers and person-centred counsellors – alongside healthy numbers of 12 step-oriented recovering addicts who have some kind of accredited professional training.

After all, former addicts who have been clean for two or three years can make some of the best client workers – provided that they have adequate, relevant professional training. Many CDTs would benefit from this part of the 'worker mix', increasing accessibility and credibility among groups of clients and potential clients, helping to keep the team focused on what it should really be about and providing real role models for clients to identify with. The CDT's reliance on the 'methadone carrot' (and subsequent use of the related 'stick' for non-compliance) could therefore become less important as a means of attracting and holding clients and instead be directed towards its clinical and treatment role.

This worker mix would also ensure a greater likelihood of achieving the balance between a service's credibility with clients and potential clients and the need for any service to have credibility with an increasing diversity of partnership and purchasing organisations. This mix also serves to keep the work force aware of different perspectives and less likely to develop or maintain the idea that 'only we have the right answers'.

That said, qualifications or a past history of drug addiction qualify no-one to be a competent drug worker. We all know that underneath, whatever our background. The making of a good drug worker comes about through professional training and professional experience, with a good clinical supervisor and formal and informal opportunities for discussion with our peers. We all know that too.

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I write this as a professionally qualified abstinent ex-addict, who has developed and managed a street drug agency for some years. By far the best team I ever had was the one that incorporated all the individual worker disciplines and experiences mentioned in this article.

I suppose that the axe I'm grinding here is mainly but by no means exclusively directed towards statutory CDTs. You generally have the largest piece of the funding pie but also the narrowest way of using it. Can you do it any differently? I think so, if you are willing to try. Should you do it any differently? I think so, if you are open enough to accept the challenge. Try it and see, or otherwise please have the good grace to remove the words 'Multi-disciplinary' and 'Community' from your titles as they are misleading 'trophy terms' ■