The personal touch

Qualifications do not an outreach worker maketh – it takes the personal touch

NEW REGIONAL MONITORING units mean the work of many outreach services is now open to scrutiny. Their contact figures vary so dramatically that something is obviously amiss. How can one team log 800 contacts and another a mere 20? Clearly many such services are failing to make and maintain contact with a majority of injecting drug users in their areas and failing to move clients through a hierarchy of harm reduction goals. I believe the major reason for these failures is that most managers have little understanding of the day to day reality of drug use, so are unable to identify achievable goals or to translate objectives into workable programmes.

Outreach work has been a prime example of this failure. Starved of effective supervision, many workers spend more time in the office, at conferences or in the ubiquitous 'meetings', than they do on the streets. Others sit around in the homes of existing contacts, or provide a free taxi service for drug users, rather than reaching out and making new contacts.

Such workers claim they are doing 'quality' work and that their 'caseloads' deserve the same quality of service other clients receive. Such claims are indefensible. The point of outreach work is to contact the hidden sector to facilitate changes in risk behaviour. This means reaching as many people as possible to educate them and to provide the means for behaviour change. These objectives seem to have fallen foul of a workers' agenda: the desire for status, job satisfaction, and, most crucially, the inability to make contacts.

Professionalisation

The success of some early programmes was largely due to the personalities of the people appointed. The key skill for this work is the ability to contact people who would not otherwise use services. Even the worst of drug dependency units can attract clients by dishing out drugs. Attending these demoralising units is a small price to pay compared with having to go thieving every day, getting robbed, or getting arrested and separated from your loved ones behind prison bars. Many long-term clinic clients suffer such low self-esteem that they do not expect to be treated with dignity.

Drug users in the hidden sector may be a different kettle of fish. The fabric of their daily lives articulates the 'great refusal' of Britain's criminal underclass. Their lives are totally dominated by drugs, either earning the money to buy them or using them. These people probably constitute the greatest HIV risk group. To make contact and be accepted in such circles, trust is essential; middle aged, middle class professionals just can't cut it.

Once outreach workers were appointed for their personal abilities to make contact and establish rapport; since then, outreach work has been subject to professionalisation – a process used to restrict the access of *outsiders* to resources and opportunities. Today this is generally achieved by insisting on academic or professional entry qualifications. Many employers now seek outreach workers with qualifications which may actually render them unsuitable for the job. In some areas only outreach workers with a nursing qualification are being hired, yet nursing training often makes people uniquely unqualified for such work. Nurses are trained in the rigid hierarchical world of the hospital, where the consultant is God and the patient is little more than a child.

Sick people are usually happy to abdicate responsibility for their health care. Drug users are different. Of course, many do present to services seeking help with their lives in a mess, mentally and physically in need of care. But outreach workers are employed to reach those who *aren't* asking for any help. If workers continue to see these drug users as people whose experiences, opinions, skills, knowledge and insight count for less than their own 'professional' training, then the failure to achieve outreach objectives can only continue.

Management failures

One of the biggest barriers to HIV prevention is the fact that most workers would be unable to gain entry to the places where HIV risk behaviour occurs – dealing locations, shooting galleries, crack houses, etc – and even if they could, they would feel threatened or uncomfortable.

But the biggest problem of all, and the most important issue to get right, remains that of management. One of the key manifestations of managerial inadequacy is a tendency to appoint workers in one's own image. Sober, middle class professionals will appoint clones completely unsuited to the work; they lack the judgment to identify somebody who will make it on the street. Very few managers have the experience of the workings of the illegal drug scene needed to effectively supervise their staff. Some don't have a clue what a worker should do or should be able to do, leaving outreach workers to set their own agendas.

Of course, there is a group of people who are accepted by the hidden sector, who already know a great deal about drugs, about services and about HIV risks. Other countries are beginning to make use of the euphemistically termed 'indigenous worker'. It needs evaluation, but the advantages of using current drug users over so-called professionals appear to be enormous. ■

by

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