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Professionalization in low-threshold drug aid – between managerialism and practitioner knowledge[1]

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´Not everything that can be counted counts

and not everything that counts can be counted'

(attributed to Albert Einstein)

At the end of the 1980s drug help practices in Germany experienced a significant phase of change. Open drug scenes, in which the consumption of illegal drugs took place under mostly catastrophic conditions, and the minimal scope of the previous offers of help called for reforms. In the course of this reorientation, alternative, acceptance-oriented approaches were developed which contributed to the establishment of low-threshold drug help as an integral part of the help system (Schmid 2003). At about the same time, social-work and non-profit organizations (NPOs) started applying business management concepts and instruments and employing professional managers. Today, some 50 years after the start of these initiatives, it is time to ask: (How) Did Social work organizations benefit from management techniques? What alternatives do they offer with regard to a development that is sometimes referred to as "managerialism"? (cf. Enteman 1993).

The focus in this article is on changes in social policy "towards more managerialism" and its effects on low-threshold drug aid. We will describe the logic that underlies both areas and that motivates the employees in these areas and dominates their professional actions. Examples from the everyday world of low threshold drug aid are given to exemplify a situation, which we describe as a ´dilemma between managerialism and practitioner knowledge´. We will use theory and ideal-typical case studies to justify our hypothesis: This is that the question of the success of low-threshold drug aid depends to a large extent on the definition of what "success" is. Additionally we ask: Does low-threshold drug work run the risk that bureaucratic administration will diminish the helping and healing engagement with clients?

1 Low-threshold work: Goals and methods

Fundamental goals of low-threshold work are formulated in the "Capability Approach" (according to M. Nussbaum (2000) and A. Sen (1985)) as a minimum for a dignified life and for social justice as well as a conceivable normative basis for low-threshold assistance. These are essentially: Life (not dying prematurely), physical health (nutrition, shelter), bodily integrity (protection from violence), senses, imagination, thinking (making use of one's understanding), feelings (attachments to things and persons), practical reason (one's own life

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planning), belonging (recognition), and control over one's environment (housing) (Schmid 2014).

In practical terms, these basic goals are specified and supplemented in the sense of inclusive assistance: gaining daily structure, activity and employment as elements of participation, expanding social and work-related skills, enabling experiences of self-efficacy, public recognition and planning for the future (Hecht/v. Well 2016).

Low-threshold services help save lives. Contact and emergency sleeping facilities, drug consumption rooms, syringe exchange, "safer use" and many other services help drug addicts to survive. Without specific exit scenarios or abstinence requirements, addicted people find contact and support in these offers: Low-threshold facilities are a home for many of those affected, the various employees are a substitute for a family, or at least a point of reference (Hörter 2011).

After all, it is also a matter of bringing together players from the middle of society to encourage civic and entrepreneurial engagement, to help (re)establishing the participation of disadvantaged people in society (ibid). With the support of low-threshold addiction assistance, existing actor networks are established and strengthened. These are social processes that require long-term support and moderation. In this context, connections to actors who have acceptable, low-cost housing, to doctors who understand the special fears and problems of addicted people, etc. are of central importance. Work in low-threshold addiction support is oriented towards the following methodological orientations:

- Interdisciplinarity instead of fragmented action according to areas
- Concept, rather than sum, of individual activities
- Participation - or how to help those who are difficult to help

Low-threshold support can only achieve its goals if it succeeds in establishing contact with the client and securing this contact in the long term. Good contact is therefore itself an essential goal of low-threshold support (CaSu 2013).

We want to place these statements within the framework of the theory of resonance introduced by the German sociologist Hartmut Rosa: For Rosa (2016, 666f), processes of education, care, therapy, and healing emanate from the physical presence or face of the Other, from whom there is always a direct invitation to resonate. They therefore require a minimum of resonance relations. Especially in the long run - according to Rosa - these processes cannot be designed without resonance. Furthermore, Rosa states that all contexts for which the formation of resonances is essential and functional are under an almost permanent pressure of reification, connected with a compulsion to increase and to succeed. The compulsion to succeed in the social-therapeutic, creative, pedagogical and nursing professions themselves, however, requires the formation of resonance ability and resonance sensitivity. This leads to tensions and contradictions in two respects:

Firstly, resonance relationships and experiences always contain an "overshooting moment," a moment (like enthusiasm for a cause or a touching encounter) that cannot be contained and made available and that eludes the reifying logic of enhancement. **Secondly**, conversely, all contexts that are essential and functional for the formation of resonances are under almost

permanent pressure of reification (e.g. in school, where it is about fulfilling the curriculum, or in theater, where it is not about changing the world, but about filling the house). Social therapy professions are even more familiar with such pressures: The clock runs relentlessly at work and resonance must be constantly suppressed because it is not affordable (ibid).

The reification and the pricelessness of resonance leads to important questions about the valorisation/devalorisation of social relations in a care setting. Furthermore, Rosa's theory of resonance and reification highlights the tension between orthodox economism (unlimited growth in material terms, i.e. profit maximisation) and "social productivity", i.e. being productive for society and for social relations (values that are often overlooked in economic measurements and valuations). The abstract freedom of the market, as represented by neoliberal economic theory, is contrasted with the concrete freedom of people in an economy that serves life. This is explored further in the following section.

2 Economic aspects of social work

The role of the market is to ensure economic value creation and to integrate people by making them part of the labour force. State policy is to ensure the distribution of value and corrections in market access and performance. Taxation of economic enterprises serves to finance social tasks such as education, public infrastructure, culture, social work and the health system, while social health and security systems should ensure the security of the labour force (Elsen 2007). Social (re)integration is one of the tasks of professional social work. This division of labour in the "social market economy" only leaves social work with flanking and stabilising tasks that lie outside the orthodox field of economic valorisation.

In recent decades, the parameters for this model of industrial modernity have been reversed under the influence of the epochal changes brought about by "neoliberal globalisation" (Baccaro/Howell 2017). Within the framework of this development the pressure on the practice of social work institutions to demonstrate the effects achieved has increased, and there is pressure within the profession to further develop social work institutions professionally (Burmester et al. 2020). The economization of the social sphere, as indicated by the term managerialism, has introduced a corresponding perspective of progress into social discourse: According to this perspective, social progress can be achieved primarily through a continuous increase in economically defined productivity, i.e. as a value creating enterprise.

Ultimately, impact orientation means "the goal-oriented striving for a defined quality of results to be defined in each case - the impact" (Bundesarbeitsgemeinschaft der freien Wohlfahrtspflege 2014). Consequently, it is necessary to describe and critically reflect on the planning process with reference to which effects are to be achieved with measures and activities of lower threshold drug help initiatives (intended effects), but also which effects are to be avoided (undesired effects) (Caspari 2012). Nevertheless, the question of meaningfulness and feasibility must always be asked. Is it even possible to measure effectiveness and economic efficiency in this field of drug work (Sielaff 2009)? Although there are approaches such as Moral Reconation Therapy (MRT) (e.g. Ferguson/Wormith 2013), these are considered unhelpful, if not counterproductive, in practice (Gettys 2016; Szalavitz 2016).

Effects can come to bear in different content dimensions. At the aggregate level, Schober and Rauscher name the following six dimensions:

- Economic
- Social
- Political
- Ecological
- Cultural
- Psychological and physiological (Schober/Rauscher 2020)

The identified effects in low-threshold addiction support can be located in one or more of these content dimensions. **Economic** effects are effects that directly or indirectly affect the economy. An example of this is the prevention of deviant and illegal behaviour, e.g. stealing. **Social** effects concern the coexistence of people, i.e., these effects relate to a local community, for example, to what Rosa calls "resonance orientation" (Rosa 2016). In terms of **policy** effects, the focus is on regulating the affairs of a community. Specifically, it is about actions and attitudes that have an impact on the political system as well as the process of (co-)shaping and participating in the community. **Ecological** effects, on the other hand, concern the environment or the interaction between people and their natural environment. An example here is the regular collection of syringes in public spaces. **Cultural** effects, in turn, comprise all that which humankind, morally oriented, produces in a formative way. Through the cooperation of the Osnabrück University of Applied Sciences and the low-threshold addiction support of Caritas Osnabrück, for example, it was possible to initiate cooking courses, dance courses and theater courses with addicted people. The sixth dimension of impact relates to the **health** of clients in low-threshold addiction support and includes both the psychological and physiological manifestations of this. The latter means vitality and freedom from physical complaints, while the former primarily refers to positive feelings and freedom from psychological complaints. The psychological dimension, however, is defined even more broadly and means the well being of persons, in the sense of their mind and psyche. Examples of such effects are therefore not only an increased self-esteem or positive emotions, but also the increase in knowledge or know-how (Schober/Rauscher 2020).

In all these dimensions the social work profession is challenged to establish its complementary and independent competence (Sommerfeld 2016). The description of the responsibilities and effects of social work in addiction support, specific competence profiles and service descriptions, the proof of their effects and effectiveness in the respective segments of the care landscape of addiction support are thus still to be seen as central challenges for the science and practice of social work (Hansjürgens 2019).

The proof of the effectiveness of social services presupposes conditions which are still in their infancy in social work and which expand the paradoxes and tensions through partly contradictory requirements and different logics of action of social services. Nevertheless, progress has been made in certain areas. In a position paper of Caritas Suchthilfe e. V., central factors for low-threshold help for people with addiction-related problems were identified:

- Development of self-responsible action strategies, help for self-help and - as far as possible and wanted - the transition to further and exit-oriented measures;

- Gradual removal of clients from the subcultural milieu and promotion of participation in life in society as well as (re)integration into secure housing, employment and participation structures;

- Showing ways to a life worth living, to social participation and to abstinence. Relating the clients' current concerns to these broader goals and responding sensitively to the clients' willingness to address them;

- Ensuring sustained contact with clients. Good contact is itself an essential goal of low-threshold support (CaSu 2013).

Nevertheless, it can be assumed that there is a need for further action and research in various areas:

- the impact factors and interrelationships are complex and, for the most part, have not yet been researched,

- evaluation research of methods and interventions is still in its infancy in many fields of social work and is controversially discussed with regard to a claim to evidence,

- user research, which deals with the effects and non-effects for users or even non-users, is hardly known in practice (Gesman/Merchel 2019).

The state of knowledge in the field of addiction support still needs to be demonstrated in a clearly arranged way. It is easy to imagine that there will be dozens of impacts that are located at different levels in terms of time, content and structure. Depending on the size and nature of the project or organization, this quickly becomes complex. One could imagine that a study on the benefits or the question of a social return (Schober/Then 2015) in low-threshold addiction care would conclude with the result of a clear 'social return' on the investments made.

Based on the categorical imperative, it could be assumed that the addressees of the field are interested in a good and largely self-determined life. It can also be assumed that the beneficiaries of social work expect a respectful and resource-promoting relationship from their professional participation facilitators and benefit from this as one of the most important support factors for a successful appropriation of direct and indirect services. From an educational point of view, it should be about functional health and self-determined activity and participation, about coping with bio-psycho-social problems, about quality of life and satisfaction - independent of the respective field, service setting or context of voluntariness versus coercion (Tranel 2019).

However, one can imagine a situation where the client is not satisfied with such a result at all. The (underlying) aim of the study could be to find ways to save money by means of a financially and personnel-intensive impact analysis. Unfortunately, we have to assume that such a strategy is much more plausible in today's world than one in which impact analysis is carried out with the aim of proving the high-quality work of employees. Such a "negative" assumption is at least closer than its "positive" variant. In this respect, the German social pedagogue Lothar Böhnisch's criticism of impact analysis is not to be dismissed.

Böhnisch assumes that the economic-technological feasibility mentality is deeply implanted in our thinking. Our social orientation is linear. Many can no longer imagine that detours,

breaks or conflicts can be productive, that the less and the different mean more than the yet-more. It's all about costs and benefits; the market principle has long since found its way into the social sphere. With the cost-benefit calculation, we have landed in the market. It is not only about the recipients, who have a right to effective services. Rather, it is about offers that are to prove their worth not only to the clients, but above all on the social and health market. To this end, they must be modularized in a comparable and generalizable way and be able to demonstrate if-then evidence. Evidence is required against the background of linear cost-benefit considerations (Böhnisch 2020, p. 98ff).

To sum up, economistic and managerialistic strategies of valuing, measuring and quantifying social relations (in our case in the context of social care) increase the pressure on the practice of social work institutions to a) demonstrate the effects achieved and b) strive for social progress, which c) can be achieved through a continuous increase in economically defined productivity, i. e., as a value-creating enterprise.

This focus on economic criteria and arguments is one-sided. It neglects (and threatens!) the positive effects of the work in low-threshold addiction support in the social, cultural, ecological and health areas. Above all, however, the generalized economic view impairs a very important criterion of low-threshold addiction support: to regard the respective person as an individual and thus to be able to offer individually suitable support options. Furthermore, a purely economic view is not meaningful, because human services cannot be reduced to a purely economic view.

3 Case Studies

We do not want to just theorize. Using various examples from the practice of low-threshold addiction support, we want to bring the theoretical results presented to life in the following. The aim is to illustrate a) what the practice of low-threshold addiction support looks like and b) how far it is from the abstract targets derived from management theories and c) how strong the pressure is on social workers who are in a constant balancing act between the real demands of practice and the abstract targets of management.

We use the ideal-typical procedure so that the contours and structures of subjective problem situations become particularly clear. This procedure goes back to Max Webers' reflections on the ideal type and from the consideration that biographical data, because they are life-historical, can be compared with historical material. For this reason, the sociological explanation of historical contexts can also be applied to biographical data (Borgetto 2003; Thönnessen 1995, p. 27;). Using the distinction between "proper" and "non-moderate" clients, we want to draw attention to the reality of addiction help. This consists largely of dealing with problematic cases, i.e., cases that cause more work than "proper" clients (which exist only as ideal-typical cases). In the abstract calculations and specifications of the management, this extra work is not taken into account!

We distinguish between one (ideal) positive and „proper“ case history and "difficult" case histories. It should become clear what steps and encounters take place in the run-up to admission and during a social therapy stay that are not necessarily goal-oriented and promising. In the practice of low-threshold addiction support, there are no monocausal treatment structures: the social workers do not know in advance what will lead to success and what will not. In the case of relapses, the whole process has to be started all over again; the common thread of social support is always taken up anew.

3.1 A „proper“ client

A client who is undergoing inpatient detoxification treatment in a psychiatric hospital contacts the low-threshold assisted living facility via the addiction counselling service and expresses his interest in changing his lifestyle. The staff member in assisted living opens a file and sends the interested person a form for the specialist's opinion and a form for the confidentiality agreement between the funding agency, integration assistance (assisted living) and client. The ward doctor documents the client's dependency disorder in the specialist medical opinion and makes a recommendation for a support measure and sends the specialist medical opinion to the staff member in assisted living. In the meantime, time passes and the staff member contacts the department of integration assistance in the municipality. The staff member in charge contacts the client and asks about the need for help by telephone. The client is admitted to assisted living (a place is available, the client is persistently motivated, was able to end his previous living relationship) and comes directly from the completed detoxification treatment to be admitted to assisted living. Here he takes possession of his furnished room and immediately joins a day structure in assisted living with motivation. A relationship of trust with the staff is established and he arranges further help with the addiction counselling service, doctors who can take care of the treatment of secondary diseases. The prescribed medication is taken regularly and independently. Integration into the existing life in the shared flat takes place without conflicts. The client feels comfortable in the shelter and stabilises himself, i.e. s/he maintains abstinence. S/He immediately reports addiction pressure to a fellow resident who is experienced in coping with it, and s/he also works out constructive ways of dealing with moments of danger with the staff member. Relapses do not happen, treatment of the secondary illness and dental rehabilitation take place promptly. All relevant appointments are kept punctually and without exception. Side effects and special difficulties in the treatments do not occur. The motivation to make use of this low-threshold help is unbroken. At no time is there a need to use substances to change or improve their state of mind. A distance to the previous environment (drug scene) is implemented without impairments. In the course of the existing abstinence, the client builds up a new social environment. In couple and family talks, s/he clarifies the existing conflicts and thus eliminates the danger of relapse. The corresponding triggers are dismantled. In an integration project for people with placement barriers, s/he faces professional integration and gets a place on the first labour market through a positive internship. Here s/he regularly meets his/her requirements, deals with excessive demands and limits in a reflective manner and maintains his/her abstinence. After three months of integration in the primary labour market, s/he starts looking for a place to live with his/her income certificate and a positive General Credit Protection Agency report. S/He also succeeds in finding a partner and establishes and maintains contact with her/his new social environment. Treatment of secondary illnesses is completed and successful and integration into society has taken place. Every single encounter with the client is documented in a „patient factorization system“ (this is the flexible solution for inpatient facilities for maintaining a comprehensive, digital client file).

3.2 Non-moderate clients

- The client comes by the assisted living facility and thinks aloud whether a change in lifestyle would make sense. No further contact is made.

- The client makes contact by telephone from detoxification treatment and receives the appropriate forms (see proper client), all administrative and form steps are processed. The client breaks off contact.

- The client arrives at assisted living detoxified and immediately relapses with alcohol the next time he goes shopping at the supermarket. As a three-week detoxification has just taken place and there is no life-threatening condition, no new detoxification can take place. The client has to reduce his intoxication in the shelter and is a danger to the other residents. His addiction memory is triggered by the substance he has consumed and he goes to the scene to obtain and consume other substances. He does this secretly and tries to hide it from the staff. The flatmates find out about the relapse, some of them also use, others cut themselves off. The social worker is not told. The intoxication comes to the attention of the social worker and the client is disciplinarily dismissed.

- The client does not relapse. He maintains the structure of his previous life, sleeps through the day and watches a lot of TV-series or plays with the games console at night. Money is spent on games at the beginning of the month, which is lacking for food and tobacco at the end. He borrows money from the flatmates, has to pay it back at the beginning of the following month and loses himself in this endless loop. Frustrated, he goes on the scene and procures substances on loan basis, which he either shares with the flatmates (and thus pays off) or with the help of which he escapes reality (the bad feeling). Relapse is concealed or denied until the social worker discovers it. Disciplinary dismissal follows.

- The client arrives in assisted living and very quickly misses his previous social environment and contact. He seeks out his social contacts and is greeted happily with alcohol. In addition, he is given a drink (the drug scene takes back its clients). Client relapses, is hopeless and quits assisted living (that does me no good!).

- The client arrives at assisted living and first has to apply for unemployment benefit. There are no financial resources. The frustration is so high that he cannot stand it and drops out of the measure.

- The client has become a loner through socialisation on the drug scene and only shares the most necessary things in individual and group talks. It is not possible to build up a trusting relationship with the staff member. The burden of proof remains with the staff member and cooperation is tough and distant. The client is heavily in debt and "yellow letters" arrive every day and disappear unopened in the client's room. The bailiff appears and wants an affidavit. The job centre stops paying unemployment benefits for lack of cooperation. There is no communication and no demand for support from the employee. The frustration on the part of the client is high and leads to relapse.

- During many years of drug addiction and also in childhood, the client has learned to escape from difficult situations by using violence. After admission to assisted living, the client has a dispute with a fellow client about the use of the washing machine. He threatens the fellow client with beatings and is dismissed by the staff member due to threats of violence. Every single encounter with the client is documented in „the patient factorization system“.

4 Implications for the practice

A comparison of the different (idealtypical) clients in sections 3.1 and 3.2 shows, first of all, the considerably higher workload for the "problematic" clients. Numerous contacts and intensive relationship-building are needed to motivate these clients and keep them in line. The

(non-paid) work in the area of client intake is the most important and first step in working with clients in the first place. Solution offers are made and contacts renewed again and again. Ultimately, it is about retaining and motivating people. Lack of motivation and hopelessness among drug addicts ensure that no further helping steps are taken. Presence, constant repetition of face-to-face contacts, continuous interest and appreciation are the tools that have proven to be effective in low-threshold addiction help. Having time to approach a person individually, to accompany him or her, and to name the hope for a sense of achievement and to draw from this the courage to take further steps; to focus on people as personalities, to praise them and to accept them as they are - these are the factors of effectiveness in low-threshold addiction help.

After looking at the complex case descriptions, we recommend that the ´effectiveness´ of action in low-threshold addiction support should be determined less by the factual results but rather by the way in which the work with the ´clients´ and the other important actors is designed. Here are some examples from praxis on how exactly the work with clients can possibly be redesigned.

Client gets bored and takes a job in an arcade for minimum wage. Vocational goal planning for this 23-year-old client is thus in question. The financial basis of subsistence and medical care is also called into question by this spontaneous action. Characteristic of the low-threshold approach here is the positive connotation of getting a job (sense of achievement), trying out a new daily structure and achieving his own income. The indication that this can be a transitional situation, because in the long term training and attainment of a vocational qualification could make sense ('open view'). The goal here is to maintain the relationship and compliance, current stability and break in consumption.

Communication in the stimulus-response scheme: The learning effect for the client should be that every action entails a consequence and does not remain without a reaction. The addiction counselor is challenged in the disclosure of observation and consequent handling of shown action. Here, great sensitivity towards the client is necessary, since due to a lack of frustration tolerance and usually a pronounced avoidance behavior, this can quickly lead to a break-off of the relationship between the client and the addiction counselor. Once the relationship is broken off, no further intervention is possible. This must be avoided at all costs.

Realization that someone is not sustainable for a supervised residential community in the low-threshold help. Here, the addiction counselor is required to ensure the protection of the current group and also, if the applicant can clearly demonstrate a need for help, to refuse admission. Solution to this dilemma is again creativity and knowledge of alternative help options for this applicant. Motivation is maintained, the desire for help is addressed, and onward referral can occur.

If drug users really want to change, it should be ´their work, their drive, their will to implement and not that of experts´. At the same time, this granted autonomy should not mean that drug users are left to their own devices in crisis situations, but that, unlike in the classical understanding of help, responsibility is actively taken over for them only in corresponding emergency situations. However, this transfer/assumption of responsibility should be desired by the users, since the acceptance of drug work is based on voluntariness and is not patronising. Accordingly, the needs of the target group are in the foreground and it is important to jointly identify and promote existing resources.

Another principle is the preservation and protection of the dignity of drug users. Here, humanity and human dignity are emphatically demanded in dealing with the users and a clear distance is drawn from degrading control practices (Mjaland 2015; Strike/Rufo 2010). Social workers are to act in a reciprocal process with the drug users, taking into account biographical and individual characteristics. The individual work processes must therefore be transparent and negotiated with the users in advance. Low-threshold accepting drug work as an integral part of public drug help aims at minimising the health, social and psychological risks for drug users.

Such a dialogical view of low-threshold addiction support has direct consequences for impact analysis: a real 'evaluation' based on criteria such as service directives, administrative guidelines, annual reports etc. would presuppose that one could objectively determine what is missing, how to approach these gaps qualitatively and quantitatively and how to measure the success of the corresponding interventions - precisely these prerequisites are not given. The parameters mentioned are ultimately political determinations that define the degree of publicly produced care that is considered sufficient and acceptable in the respective social context.

From a purely economic point of view, supporting people in low-threshold addiction care means investing a lot of time. The more time spent working on and with the client, the higher the retention rate, the break in consumption and the development of a positive resource for the addict. Conversely, this also means that the more time is required for applications, administration and documentation, the less time is left for the client. The longer a break in the use of drugs lasts, the more resilience is built up. This should be the measure of success for low-threshold help.

In addition, areas of social work can be identified that could **benefit** from the introduction of economic ways of thinking. Even after many years of outpatient drug help, social workers in low-threshold addiction help are not able to name their services precisely and to distinguish them from preventive services on the one hand (for which they are overqualified) and therapeutic services on the other (for which they are not trained). Medicine, especially psychiatry, is increasing its interest in addicted people and cites good reasons for this - such as comorbidity, substitution, qualified withdrawal - and psychotherapists can bill inpatient and outpatient therapies with addicted people on a case-by-case basis. Compared to these professions social work professionals are hardly able to define their services and are far from being able to present recognised effectiveness studies on their work. Methodical work is still the exception rather than the rule in psychosocial drug help. With the introduction of case management, the reception of brief intervention methods and motivational interviewing, a renaissance of the methodological discussion is emerging. Such a discussion would be urgently needed for social work approaches in low-threshold drug help (Schmid 2003, p. 233).

5 Conclusions for the theory

If one defines low-threshold addiction support as an activity in which moments of caring, looking after, discovering needs, activating infrastructures, mediating with political-administrative problem solutions, etc. intertwine, then its effect consists precisely in the fact that it does not derive its criterion of success and quality from performance, but from the willingness to act in a caring manner, because it is structurally related to needs and the case of need. This form of care production requires organisational arrangements that do not function

in the sense of the operational logic of market-shaped or competitive service production. The logics by which these two models operate do not fit together.

Low-threshold accepting drug work requires a lot of time, energy and perseverance. In a growth-fixated competitive society, the pressure on social service providers to use their resources more efficiently is always present. However, economic goals such as profit and efficiency must not be the sole objective. This also applies to social work organisations that are caught in this goal-means dilemma.

Resonance - to go back to Hartmut Rosas' analysis mentioned at the beginning - must be constantly suppressed because it is not affordable. He writes:

> "In fact, it is precisely the attempts to ensure quality - even and even precisely when they do have a sense of relational quality, that is, when they are more than pure economisation - that constitute the gateways for the worst manifestations of the transformation of resonant relationships into mute ones" (Rosa 2016, p. 668, italics by H.R.; transl. by J.T. and C.W)

Rosa goes on to describe how the bureaucratic compulsion to give a documentary account of all steps and actions, to measure and quantify all achievements and even ideas, makes life hell for those working in almost all professions and sectors where the quality of work depends on the quality of resonance relations. It is to be lamented that the pressure to increase and the time constraints, but also the standardising specifications and documentation obligations prevent the employees of these professions from doing their work well and correctly. For him, this is the real crisis of the modern world of work:

> "The attempt to make resonance calculable and available (and promotable) leads straight to alienation" (Rosa 2016, p. 668)

What remains is a fundamental contradiction of the institutional order of late modernity, namely the discrepancy between the reifying logic of increase of this order on the one hand and the longing for resonant relationships also generated by and in it on the other (ibid). This basic contradiction, which Rosa elaborates here, pervades and characterises all modern societies. It divides them into two camps: one camp is (primarily) resonance-oriented, the other is predominantly increase-oriented. It is about the deep and seemingly irreconcilable world views (and world attitudes) of, on the one hand, an optimistic, future-oriented, world-changing natural science culture and, on the other hand, the attitude of a hermeneutic, backward-looking culture of the humanities. The former want progress, discoveries and solutions, the latter strives for empathy, preservation and attunement. Ultimately, however, according to Rosa (ibid, p. 670), under the institutional conditions of late modernity, both run the risk of being dominated by mute world relations and thus cheated of modernity's promise of resonance. Applied to low-threshold addiction support, this situation can be formulated as follows:

a) Social workers in low-threshold addiction support want to achieve, for example, that even the smallest successes are positively connoted by the clients in order to advance their positive development. Due to the constant presence of the addiction counsellor and the possibility to intensively observe the client's behaviour, it is possible to recognise problems in time and to work out implementation strategies. In the long run, such a promise of resonance will be an (unredeemable) resource-based hope for the future.

b) The economic-technological feasibility and improvement mentality is deeply anchored in the thinking of the members of the other camp. But it is threatened by a creeping resonance erosion. Against the backdrop of linear cost-benefit considerations, evidence is in demand, but the inseparable bureaucratic compulsion to document all steps and actions, to make all achievements and ideas measurable, tends to lead to a comprehensive silencing of all axes of resonance.

Supporting Rosa's argumentation, it can be summarised that the imperatives of increase of modernity ultimately make themselves felt in both cultures as imperatives of reification. Understanding their institutional anchoring and naturalisation and identifying possible ways to overcome them must therefore be a primary goal of a contemporary critique of resonance conditions (ibid).

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