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**POWER, CONTROL AND EMPOWERMENT
IN ALCOHOL AND OTHER DRUG
TREATMENT**

A thesis submitted in fulfilment of the
requirement for the award of the degree

DOCTOR OF PHILOSOPHY

From

UNIVERSITY OF WOLLONGONG

By

JANETTE CURTIS, B.A., Dip. PH.

Department of Nursing 2002

DECLARATION

I, Janette Curtis, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Department of Nursing, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Janette Curtis

2002

ACKNOWLEDGEMENTS

This thesis is dedicated to my father, John Curtis, who died on September 12, 2001.

Many people contributed to this thesis in different ways. First, I would like to thank my supervisor, Dr. Lindsey Harrison, for her patience, encouragement, advice and direction. Not only did she guide me on my research journey, she also gave something of herself, and in doing so allowed a friendship to develop. Without her direction I would never have completed this task. I would also like to thank Dr. Patrick Crooks for his initial encouragement to undertake PhD studies and his ongoing support and interest in what was happening. I want to acknowledge and thank the participants in this study who were kind enough to share their experiences and without whom this thesis would never have eventuated. To Debbi Tohill who typed the transcripts, to Magda Heaslip for her technical support, and to my colleagues and friends who supported me through the highs and lows of my journey, thank you. Finally, I want to acknowledge a debt of gratitude to my family who believed that I could achieve my goal and never stopped encouraging me. In particular, I want to acknowledge the support, patience and love of my husband, Bill Millward. Without him I could not have reached my goal.

ABSTRACT

The concept of empowerment has been used extensively over the last decade in an attempt to improve clinical practice, to minimise power imbalances and to offer better care to consumers. Working collaboratively is seen as a cornerstone of empowerment and it is generally assumed that health professionals strive to achieve this in their clinical practice. This research investigates these issues within the context of alcohol and other drug (AOD) treatment.

The study that is presented in this thesis was carried out in a variety of AOD treatment facilities including an in-patient detoxification unit, an AOD outpatients' clinic, a methadone maintenance clinic, a residential detoxification and rehabilitation unit using a twelve-step treatment model and a residential unit using cognitive behavioural therapy. The non-probability sample consisted of fifty-seven staff and consumers who were interviewed in depth using a semi-structured interview format. Data were analysed using a modified grounded theory approach. The findings, which are summarized below, were further analysed using the 'frames of power' developed by Michel Foucault.

Although clinicians use the rhetoric of empowerment to explain how treatment is implemented, it is a contradictory discourse and it is compliance that they describe, not empowerment. Institutional arrangements assist in ensuring that empowerment does not happen. The major value underpinning practice is not empowerment but control. Clinical practice is concerned with who has control, who wants control and how control is maintained. Clinicians are afraid of losing power and employ discursive practices which serve to maintain their position and reinforce their notion of 'truth'. The real

purpose of treatment accepted by both clinicians and consumers is to make people ‘normal’.

Women in AOD treatment face more difficulties in accessing treatment than do men. The dominant 12-step abstinence philosophy was designed *for men by men*, and the organisational structure of many treatment facilities is geared more towards the needs *of men*.

AOD clinicians feel disempowered by the attitudes of other health professionals; by the attitudes of their own multi-disciplinary team; by the attitudes of clinicians from disciplines other than their own; and by the volatile and political nature of AOD policy and treatment. These are factors in the ways in which they disempower consumers.

By exploring the notion of discourse and discursive practices, the link between power and knowledge assists in explaining why the ‘taken for granted’ practices’ in AOD treatment occur and are perpetuated. The process by which consumers and clinicians are subjugated exposes the dominance of the medico-scientific disciplines and the dominant discourses that operate in AOD treatment. Foucault’s metaphor of the panopticon is important in understanding issues of discipline, surveillance and the subsequent use of the gaze. Self-surveillance, the birth of the clinic and the production of docile bodies allow yet another way of viewing and understanding AOD treatment. Finally, the power of compliance, which is the unspoken goal of AOD treatment, can be clearly identified using a Foucauldian analysis.

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CHAPTER ONE

INTRODUCTION

Introduction

The concept of empowerment has emerged rapidly over the past two decades. The World Health Organisation (WHO) noted that mental health consumers must be involved in decisions pertaining to the development, planning and evaluation of services, and described empowerment as important to an effective dialogue process (Bertolote 1993). Consumers who access alcohol and other drug (AOD) services should be able to expect the same level of involvement and dialogue as mental health consumers. AOD services' documents provide evidence that, in principle, participation and collaboration between clinicians and consumers is encouraged, but whether this is translated into practice has not yet been explored. Therefore, this study explores how the concept of empowerment is understood and put into practice in AOD treatment.

The fifty-seven interviews of clinicians and consumers, undertaken in a variety of AOD treatment facilities, were analysed using a modified grounded theory approach. This means I used grounded theory to collect and analyse data, because it offers a structured and rigorous approach in these stages. It provides a systematic analytic approach to qualitative analysis of ethnographic material because it consists of a set of explicit strategies. Glaser and Strauss (1967) acknowledge that some researchers use procedures associated with grounded theory when they have no intention of developing theory. Grounded theory methods can be used as

flexible, heuristic strategies rather than as formula driven procedures (Charmaz 2000). This is discussed further in chapter four.

The findings of this study were subjected to a Foucauldian analysis. Michel Foucault was a French social theorist, a self-proclaimed 'historian of the present' (Foucault 1977, p. 161), who was, in part, concerned with the relationship between power and knowledge and how existing social reality has been shaped by the relationship between these two concepts. Michel Foucault's work was chosen in preference to any other theorist (although six other theorists were presented for comparison) as his work focuses on the micro relations of power, while most others focus on power at the macro level.

This chapter is structured in the following way. First the aims, objectives and significance of the research are presented. Secondly, a brief background introduction to AOD treatment, followed by an introduction to the methodology, research method and explanation of the theoretical framework used is given. The third section presents the main research findings, and the final section outlines the structure of the thesis.

In contrast to traditional approaches to writing research, this thesis is written in the first person where appropriate. Using the first person reflects my role as the medium through which the research happened. Writing in the third person reinforces the role of the researcher as objective 'observer' through the use of a linguistic device, and the role of objective observer has not been my experience throughout the research process. I agree with Webb when she says that it is not possible to be completely objective and that the use of the first person must be used when the role of the researcher has been integral to the development and interpretation of the data. The use of the third person in such

circumstances would be ‘deceptive and biased’ (Webb 1992, p. 747). She goes on to say that researchers:

will inevitably invest and divulge much of themselves in their research. Just as others respond to us in personal ways in any social encounter, so in a research encounter they [participants] make judgements about researchers’ background, motives, intentions, beliefs and preferences and respond, as they judge appropriate (Webb 1992, p.749).

Aims and objectives of research

There are two main related areas in this study: first, that of alcohol and other drug treatment itself; and secondly, how the concepts of power, control and empowerment are contextualised and influence the manner in which AOD treatment is experienced by consumers and provided by clinicians.

The **aim** of the study is to explore the perceptions of power, control and empowerment from the perspective of consumers and clinicians in AOD treatment.

The **objectives** of the study are:

To explore and identify:

1. ways in which empowerment is used or could be used;
2. whether consumers want to be empowered;
3. if clinicians can and do empower consumers and if so, what methods they use;
4. any barriers impeding empowerment;
5. the positive and negative aspects of empowerment and its impact on clinicians and consumers.

Significance of study

A review of current literature reveals that while there is a growing body of work concerned with empowerment, it is mostly written from a philosophical perspective with little of it being research based on, or implemented in practice. In addition, there is a dearth of literature pertaining to the topic in AOD treatment. This research covers an area that has not yet been researched in any great depth and the results will add to the small existing body of knowledge. Although this study is undertaken in the area of AOD, it has significance for clinicians working in other areas of practice, as the principles guiding the practice of empowerment or impeding its implementation have been shown to be applicable in many situations (Carlson-Catalano 1992; Croft & Beresford 1992; Hine, 1996; Worrell et al. 1996).

For AOD clinicians, the ways in which treatment is delivered and practised is of utmost importance. Clinicians need both qualitative and quantitative evidence on which to base their practice. The results of this study will provide clinicians with new or additional knowledge, which will allow them to reflect on how they deliver treatment and how they can work to improve the services that they offer. This study will also have significance for those who teach AOD clinicians and other health professionals. If the move *is* toward consumer empowerment and collaborative practices, then the more that is known about its implementation is important. Finally, if clinicians are better informed and more reflective on their practice, then the consumer, who is central to this area, will benefit.

Background to study

There are many social, cultural, political and economic factors which influence AOD use and ultimately the provision of AOD treatment. These factors operate at many different levels and

it is within a very broad context that this study takes place. The following sections discuss many of these factors.

Although empowerment is stated by treatment providers as an important concern in AOD treatment, and it is written into 'statements of best practice' by many organisations, problems exist in the way services are provided. People hold strong and often negative views about AOD and many AOD clinicians and members of the wider population perceive AOD clientele as 'difficult' and lacking in moral willpower (Burman 1994; Kellehear and Cvetkovski 1998). AOD facilities are considered to be an undesirable place to work and AOD practice an atypical field of nursing (Cusack 1995; Happell and Taylor 1999c). In addition, AOD treatment is highly politicised and organised around two opposing treatment philosophies: abstinence or harm reduction. All of these issues affect the way in which treatment is implemented.

By far the majority of people undergoing treatment for AOD issues are introduced to the twelve-step model of treatment through either Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). These are self-help groups, built on a disease theory of addiction, where members 'sponsor' other members and keep in contact with them to ensure that they are not using AOD. One way by which they do this is to practise self-surveillance and discipline in order to conform to the norms of society. Although AA/NA is based on a disease model, a moral undercurrent pervades 'addiction' and is reinforced by the 'black or white' abstinence approach of AA/NA.

According to the AA/NA philosophy, once people are classified as alcoholics or addicts, they remain addicts or alcoholics for the rest of their lives. If they do not drink

or use drugs they are referred to as ‘recovering’, but are never referred to as recovered. In other words, there is an ongoing attempt to ‘normalise’ them, but they will never make the grade. These ‘addicts/alcoholics’ are defined, counted, marginalised and treated through voluntary means, coercion or by compulsory treatment orders imposed by the judicial system.

Once they enter AOD treatment, consumers (bodies) are scrutinised (surveillance) and the body is held up to critical gaze. Consumers are assessed and categorised by AOD clinicians in terms of their risk-taking behaviour and their potential to contract certain diseases (Hepatitis C, HIV/AIDS).

Furthermore, politicians and the media promote the tenets of the dominant discourse of abstinence through overt and covert reference to the moral issues of substance use, particularly of heroin use, as evidenced during the federal and state election in New South Wales (NSW) in 1999 where individual drug users were portrayed as ‘undesirables’ and the sub-text delivered was that heroin users were a ‘threat’ to society (Henderson 1999; Charles 1999; Duffy 1999; Carty 1999). Interestingly though, the same message was not delivered about alcohol use.

The health and judicial spheres overlap in AOD treatment and the consumers is seen as a potential or actual offender. The consequence of which is the development of non-legal experts (Foucault 1977). These ‘non-legal experts’ scrutinise the character and personality of the individual and as such become the apparatus of social surveillance. This is particularly evident with AOD use. Health related staff working in AOD health policy development, AOD health promotion activities and AOD treatment all take on

the surveillance role (Gastaldo 1997). For instance, an individual's drinking is scrutinised, the number of alcoholic drinks consumed on a daily basis is counted and a person is categorised as being a normal, heavy or hazardous drinker. This categorisation fails to take into account individual differences in people and their response to the substance, the context in which their drinking takes place and the environment where they drink. It addresses harmful/hazardous drinking from a purely disease-orientated perspective and, as such, reinforces the dominant scientific/medical discourse.

Another area that includes the potential offender is the area of gambling. In 1986 an invited paper to the British Medical Journal noted that gambling was an addictive behaviour or 'dependency disorder' (Dickerson 1990) and listed on the American Psychiatric Association's diagnostic criteria. Over recent years there has been an increasing emphasis on the 'problem gambler as addict', and as more casinos are built and easier access to gambling via the Internet occurs, more emphasis is placed by members of 12-step based self-help groups such as Gamblers Anonymous (GA) on identifying 'those at risk'. This issue has come under the auspices of health as it is seen as an 'addiction' and fits with the medical/scientific discourse.

Not only are health related staff the surveyors, but also religious social agencies, such as the Salvation Army and the Catholic based organisations, who provide treatment and whose nominated members sit on Government Advisory Boards such as the NSW Drug Taskforce. The involvement of these religious groups in providing treatment to AOD consumers serves to promote the moral perspective associated with AOD use, as historically religion has had the role of 'moral regulator'.

Methodology, theoretical framework and research method

The research methodology, or paradigm, employed is non-positivist, and as such supports a qualitative approach. The interviews are analysed using a grounded theory framework, the purpose of which is to gain information through discovering insights and to generate an in-depth account of the phenomena under interest. A grounded theory model involves three stages which were followed in this study:

- an initial attempt to develop categories which illuminate the data
- an attempt to 'saturate' these categories with many appropriate cases in order to demonstrate their relevance
- developing these categories into more general analytic frameworks with relevance outside the setting (Silverman 1993).

In addition to these three stages, a further analysis was undertaken using a Foucauldian analysis.

The theoretical framework underpinning this study is poststructuralism which is explained and its use rationalised in the following section.

The terms postmodernism and poststructuralism are under constant debate and are often used interchangeably. Giddings (1996), in her doctoral study which was jointly undertaken in the United States of America and New Zealand, posits that the term poststructuralism is used globally, while postmodernism is more commonly used in the USA to refer to a range of postpositive theoretical positions (Giddings 1996). However, the terms are contestable and therefore it is not possible to arrive at an absolute definition for either one. Postmodernism and poststructuralism are difficult to neatly separate (Cheek, Shoebridge et al. 1996). Bertens (1995) writes that, 'Postmodernism has been a particularly unstable concept. No single definition of postmodernism has gone uncontested or has even been widely accepted' (Bertens 1995, p.12).

Poststructuralism has been interpreted by some authors as a subset of postmodernism. In this interpretation, postmodernism offers a more socio-historical perspective whose discourse 'entails a more detailed analysis of postmodern society' (Mitchell 1996, p.202). Postmodernism seems to be concerned with social practice and social behaviour whilst poststructuralism appears to be more concerned with abstract thought and language (Larrain 1994). Agger (1991) views poststructuralism as a theory of knowledge and language, and postmodernism as a theory of society and culture.

Postmodernism and poststructuralism do share a number of premises, including the centrality of discourse for social life and a relativist distrust of a universal truth. Postmodern perspectives, which include poststructuralism, are those theoretical understandings, which reject:

modern assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation and indeterminacy (Best and Kellner 1991, p.4).

As mentioned, it is difficult to neatly separate postmodernism and poststructuralism and ambiguity remains. The adage of 'the more you learn, the less you know' fits this debate. Whether Foucault's work fits into postmodern theory or poststructuralist theory is contestable. Although Cheek (2000) would classify the work of Foucault in the postmodern category because of its links with culture and society, it could equally be argued that his work fits within poststructuralism because of the emphasis on discourse and theory of knowledge, which includes spoken language, not just text. In fact, Foucault would have welcomed the debate as his work does not support the notion of any one grand theory and while there is contestability, there is still opportunity for

reflection and change. The complexity of the debate mirrors the maze of power relationships and Foucault's work, and whilst acknowledging the multiplicity of his perspective, I am cognisant that by attempting to explain it I am at risk of simplifying his work and therefore underestimating the intricacy of his theory. As Julianne Cheek (2000) says:

It is possible to explore the reasons for such contestability and to arrive at a stated position for any piece of work. While not all may agree with such a stated position, at least it will be possible to determine what the position is. (Cheek 2000, p.5).

This thesis follows a poststructuralist perspective as outlined by Foucault.

Poststructuralists highlight the role of language in the foundation of the subjective self and social institutions. One of the aims of this thinking is to deconstruct the linguistic organisation of the subjective self and social institutions (Lister 1991; Seidman and Wagner 1992; Mitchell 1996). Poststructuralists posit that there is no intrinsic meaning in a text or phenomenon; it is always related to the time or social context in which it occurs and, therefore, it becomes inconceivable to consider it in isolation (Henneman 1995).

The poststructuralist perspective suggests that multiple paradigms are necessary for the development of knowledge, whether this is nursing knowledge, scientific knowledge or any other body of knowledge (Dzurec 1989). There is no limit placed on the ways of knowing and it is acknowledged that, 'acceptance of any one method limits the ability for a discipline to truly know' (Henneman 1995, p.361). This perspective does not suggest or adhere to the superiority of one method of inquiry over another, rather that the method of inquiry is acceptable as long as it fits the subject under inquiry.

Henneman (1995) posits that there are five assumptions that operate in poststructuralism. Briefly described below, these assumptions will be explored in chapter three:

1. Power/knowledge relations are not fixed
2. Meaning is not stable
3. The official discourse is not the real discourse
4. Theory is practice
5. Truth is not the goal of science (Henneman 1995, p.362).

Henneman herself is open to critique, particularly in relation to assumption number three. In poststructuralist paradigm, there is no one 'real' discourse, there are in fact many discourses operating at any given time. It would therefore be more appropriate to use the phrase '...not the *only* discourse...'.

1. Power/knowledge relations are not fixed:

One tenet of poststructuralism is that there is no distinct origin of power and no permanent object of its control. Power is not only held by those that govern, it is also held by those who are governed, either directly or through resistance to power (Henneman 1995).

Viewing power from a poststructuralist perspective is quite different from a more traditional way where power is viewed as a top down structure. A poststructuralist perspective allows power to be viewed at its peripheries, that is at the micro-level as opposed to being predominantly concerned with power at a macro-level.

2. Meaning is not stable:

By recognising that power exists at a micro-level, it opens possibilities to explain why health care provision is changing. Traditionally, it has been accepted that the professional knows best, but this now requires a renewed evaluation as those in power (politicians, economists, clinicians), along with consumers, call for a more integrated approach to health care. Better education has led to an increased confidence in questioning health practices and options, as well as an increase in consumer expectations. Consumers (those who have information, knowledge and are articulate) are no longer willing to accept being passive recipients of health care; instead, they are demanding a more active and participatory role in health care provision. The way in which health care is provided is changing, although not at a consistent rate across all areas.

3. The official discourse is not the real [only] discourse:

To even begin to study power, control and empowerment, one must go beyond the 'official' rules to uncover what process is occurring. The official discourse is related to the institutions' control of thought and action. In order to gain an understanding of this dominant discourse in AOD treatment, it is necessary to interview staff other than those in managerial positions and from varied professional backgrounds. It is also important and necessary to interview consumers of the service. If only managerial and professional staff are interviewed, then one runs the risk of collecting information that is reflective of the 'official' thinking, rather than uncovering other discourses.

4. Theory is practice:

Poststructuralists consider theories to be oppressive in that they are limiting. Theories are considered as starting points in relation to knowledge development; what is

important is what is done with them. Kritzman (1988, cited in Henneman, 1995) says that:

Foucault believes the role of the theorist is to disturb people's mental habits, the way they think and do things, to dissipate what is familiar and accepted, to re-examine rules and institutions... (Henneman 1995, p.363).

The study of the empowerment of consumers in AOD treatment is in its infancy. The role of the researcher is to re-examine the written and unwritten rules that guide AOD treatment.

5. Truth is not the goal of science:

Our goal should be to never stop inquiring, to keep questioning and searching for answers. There are in fact multiple truths and multiple ways of knowing the truth. 'Knowledge is viewed as contextual and localised. The goal of inquiry is finding answers to problems we are facing' (Henneman 1995, p. 363). If we remain tied to searching for just one answer to AOD treatment, one way of offering treatment, then practice would not progress, and consumers would all be treated as an homogenised group, rather than as individuals. Individual differences and individual experiences would not be acknowledged or catered for. All research would be positivist in nature and individual perspectives and experiences would not be addressed or acknowledged. Poststructuralism is concerned with power and empowerment and the assumptions that underpin poststructuralism set the scene and guide the research process.

Research overview

The study was carried out in a variety of AOD treatment facilities in a large regional city in New South Wales, Australia. The facilities include an in-patient detoxification unit, an AOD outpatient's clinic, a methadone maintenance clinic, a residential detoxification and rehabilitation unit using a twelve-step treatment model, and a residential unit using cognitive behavioural therapy. These last two represent the two principal opposing philosophical perspectives in AOD treatment.

The non-probability sample consisted of fifty-seven staff and consumers who were interviewed in depth using a semi-structured interview format. Six major findings emerged from the data and are summarised below:

1. The rhetoric of empowerment is used to convey the 'truth'. Although clinicians use the term empowerment in their explanation of how they implement their treatment regime, when analysed it becomes clear that in fact it is compliance that they describe, not empowerment. In other words, it is a contradictory discourse and as such is described as 'the rhetoric of empowerment'.
2. Empowerment does not happen. The structure and organisation of treatment facilities, other health care organisations and individuals and professional organisation all have an impact on empowerment. AOD clinicians are afraid of losing power and employ a range of strategies which maintain their position and reinforce the perspectives that they hold (their notion of 'truth').

3. The major value underpinning practice is not empowerment, but control. Clinical practice is concerned with who has control, who wants control and how control is maintained.
4. The 'real purpose' of treatment is to make people normal. Both clinicians and consumers appear to accept this, and this belief is reinforced by the overlapping roles of the health and the criminal justice system.
5. Women in AOD treatment are particularly disadvantaged. They feel particularly disempowered, by the treatment philosophy which was designed for men by men, by a lack of childcare facilities and also by their gender.
6. In addition, AOD clinicians themselves feel disempowered by their peers, other health professionals and by the wider political and social sphere. Added to this is the volatile and political nature of AOD policy and treatment which compounds their feelings of disempowerment. Consequently, it is found that, at times, AOD clinicians disempower AOD consumers (the very people that they set out to empower).

These six findings will be explored in detail using a Foucauldian framework to illustrate the role of power in perpetuating them. Limitations to the usefulness of a Foucauldian analysis will also be presented and an argument/rationale contesting and refuting claims made against the usefulness also addressed. Finally, the major question of whether empowerment is possible in AOD treatment will be explored and the emergent issues addressed.

Structure of thesis

This study uses qualitative methods of data collection and analysis to explore the concept of power, control and empowerment in AOD treatment. A Foucauldian analysis of the data has been undertaken.

Chapter two reviews literature pertinent to this study. It commences with an historical overview of AOD use and the influence of psychological and sociological theories on the way people with AOD problems are viewed and treated. Chapter three describes and explains various theories of power as well as introducing literature on the notion of empowerment. The work of Michel Foucault is also introduced in this chapter and his theories described. Chapter four describes the research method used in this study and the steps taken to collect, analyse and conceptualise the data. Chapters five, six and seven are the data chapters where the results of the research are presented: Chapter five is concerned with the way institutional practices and beliefs impact on AOD treatment; Chapter six presents data from clinicians perspectives; and Chapter seven presents data from the perspective of consumers. A discussion of the major findings is presented in Chapter eight together with a Foucauldian analysis of them. Chapter nine presents a summary of the findings, discusses implications for practice, the limitations of the research and suggestions for further research.

In addition, this thesis has five appendices. Appendix 1 is a copy of the University of Wollongong Human Research Ethics Approval; Appendix 11 shows the interview schedule used to guide the interviews for this study; Appendix 111 provides the conditional/consequential matrix used in this study, Appendix 1V is a glossary of terms

referred to throughout this document; and Appendix V is a published journal article produced from data collected from this study.

CHAPTER TWO

ALCOHOL AND OTHER DRUGS

Introduction

Alcohol is the most used drug in Australia. It is present on most social and celebratory occasions, from diplomatic banquets to informal meetings with friends. Social drinking is a rule-laden activity; it may be accepted that drunkenness is appropriate during certain rites of passage such as stag nights, but there is a clear line between this form of social interaction and continuous, excessive drinking which impacts heavily on the individual, on the community and on the economy. This chapter looks, firstly, at the costs of excessive alcohol use and then at the way this kind of alcohol use has been viewed, both from the popular perspective, and from the perspective of the scholarly disciplines which have attempted to explain or treat it.

Other drug use shares some similarities, but also has some differences, with the way alcohol use has been approached. On the one hand, other drug use is illicit and tends always to be viewed negatively, unlike alcohol which has a firm place in social life. On the other hand, explanations for this kind of activity have tended to use the same theoretical approaches as for alcohol addiction, and it is these which underpin treatment regimes. In this chapter, the history and treatment of opioid use is explored. While there are a variety of illicit drugs consumed in Australia, opioids represent the major group and their use readily receives media attention. They are likely to be mixed with additives and injected intravenously and, as a result, there is increased risk of morbidity and mortality. The consideration of tobacco use is excluded here. Although it is the

most harmful of all the drugs routinely consumed in Australia, none of the treatment agencies participating in the study offered treatment programs for tobacco use.

The chapter identifies three ‘grand theories’, so called because they attempt to provide a universal explanation for drug use. These are moral theory, disease theory and labelling theory. All view the consumer [addict?] as deviant in some way and these theories are essentially moral ones. They developed at different times and from different sources, and because each of these theories or explanations tends to hold a fixed rather than a changeable view of human nature, they are inclined to ignore the social context of human behaviour, but they have proved remarkably resistant in the public, and in the political, mind. An amalgam of these explanations tends to surface, and to be reflected in the media, both in response to the perceived drug ‘problem’ (eg crime, syringes in the street) and in response to suggested ways to deal with the problem, particularly the more controversial ones (eg injecting rooms, heroin trials). It should be remembered that consumers and clinicians are also members of the public, no matter what their personal or professional background. Grand theory thinking, in many ways, represents the dominant drug and alcohol discourse. No matter how it may be decentred by alternative discourses, such as psychological theories, its dominance remains.

The chapter then briefly looks at a number of psychological theories, in particular behavioural theory and psychoanalytic theory, which have directly influenced treatment approaches. The chapter concludes with a discussion of social theory which is concerned with the social context of drug use, and which has influenced harm minimisation strategies.

These discussions provide the context for, and background to, alcohol and other drug treatment in Australia and set the scene for this research study. They show how varied are the theories and perspectives which underpin thinking about AOD use and treatment both in the popular and professional domains. It is argued that, while some of these approaches have provided useful insights which have improved treatment, others have lead to a partial view and to victim blaming. This is particularly the case with approaches which neglect the social context of drug use. While major shortcomings of the various approaches are identified, it should be pointed out that a comprehensive critique of each was not the purpose of this research. The focus of the research was on the micro social relations between consumers and clinicians, and on their institutional setting. However, as the data and analysis chapters will show, when exploring the concept of empowerment in AOD treatment, it is impossible to ignore the larger social context within which the micro is embedded.

Alcohol

Alcohol is second only to tobacco in drug-related deaths and hospitalisations and, as a consequence, impacts heavily on Australia's health, welfare and criminal justice systems. The prevalence of excessive alcohol consumption in Australia is difficult to estimate for a number of reasons, including under-reporting of alcohol consumption and private manufacture of alcohol. Australia has been ranked 19th out of 31 countries on total absolute alcohol consumption and the highest consumer of alcohol in the English speaking countries that were surveyed (Australian Institute of Health and Welfare 2000, p.148). In the same report it was estimated that 7.3 million Australians were regular drinkers a further 4.8 million Australians were occasional drinkers with over 480, 000 teenagers being regular drinkers

There are a substantial number of Australians who consume alcohol at levels that are #hazardous or *harmful. Alcohol dependence and harmful use is listed as the 7th most prevalent health condition in Australia. 'It is estimated that the harm caused by alcohol consumption accounts for 4.9 per cent of the total disease burden' (Australian Institute of Health and Welfare 2000, p.146). Available data suggest that 9.5 per cent of men and 5.8 per cent of women were defined to be in the medium or high-risk groups[◇] (Mattick 1993). Subsequent studies reveal a slight variation in the percentage of men and women in the medium and high risk groups, but all available data provide numbers very close to these ones.

The consequences of excessive alcohol consumption are linked to a wide variety of physical diseases. The most common diseases that can be directly attributed to excessive alcohol consumption are 'carcinomas, hypertension, cardiomyopathy, liver cirrhosis and pancreatitis' (Australian Institute of Health and Welfare, 1998, p. 18).

Searches conducted to find literature pertaining to social and economic costs of alcohol and other drugs in Australia found only six entries, five of which referred to work

Hazardous use

Use involving heightened drug related harm for the user. This high level of risk may be present despite the current absence, for the user, of any evident drug related problems (Hamilton, Kellehear et al. 1998, p.282).

*** Harmful use**

Drug use that is injurious to either physical health or mental health. Harmful use generally produces adverse social consequences for the user (such as contact with the criminal justice system), although in, and of themselves, such consequences do not warrant a diagnosis of harmful use (Hamilton, Kellehear et al. 1998, p.282).

◇ Assessing drinking patterns

In relation to any particular alcoholic beverage, the amount containing approximately ten grams (12.5 ml) of ethanol. This amount is generally equivalent to the usual 'serve' of that drink obtained at a hotel or restaurant. The number of standard drinks consumed over a period is used to assess drinking patterns, which are typically classified according to the following categories: safe, hazardous, harmful or binge (Hamilton, Kellehear et al. 1998, p. 281).

undertaken by Collins & Lapsley in the late 1980s (Collins and Lapsley 1991). More recent studies still refer to this work; hence their figures are presented to give an indication of the cost to the public of excessive alcohol consumption. Collins and Lapsley estimated that in 1988 the tangible cost associated with alcohol abuse totalled \$3,245.3 million.

These costs were calculated by determining the cost of alcohol related road accidents, determining the costs associated with decreases in productivity associated with alcohol related morbidity, mortality and absenteeism; then removing the savings made in terms of the use of goods and health services by the prematurely dead; then adding in the health care costs associated with alcohol consumption; and adding the costs of alcohol consumption by abusers (Mattick and Baillie 1992, p.5).

Alcohol related crime is a growing concern within the Australian population and a study undertaken by Williamson (1997) investigating alcohol related crime found that at some time '34 per cent of the population have been subjected to verbal abuse, 9 per cent have been physically abused and 15 per cent were victims of property theft or damage' (Australian Institute of Health and Welfare 1998, p.145).

These reports illustrate the impact of the far-reaching effects of excessive alcohol use on the individual and on the economy. To understand the consequent current situation with treatment services and treatment philosophy, the history of AOD treatment needs to be examined.

Excessive alcohol use: history and perspectives

Prior to the emergence of the disease model of addiction in the late 19th century, there was an accepted belief that personal choice was the key causative factor in excessive drinking (Levine 1978). This meant that the individual who drank excessively was either punished (having transgressed secular law), or received moral counselling (having transgressed religious law) (Cormack, Ali et al. 1995). In the late 19th and early 20th century the temperance and prohibitionist models stressed the danger of the addictive properties of alcohol as the cause of the problem rather than any weakness of the person themselves. This model suggested that the person who drank to excess should receive medical management rather than religious counselling or punishment, and implied that alcohol availability should be controlled (Miller and Hester 1989).

The American disease model of excessive drinking as defined by Alcoholics Anonymous (AA) first appeared in the 1930s and is arguably still the dominant influence in AOD treatment. It identified the cause of alcoholism as some unknown, pre-existing characteristic of certain people which caused them to be incapable of drinking alcohol moderately. The ‘disease’ of alcoholism was irreversible and incurable, but its progression could be halted by total abstinence from alcohol (Miller and Hester 1989). Thus, there was a qualitative distinction between ‘alcoholics’ and other people (Cormack, Ali et al. 1995).

A slightly modified version of the AA disease formulae appeared in the 1950s and became the dominant influence in the field until the mid 1970s. It was contended that some types of ‘alcoholism’ were diseases while some could be caused by a personality disorder (Jellinek 1960). This gave rise to a strong emphasis on psychotherapy as a

treatment modality (Miller and Hester 1989), and effectively separated treatment of these problems from the penal system, thus strengthening the medicalisation of substance abuse.

Following the disease and mental illness definition of alcohol dependence developed by Jellinek (1960), there was an increasing emphasis on the social and psychological factors apparent in alcohol and other drug problems. Edwards and Gross (1976) described an Alcohol Dependence Syndrome, which included the concept that dependence was not all or none, but a graded intensity (Edwards and Gross 1976). This continuum of dependence is described by Edwards as being central to thinking in the field and influences many treatment philosophies. However, as this study will show, the influence of the abstinence approach subscribed to by the 12-step philosophy remains dominant and, in fact, it is this approach which influences treatment practices.

Opioids

The history of other drug use reflects a similar belief about its use: drug use as a crime, sin or disease. However, the influences have been very different. It is estimated that in Australia in 1998 there were over 3 million illicit drug users aged 14 years or older, and that there were close to 110,000 injecting drug users (Australian Institute of Health and Welfare 1998, p.20). The prevalence of opioid dependence in Australia is very difficult to estimate because of the high percentage of people who use opioids illicitly and are likely to under report their use or not report it at all in surveys. Researchers can only 'best guess' just how many current users of opioids there are.

Taking all the estimates together, we will use the estimate arrived at by the Commonwealth Department of Community Services and Health (1988), namely, 30,000 to 50,000 heroin users in Australia, with a

further 60,000 irregular or recreational (non-dependent) heroin users (Mattick and Hall 1993, p.4).

It is also difficult to obtain a precise estimate of morbidity and mortality associated with opioid use, as shown by the following quote, although there is evidence that opiate dependence is associated with increased rates of both morbidity and mortality.

The Institute estimates that in 1997, 831 persons died and there were over 11,000 hospitalisations from illicit drug-related causes. Although apparently small in numbers relative to deaths and hospitalisations due to tobacco and alcohol, illicit drug-related morbidity and mortality usually affects the young, resulting in relatively more life years debilitated or lost (Australian Institute of Health and Welfare 1998, p.4).

In Australia, the major causes of premature mortality in opiate users are accidental overdoses due to lack of knowledge regarding the purity of illicit opiates, and infectious diseases such as Hepatitis B and C, infective endocarditis, osteomyelitis, septicaemia and HIV/AIDS due to the sharing of needles. The major forms of morbidity are infectious diseases, complications of injection as a mode of administration and accidents while intoxicated (Mattick and Hall 1993, p.4).

The economic cost of opioid dependence is great and has implications for both direct health care costs (treatment) and indirect costs (unemployment, crime and absenteeism). A study undertaken in Australia by Collins and Lapsley (1991, cited in Mattick and Hall, 1993) has 'conservatively estimated that in 1988 the tangible costs of illicit drug abuse totalled \$1042.4 million' (Mattick & Hall 1993, p.4). The tangible costs were calculated by adding together:

The direct total costs of law enforcement;
The cost of the drugs themselves;

Economic costs of lost productivity caused by morbidity, mortality and absenteeism related to illicit drug use;

The health costs associated with illicit drug consumption; and

The costs of opiate consumption by users.

The study also estimated the intangible costs (personal pain and suffering) of costs of illicit drugs at \$398.8 million which brings a total of \$1, 441.1 million.

(Mattick & Hall, 1993, p.5).

Opioid use: history and perspectives

Opium was known as a recreational and medicinal drug in a number of prehistoric and classical cultures. In Australia, opium in all forms was popularly used for tranquillising and all-purpose palliative treatment throughout most of the 19th century (Manderson 1988a). Opiates were widely available and legally sold without a prescription. Opium smoking, which was practised almost exclusively by the Chinese community in Australia, became a focus for racist sentiment, and suppression was a step towards the ‘white Australia Policy’ (Manderson 1988b). Prohibition of opium for smoking was achieved in Australia during the early 1900s and thus opium smoking became a crime, predominantly because the Chinese in Australia practised it, not because of the harm arising from it (Manderson 1988b).

Control over other methods of using opium and related substances expanded during the early part of this century with the battle for professional dominance between pharmacists and medical practitioners (Manderson 1993). Growing controls over opium, as a result of international pressures, gave the medical profession the incentive to lobby for further expansion of controls. This resulted in removing the individual choice for the use of these drugs for recreational use, and restricting the use to

legitimate use only under medical supervision, and imposing severe penalties on those who attempted to use for other reasons. This had the added impact of creating a black market in illicit drugs, and of creating secrecy amongst drug users. It served to reinforce that illicit drug use was a criminal matter.

After World War II Australia increasingly followed the wishes of the USA which viewed dependence on drugs as a criminal matter, rather than following the British model where dependence was viewed as a medical concern (Manderson 1993).

Cormack, Ali et al. sums up the situation succinctly in the following:

Thus the influences on the changing legal status of these drugs were not so much the problems experienced by users of the community as a result of drug use. Rather they were initiated by racism and fuelled by the battle between the medical profession and pharmacists for professional dominance and Australia's passive adherence to international influences led by the views of the USA. Furthermore, accompanying each of the changes in the legal status of opium and related compounds was a greater or lesser emphasis on the drug user as a criminal or victim, sinner or patient (Cormack, Ali et al. 1995, p. 343).

Treatment models and perspectives

Many of the models of AOD use described here in the historical context remain influential today in treatment, and the same community often applies different models of dependence to different drugs. For example, the disease concept as described by Jellinek (Jellinek 1960) remains the dominant model for alcohol problems although there are significant parts of the population who subscribe to a moral model for illicit drug use (Brower et al. 1989; Henry-Edwards & Pols 1991; Kellehear & Cvetkovski 1998).

Grand theories

There are three major grand theories of the drug user as deviant. These are the theory of the user as sinner (moral theory), as sick person (disease theory), and as social victim (labelling theory) (Kellehear and Cvetkovski 1998). The influence of these theories was evident during the Australian federal election in 1999, when there were almost daily references by politicians in the newspapers, about the emotional and moral aspects of illicit drug use (Henderson 1999; Charles 1999; Duffy 1999; Carty 1999). Thus, while alcohol dependence may be considered within the framework of the disease model, heroin dependence is often considered within the framework of the moral model, which emphasises personal choice (and personal failure) as the reason for dependence (Cormack, Ali et al. 1995). These opinions do not reflect knowledge about the understanding of drug dependence as much as they reflect the values of society.

Moral perspective (The user as sinner)

Adherents to the moral perspective view excessive use of AOD as a sign of weak will and immorality. People are held responsible for their situation and drug users' dependency is essentially seen as the result of moral weakness. Will power must be exercised to gain self-control in order to return to sobriety and respectability.

Individuals are at fault in this explanation as they are perceived to have a bad or sinful character (Hughes 1989; Henry-Edwards and Pols 1991; Kellehear and Cvetkovski 1998).

The moral perspective is subscribed to by many Australians, although they may not be aware that they do. The use of alcohol is considered 'part' of the Australian culture; however, there are many unwritten and often unstated rules governing its use, and when

people fail to conform to these unspoken rules, they are blamed and viewed as being morally weak.

Clinicians and consumers form part of Australian culture and they reflect a perspective held by many people in Australian society when they describe how some people feel empowered by their use of alcohol. This perspective is reinforced by television shows, alcohol advertisements and popular fiction which portray people who drink as being more relaxed, becoming more sociable and having more fun. Drug use though, is usually portrayed as negative. In addition, alcohol is a legal drug and in most circumstances, a socially acceptable drug, although juxtaposed amongst the enticements for drinking are standards that are often confusing and vary widely. For example, in some situations, heavy drinking by men is seen as a badge of virility. Yet there is disapproval from others when they are unable to hold their liquor. Australian people are generally more accepting of drinking and drunkenness among men, but more critical of the same behaviour among women (Hamilton 1991; Ezard 1998). Women may have the right to drink, but they must also learn to manage the unwritten rule that they must 'drink like ladies', without knowing exactly what this means. When they do not meet the criterion, they may be labelled as 'lushes' or 'loose' and become ostracised.

The moral perspective may also locate the problem in the drug itself, which is seen to inevitably lead to physical, moral and social decline. Recovery inevitably depends on consumers changing their lifestyles and believing that total abstinence is necessary (Hughes 1989; Henry-Edwards and Pols 1991; Kellehear and Cvetkovski 1998). This can be seen in the steps of AA/NA where individuals must admit that they are

powerless over their use of AOD and ‘hand themselves over to a higher being’ (A.A 1939; A.A 2000).

By attributing all the problems to an individual’s bad or sinful character, a myth is created about the user as a sinner and other important dimensions are obscured. For example, the inferior role of consumers compared to clinicians is reinforced and emphasises their lack of ability, control, shame and guilt. In addition, it gives the message that individuals are not capable of change without giving over completely to a higher authority. Change is located outside the individual. This is in contrast to the more generally accepted psychological perspective, that identification of an internal locus of control is more conducive to long term change (Kellehear and Cvetkovski 1998, p.52). Finally, as there is no complete resolution of the problem, only its control, the powerlessness of the individual is reinforced.

Disease perspective (The sick person)

This is the most common grand theory of addiction. From this perspective, the disease of alcohol/drug addiction is viewed as a medical problem. It is the disease perspective which underpins the A.A. philosophy and the 12-step approach to treatment. The fundamental condition of the disease is the irreversible loss of control over alcohol and other substances. Supporters of this perspective believe that ‘alcoholics’ have certain predisposing characteristics that consistently differentiate them from ‘non-alcoholics’.

Alcoholism is described from a disease perspective as being a progressive irreversible process that progresses through identifiable stages’ (Hughes 1989; Jaffe 1990; Mailto et

al. 1996). It is suggested that this group of people are unable to control their drinking because once they start, they are unable to stop. This theory holds that some individuals simply cannot drink alcohol or take other drugs. These people are prone to addiction and there is no known cure for the disease and once the person has the disease its progress is often fatal. Hughes explains that alcoholism is located in the physical make-up of certain individuals:

Proponents of the medical or disease perspective posit that alcoholism and drug addiction occur in persons whose body chemistry make them susceptible to addiction (Hughes 1989, p.4).

As there is no known cure, the goal of treatment as in the moral approach, is complete abstinence. The major treatment strategy is to focus on the chemical dependency itself with the person being guided to develop a positive identification as a recovering alcoholic or addict who is powerless over substances' (Brower, Blow et al. 1989; Mailto, Galibi et al. 1996). Although there is a lack of empirical evidence to support the progressive nature of the 'disease' (Sobell & Sobell 1993), AA continues to thrive and the disease perspective remains dominant.

Evidence for a genetic predisposition comes from controversial adoption and twin studies (Goodwin, Schulsinger et al. 1973; Goodwin 1976; Fillmore 1988; Anthenelli and Schuckit 1990-91; Sanders and Phillips 1993). Goodwin's study of 5,483 adopted sons of alcoholics in Denmark found that adopted sons whose birth fathers were alcoholics were more than three times as likely to become alcoholics as the adopted sons of non-alcoholics (Goodwin, Schulsinger et al. 1973).

However, significant problems with the evidence for genetic predisposition have been found and some evidence contradicts the study described above. A meta-analysis of research suggesting that alcoholism runs in families undertaken by Cotton (1979, cited in Sanders and Phillips 1993), also showed that a large proportion of alcoholics did not have a direct ancestor who was alcohol dependent. In addition, as pointed out by Sanders and Phillips 'many behaviours run in families such as eating pizza or supporting the same political party and no one suggests that these behaviours are genetically determined' (Sanders and Phillips 1993, p.292). Although the search for a genetic cause is not new, it still continues amongst much scepticism. As Peele and Brodsky (1991) point out, if a gene for alcoholism were found, would it also cause other addictive behaviours? Would it be related to overeating, gambling and smoking? If so, perhaps the person without this inheritance would be the notable exception.

The search for a genetic explanation continues. Professor Peter Doherty, a winner of the Nobel Prize for Medicine in 1996, described the search for gene abnormalities. He is quoted during a radio interview as saying:

What's starting to emerge is that there are genes that predispose towards heroin addiction. Out of five people who use heroin, only two perhaps may become addicted. There may be a genetic basis for that (Doherty 2001, p. 5.).

The major advantage that disease explanations have over moral explanations is that substance dependent people are treated like anyone else with an illness and therefore not subjected to punitive treatment or blame (Brower, Blow et al. 1989; Henry-Edwards and Pols 1991). The disease explanation underpins the philosophy of the AA 12-step treatment programs.

On the other hand, while moralism may be attacked and people may even deny that it influences their beliefs and interactions, in practice, AOD policies and programs remain highly moralistic and punitive (Drew 1987). This occurs even when the treatment program is based on a disease perspective or on a harm reduction philosophy. There is a moral assumption associated with the notion of self-responsibility for seeking help, complying with professional advice and changing AOD behaviour. People continue to view those with AOD problems as being weak willed *and* having a disease, therefore linking moral explanations and disease explanations (Moore 1992).

As Kellehear and Cvetkovski (1998) discuss, both disease and moral explanations use what is assumed to be the 'normal' to evaluate and define deviance, but these explanations do not offer the opportunity to reflect on the nature of this normality. By focussing on the individual's genetic or psychological defect, these explanations take the moral dimension and social context for granted without looking any further. As a consequence 'their oversimplifications trivialise the diversity and complexity of substance use and abuse' (Kellehear and Cvetkovski 1998, p.55).

Social perspective (The social victim)

Theories about how being downtrodden or a victim of an unfair social structure can produce drug using problems are based in sociological thought. Theorists such as Merton (Merton 1971; Merton 1996), from the functionalist school of thought, developed the idea of social strain, which means that when there is a distance between people's goals and their means to obtain them, tensions are created which place people in stress. To relieve this stress, people resort to alternative means to obtain those goals. For example, instead of staying at school, saving money and having a job, their poor

living conditions and inadequate role models encourage them to seek some alternative way of obtaining life's comforts. They may turn to a life of drug using and crime (Gabe and Bury 1991).

Labelling theorists view deviance not as a set of characteristics of individuals or groups, but rather as a process of interaction between deviants and non-deviants (Giddens 1997). Why some people become tagged with the label deviant must be uncovered in order to understand the nature of deviance itself. Two types of deviance have been identified; primary and secondary. Primary deviance occurs when there is a minor violation of the law. The individual may be seen as untrustworthy and is stigmatised as a criminal, and as a result commits further crimes. Secondary deviance occurs when the individual accepts this label and perceives him/herself as a criminal (Giddens 1997). For example, a person feels comfortable with his/her own AOD use and becomes known as an 'addict'. This can act as a powerful status label distorting the image that the public holds of this person. Other people then start to expect the individual to conform to the role of 'addict' and this, in turn, can lead to the person internalising this identity and believing that he/she is unable to change.

One problem with this perspective is the assumption that people take on the deviant label passively and display self-determination only after their identity has been formed. There is no discussion of resistance to being labelled a deviant, or of the contextual factors that contribute to this labelling. In addition, the labelling theory does not explain how the deviance occurred in the first place; rather it concentrates on how it is reinforced through people's perception.

Criticism of grand theories

These theories ignore local social contexts of experience. Moore (Moore 1992) argues that dependence has little to do with ideas such as genetics or psychological inadequacy and much more to do with changing social contexts of use. For example, rather than AOD dependency leading to disordered social lives, perhaps disordered social lives lead to periods of dependency. Dependence may be the outcome of certain social changes in the individual's life such as powerlessness in their relationships or workplace, lack of secure employment or financial worries.

In addition 'grand theories of drug use place the cause of drug use, and therefore the responsibility for change, on the individual user' (Kellehear and Cvetkovski 1998, p.57). By focusing entirely on genetics, moral depravity, psychological or social disabilities, these theories fail to examine how cultural circumstances and social situations create conditions of extreme use and/or illicit use. When the emphasis of grand theories is on individuals, the role of social institutions escapes analysis (Nathan et al. 1996). Grand theories fail to investigate or explain changing social contexts of drug use such as issues of powerlessness in gender relations, security of employment, financial instability – social contexts, that if stable, serve as anchors in the non-drug using world (Moore 1992).

Grand theories 'encourage the moral view that the (deviant) drug user is, at worst, a villain, at best, perhaps a member of the growing ranks of the walking wounded' (Kellehear and Cvetkovski 1998, p.58). When AOD users are not being categorised as criminals, they are being medicalised, which adds to the growing tendency to medicalise every form of non-criminal deviance. By ignoring the complex diversity of

social, cultural, biological and personality factors that affect each individual differently, the use of these grand theories continues to hinder our ability to understand the complex issue of AOD use.

It is important to understand some other popular theories that form the basis of many treatment programs in AOD treatment. These theories have been developed in order to understand the how and why of human behaviour and to attempt to predict health related behaviours (Nathan et al. 1996). The theories that are presented below are referred to as psychological theories.

Psychological theories

Psychological theories attempt to understand individuals' problem drug use by considering their personality, life experiences, current relationships and possible sources of stress (Fitzgerald 1998). Psychological theories vary depending on their theoretical orientation. Behavioural theories focus on the reinforcing aspects of AOD use, while psychoanalytical theories consider internal emotional responses and formative life experiences.

Behavioural theories of AOD dependence

Behavioural theories of dependence, which includes cognitive behavioural therapy (CBT), are popular ways of considering AOD use. Within this framework, problem AOD use is seen as a learned set of dysfunctional behaviours rather than as a result of psychological trauma or illness (Mattick 1996). This perspective views AOD use as being able to be unlearned. Problem AOD use is simply another activity where the behaviour is reinforced. Positive and negative rewards compete against each other and

if the rewards are positive, the individuals will continue with the behaviour. If the rewards are not positive, they will cease using AOD. If rewards occur intermittently, the behaviour will continue for a longer period of time (Birnbauer 1996).

Criticism of behavioural theories of AOD use

CBT takes into account cognitive factors such as the thoughts, images and memories related to 'dysfunctional' behaviour (Bellack and Herson 1985; Depret and Fiske 1993). A limitation of the behavioural perspective is that it is based on the premise that humans act in a way to increase pleasure and avoid pain. Cognitive behavioural therapies assume that after weighing up the pros and cons or dangers and risks of AOD use, individuals will act in a deliberate and rational way and will abstain from its use. However, humans have complex emotions and motivation and do not always react in an expected and consistent way. Psychological explanations do not have an explanation that deals with this.

Emotional regulation and AOD use

In contrast to behavioural and cognitive approaches, psychoanalytic theory focuses on the inner emotional world of the AOD user. It is organised around the idea of the unconscious, whereby mental processes operate outside the realm of the conscious awareness and are expressed through a person's behaviour. The clinical practice, which involves a specific relationship between the consumer and the therapist, aims to make the consumers become more aware of the unconscious aspects of their identity (Minsky 1996). By becoming more aware of the hidden aspects, it allows the individual to consciously make different choices.

From this perspective, individuals with problem AOD use are viewed as using substances as a way of self-medicating, to make up for deficits in psychological functioning. Drugs provide the user with a mechanism to remove unpleasant feelings and to lessen unwanted emotions. Fitzgerald argues that, 'there is no universally accepted psychoanalytic theory of drug addiction and dependency' (Fitzgerald 1998, p.75). Explanations vary, depending on the clinician's background and training, but the emotional regulation hypothesis supposes that AOD is used to lessen emotional pain and to induce pleasant emotional states.

Criticism of psychoanalytic approaches to AOD use

Although these theories allow for a diversity of approaches to treatment of AOD use, psychoanalytic theory is limiting because it relies on the premise that emotional regulation which is learnt in infancy continues throughout life, and that drugs are used to make up for gaps in psychological functioning. By adopting a psychoanalytical perspective, it may mean that 'collective' influences such as culture and social conditions are overlooked and ignored. This perspective is individualistic in its approach and as such may overlook the 'collective' needs of different cultural and ethnic groups.

Social context of drug use

Social theorists question the assumption that we can know things exactly as they are. Knowledge is constructed through ongoing interactions with others and therefore is continually undergoing transformation. 'They [social theorists] emphasize the cultural and historical specificity of knowledge and suggest that our understanding of the world is indicative of our sociocultural context' (Keenan 1998, p.61). Social constructionists

focus on the social interactions and processes through which people create meaning, and a social constructionism framework is useful when considering AOD use because it can accommodate the changing patterns, beliefs and responses to its use. The social context of AOD use can vary between individuals. For some, it may conjure up images of a celebration such as a religious holiday or a birthday, where people indulge in more alcohol, while for others it may mean the consumption of ecstasy tablets to enhance the enjoyment of a dance party.

Social institutions such as the legal or the health care system can also constitute an important aspect of how drug use and drug users are characterised. Some drugs are categorised as illegal and incur criminal penalties for their possession and consumption. This creates difficulties for public health intervention, as discussed earlier in this chapter when outlining the history of opium use in Australia. The sanctions for drug use have increased over the course of the 20th century. In addition, the media are also an important influence in the construction of our views of appropriateness, or not, of particular drug use (Keenan 1998). The media have been used to relay messages about drink driving (harm reduction strategy) and also to report horror stories about young people injecting drugs intravenously.

As Bourgois says, there is a link between the informal economy of drug dealing and the marginalisation from active participation in the formal economy of the labour market (Bourgois 1996). Keenan explains this further and suggests that there needs ‘an acknowledgment that the drug issue masks deep social and racial inequity’ (Keenan 1998, p.63).

Harm reduction/minimisation approaches

There are a variety of ways in which AOD use can be understood and it is not possible to identify a definitive notion of a social context of AOD use; rather, it is important to investigate the spectrum of influences which inform our beliefs, values and actions.

Zinberg (Zinberg 1984) highlighted the importance of three ‘sets’ when considering the influence of AOD use. These are the pharmacological action of the drug itself (the drug or agent), the attitude, personality and expectations of the persons themselves (the persons or hosts) and the physical setting where the drug is used (the environment).

When this model was first proposed, the use and meanings of AOD use represented a marked departure from the prevailing belief that AOD use inevitably resulted in addiction. Zinberg’s work was instrumental in examining the myriad of strategies that AOD users adopt to moderate their own AOD use.

Harm reduction, or harm minimisation is a ‘new’ way (over the past decade) of thinking about drugs. Harm reduction tries to assess the actual harm associated with any particular drug use and asks how this harm can be minimised or reduced. This approach accepts that psychoactive substances are and will continue to be part of our society and that their eradication is impossible. By using this approach, the aims are to identify the harmful consequences for individuals and those around them, and to implement strategies that will minimise this harm. Strategies include:

- demand reduction (prevention through information-provision and education;
- supply reduction (regulation and law enforcement);
- environmental responses that aim to assist people using drugs to do so in the safest possible manner (Rumbold & Hamilton 1998, p. 136).

More recently, in Australia, researchers have employed ethnographic methods to gain a deeper understanding of the experience and interpretation of local AOD users, and the regulations and practices that they use to minimise and regulate self-harm. (Moore 1990; Dance 1992; deCrespigny, Vincent et al. 1998a; deCrespigny, Ask et al. 1998b; deCrespigny, Vincent et al. 1999).

Of particular note is work undertaken by deCrespigny et al (1998) into young women's decision-making, drinking and hotel environments in South Australia. Her research found that young women do binge drink, usually on a weekly basis and that hazardous drinking patterns tended to subside as these young women matured. The role of 'girlfriends' emerged as critical in anticipating, preventing and managing difficult situations, in particular dangerous male behaviour.

Opposing approaches to AOD Treatment

There is a continuum of intervention strategies in AOD treatment; ranging from health promotion, education, and brief interventions, to either inpatient or outpatient facilities. Some facilities adhere to a twelve-step approach (medical model), while others adhere to a harm reduction approach and use psychological approaches such as cognitive behavioural therapy (CBT). Harm minimisation approaches aim to minimise the harm to the individual and to the broader society. When evaluating whether a particular response to AOD use has worked or not, it is important to look at the drug itself, where the use takes place, and the technique for using it as well as the context in which the use takes place. The harm minimisation approach is able to take these factors into account in a way that isn't possible with the abstinence approach.

However, the conflict that exists between scientific knowledge and personal and societal values is evident in AOD treatment. Edwards (1984) summed up this conflict over sixteen years ago, and while there have been changes, the chasm still exists:

The ultimate polarizations in current thinking in the alcohol field are witnessed by continuing embattled division between those who see drinking behaviour as a total continuum explicable at every stage by psycho-sociological accounts of behaviour (with disease theories outmoded and perverse), as opposed to those who believe that to surrender the disease concept would be a betrayal of the most fundamental truth. These disputes have become unprofitable, although to attempt reconciliation is probably to invite attack from both camps (Edwards 1984, p.75).

Conclusion

This chapter has presented literature pertinent to this study. A brief overview of the history of alcohol use and opioid use is useful for understanding the underpinnings of the dominant treatment models and modalities operating in AOD treatment in Australia. It looked firstly at the costs of excessive alcohol use and then at the way this kind of alcohol use has been viewed, both from the popular perspective, and from the perspective of scholarly disciplines which have attempted to explain or treat it. The conflictual and opposing stances that can occur within and between treatment agencies and individuals was explored, and the reasons were linked to various theoretical perspectives, in particular grand theories, psychological theories and social theory. It has been argued that while some of these approaches have provided useful insights which have improved treatment, others have led to a partial view and to victim blaming.

The following chapter explores theories of power which are also important in setting the scene for AOD treatment.

CHAPTER THREE

POWER AND EMPOWERMENT

Introduction

This thesis is about power, control and empowerment. It focuses on a concept used and developed by different theorists in different discipline areas. For example, Foucault's (1980) work is used and referred to by writers and researchers in the fields of psychology, nursing, medicine and social science to name a few. Later in this chapter I discuss the application of these theories in health research (p.78).

Whilst empowerment is subsumed within the larger aspect of power, there is a separate body of literature which explores the notion of empowerment. An overview of relevant literature on empowerment, including that of collaboration, which is seen as an essential ingredient in empowerment, is presented and discussed in this chapter.

Power is the underlying concept in understanding the meaning of empowerment in AOD treatment. There are at least two views of power. One view is of power as a legitimate capacity. This perspective presumes the consent of those over whom power is executed; therefore, those with the power have the right to act on behalf of those without power. The second view is that power is conceived as a simple capacity to act; therefore, social/political power is regarded in the same way as electrical power or the power of a car engine. It is seen as a quantitative capacity that may be put to work for a variety of purposes. This notion of power posits that people employ power in their

dealings with each other, and that the wishes of those with power will prevail over those people with less. This viewpoint suggests that there is an unequal relationship towards power and that power may be used as an instrument of domination.

A major focus of this chapter is concerned with the theoretical insights into power offered by Michel Foucault, a French social theorist. Although Foucault's work is closely associated with the poststructuralist perspective, he resisted his work being placed in any theoretical category, instead describing it as a 'history of the present'.

Foucault offers a completely different perspective on power which he perceived was not held by individuals or groups; rather he conceived it as both a complex flow and a set of relations between groups and areas within society. In addition, he viewed power as productive rather than purely repressive.

This major section of this chapter addresses power and its manifestations as conceived by Michel Foucault, including a section detailing criticisms of his ideas. To explain how power is conceived of and acted upon, a broad overview of the ideas of six other theorists, Rorty (1992), Wartenberg (1992), Giddens (1984), Wolfe (1990), Lukes (1974) and Toffler (1990) are presented. These theorists are presented to illustrate that power is viewed in different ways according to different theorists. While I have eventually chosen Foucault, as I believe his interpretation best fits this study, I readily acknowledge that his theory, as shown, does not provide all the answers. Therefore other interpretations of power have been presented.

The main difference between these six theorists and Foucault is that Foucault does not only address the issues associated with power in a broad way, rather he addresses power

at the micro level, or what he terms ‘at the capillary network’. Investigating power in this way encourages exploration of how it is operationalised in AOD treatment between AOD clinicians and between them and consumers. Foucault is not the only theorist who offers some understanding of power differentials in AOD treatment. The work of both Toffler and Giddens have explanatory power based on their moral and philosophical beliefs about equality and how certain groups are discriminated against and disadvantaged, but it is the work of Foucault that has been selected as offering the more explanatory power for this study. The final section explores the way ideas and theories of power have been applied to the health setting.

This chapter begins with a discussion of the literature on empowerment and collaboration. Empowerment features heavily in recent health, education and social science literature and it is a word that is freely used by clinicians and academics. In order to begin to understand its importance in the provision of contemporary health care, we need to trace its origins.

Empowerment

The concept of empowerment emerged during the 1960s from philosophical study by the Brazilian educator, Paulo Freire (Freire 1973; Heaney 1999). Although Freire’s philosophy was primarily concerned with the class struggle, it has since been widely applied to a variety of movements such as the women’s movement, the gay rights movement and the consumer movement (Wallerstein and Bernstein 1988; Falk Rafael 1995). It refers to a liberating pedagogy that reverses the dehumanisation and objectification of oppressed people through development of their own critical consciousness and simultaneous action.

Part of the problem with defining the concept of empowerment is that it takes on different meanings to different people in different contexts. Empowerment cannot be defined in a single way. Rappaport (1984) says that when a concept lacks a clear definition people will define it in the context of their own experiences, and, in fact, the people concerned most appropriately define it. Empowerment is a complex concept and cannot be captured by a single measure (Gibson 1991). It can be seen as a process or an outcome (Rappaport 1984). If it is used as an outcome it reflects a quality or property. Gibson (1991) says it is an abstract concept that is independent of a specific time or place. In a broad sense, empowerment, according to Rappaport (1984), is a process by which people, organisations and communities gain mastery over their own lives. It appears that most often it is conceptualised as a process (Gilbert 1995; Shields 1995) and that the goals of the process or identified outcomes vary, based on the individual who is to be empowered, as well as the characteristics of the social context in which the individual exists (Hawks 1992).

Empowerment is difficult to define and is often easier to understand by its absence: powerlessness, helplessness, hopelessness, alienation, oppression, paternalism, loss of control over one's life and dependency, and, in fact, it is very often defined in this way (Rappaport 1984; Wallerstein and Bernstein 1988; Gibson 1991).

Intuitively the notion of empowerment is appealing because of its psychosocial, political and ethical considerations (Freire 1973, Gibson 1991, Kieffer 1984; Sines 1994). In an era of 'political correctness', the notion of empowerment is an easy bandwagon to board. It is rooted in the self-help movements of the 1970s (Rappaport

1984; Matzat 1993) and the advocacy and user involvement movement of the 1980s (O'Neill 1992; Jewell 1994; Wallcraft 1994).

Without a shared understanding of empowerment, it becomes difficult to implement strategies that foster it. Certainly much has been written about empowerment, but this is from a predominantly philosophical perspective and is characterised by conceptual ambiguity and demonstrates a lack of empirical study (McLean 1995; Sheilds 1995). Whilst there has been increasing interest in the concept of empowerment and nursing praxis, which is evidenced by the increasing articles in nursing literature (Butterworth & Rushforth 1995; Barker 1996; Hine 1996; Harden 1996; Worrell et al 1996; Smith 1997; Ryles 1999; Patterson 2001), little has been published relating to empowerment in AOD treatment. In light of this, the literature needs to be drawn from other areas of health care delivery and whilst much can be transferred from other areas of clinical practice, until research is undertaken in this area of clinical specialty, it is not known how applicable it is to AOD treatment.

Much has been written about the concept of consumer empowerment and the need for collaboration with consumers of health services if empowerment is to occur. The idea of collaboration is not new and seems like an easily workable strategy. It has been described as involving 'the mutual give and take of cooperativeness and an active participation of all parties' (Kyle 1995, p. 174). However, the available literature would suggest that this is not as easy to achieve as it first appears (Kasch 1986; Winkler 1987; Henneman 1995; Opie 1998).

Within the context of the health system, collaboration requires a readiness on the part of the individuals to work together, as well as with the institution where the encounter takes place. For a collaborative process to occur, it must involve collaboration between team members as well as between clinicians and consumers of the health service. Individuals must feel valued and have a sense of security about their own contribution, their own discipline, and a respect and trust for other disciplines within which they work. A philosophy that values participation, autonomy and freedom of expression is essential to collaboration (Henneman 1995). Developing such practices involves a shift in the power relationships between the professional and the consumer.

Collaboration cannot occur unless all individuals understand their contribution to the decision-making process (Henneman 1995; Opie 1998). Kasch suggests that further barriers impeding collaboration are the communication practices of nurses (and other health workers), which are likely to:

... reflect a tension between expert knowledge and patient knowledge, between provider control and patient control, and between patient dependence and patient efficacy and autonomy (Kasch 1986, p.45).

In AOD treatment, a philosophy of empowerment is ‘understood’ by clinicians as essential to favourable treatment outcomes, and collaboration with the consumer is held to be an important goal. Yet many of the conditions described above, which are necessary for empowerment and collaboration to occur, appear to be absent from this area of practice, as this research will demonstrate.

Some writers have rejected the idea that health care professionals can empower consumers and suggest that the concept ‘advocacy’ be considered (Falk Rafael 1995).

Some authors suggest that advocacy and empowerment are often seen as synchronous concepts and one cannot function without the other (Estroff 1981; Rose and Black 1985; Harp 1994; Wallcraft 1994; Snowball 1996). Falk Rafael (1995) holds the premise that nurses facilitate the empowerment of consumers and that empowerment is an enabling process that enhances personal control. She goes on to say that existential and human advocacy are synchronous with empowerment and that the prerequisites of empowerment are a 'regard for the client as subject, and a caring, valuing attitude in the nurse' (Falk Rafael, 1995, p. 29). In effect, it is the process and characteristics of empowerment that are important.

Wallcraft (1994) and Sines (1994) would argue that we do not have a mandate to empower consumers, either from the service users perspectives, current social policy or from our professions. They would argue that the concept of empowerment has been adopted because of its 'political correctness' and clinicians can feel virtuous if they use the term.

Roger Gomm (1993) takes a skeptical view of empowerment, arguing that it has different meanings to different people. He suggests that people only empower others to the extent that it serves their own needs. Through his exploration of the concept of empowerment in relation to the notion and practices of power in health and welfare, he argues that by continuing with this term we encourage relationships of an 'oppressive' type (Gomm 1993). Walmsley, et al. echo his sentiments and suggest that 'it [empowerment] can be used and abused in the name of enlightenment and progress' (Walmsley, Reynolds et al. 1993, p.129). If clinicians and managers decide that it is beneficial to 'empower' consumers, then the risk of deciding what is best for consumers

without necessitating their input into the process could become a reality. By doing this it encourages a power differential in relationships based on the ‘special knowledge’ that the clinician has and that the consumer is not privy to.

In a study using grounded theory to examine self-care decision making of 22 Canadian adults with longstanding type 1 diabetes, Barbara Patterson (Patterson 2001) found that participants identified several covert and subtle ways in which clinicians’ contradict their stated goal of empowerment in their interactions with diabetics. It was found that despite their intention to foster participatory decision-making, clinicians frequently discounted the experiential knowledge of diabetics over time and did not provide the resources necessary for consumers to make informed decisions. This led the authors to conclude that an uncritical adoption of the discourse of empowerment:

... may lull health care professionals into a false sense of security that all people with chronic illnesses are able to enter into partnerships with practitioners if only the practitioner extends an invitation to engage in participatory decision making (Patterson 2001, p. 580).

Whilst these points of view are predominantly philosophical, they illustrate some important aspects and difficulties in the empowerment debate. Nurses and other health professionals must heed the warnings when adopting a blanket acceptance of ‘empowerment’ as a concept without exploring the underlying implications and pitfalls in uncritically accepting a philosophical concept. Empowerment encompasses advocacy, but advocacy does not necessarily encompass empowerment, as one can advocate for another person without adhering to an empowerment philosophy or practice. It is not uncommon to find someone advocating for someone else without that person either being involved in the process, or being aware of it happening, or even

desiring for someone to advocate on their behalf. Advocacy in this sense is more concerned with power and control.

The remainder of this chapter deals with the notion of power and control; how it is conceived of, operationalised and the way that it impacts on AOD treatment. The theoretical insights of power offered by Michel Foucault are addressed first.

Michel Foucault

The legacy of Foucault was to ask, what is the nature of truth in today's world and how is it modulated by power and the ability to resist it? (Kritzman 1988). From this question his major themes emerged. First, the need to explain phenomena according to the time in which they occur and secondly, the impact of power and resistance to power on scientific development (Henneman 1995). He refused to accept the polemics between ideology and science and between knowledge and power, extending the notion of power beyond the sphere of class rule and state domination (Larrain 1994).

Foucault locates power outside consciousness or intentional decision. This means he does not address the 'makers' of power, but rather, the field of power. His critique of power 'locates power at its extremities where official discourses over-assert their authority' (McHoul and Grace 1993, p.21). It is with the ends of the capillary network that Foucault is concerned, such as how power is actioned at the site of the clinic or hospital ward 'rather than at some conjectured sovereign point (the state, the law, or whatever)' (Fox 1993b).

Foucault viewed power as not simply residing in individuals or groups, but as an intricate web of 'power technologies' operating throughout society. The purpose of his work was to explore the 'web' of unequal relationships which underlie and undercut theoretical equity posited by the law (Falk Rafael 1996). He wants to explore the micro-relations of power rather than provide a universal definition or theory of power. Power is viewed as being everywhere. It does not belong to, or come from, certain persons. People cannot have or possess power; they can only exercise it. Foucault explains this by saying:

Power is something that circulates, that is never precisely localised or appropriated as a commodity (Foucault 1980, p.98).

He goes further and rejects the idea that a single individual or even a single position in the social hierarchy can be identified as having power, claiming that the latter must be conceived of not as a property, but a strategy. Power is therefore *exercised* rather than *possessed* (Henneman 1995).

One of his theses is that strategies of power actually produce knowledge. Power cannot be conceived apart from knowledge. There seems to be no incompatibility between power and knowledge and he believes that they cannot be looked at in isolation from each other, nor can they be looked at without looking at how power is exercised and how it produces a body of knowledge. Foucault is quoted as saying during an interview:

And I don't believe that the question of who exercises power can be resolved unless that same question 'how does it happen' is resolved at the same time (Boncenne 1988, p.103).

Power represents a strategic situation in any given society and the power relations that exist have a specific purpose to maintain social hierarchy through day-to-day activities.

Foucault posits that the conceptualisation of power and knowledge are inseparable and that there is no power relation without the correlative field of power (Foucault 1980; Doering 1992; Falk Rafael 1996). It is power that limits what is acceptable to be known.

Normally we regard knowledge as being essential to provide us with the power to do things, however, Foucault does not view power in this light. He argues that it is knowledge that 'is a power over others, the power to define others' (Sarup 1993, p.67). In Foucault's view, knowledge ceases to be liberation and instead becomes a mode of surveillance, regulation and deception. Knowledge develops both in *response to* and in *resistance to* the limits set by the power relations. Therefore, power has both a productive and a repressive element. Sarup explains that:

traditionally power has often been thought of in negative terms and been seen as an essentially judicial mechanism: as that which lays down the law, which limits, obstructs, refuses, prohibits and censors (Sarup 1993, p.67).

Power and knowledge are mutually generative and are always exercised in relation to a resistance. It is the presence of this resistive element that creates the possibility of change (Doering 1992). The negative, or resistive, sense of power is important in illustrating the way in which relations of power work to subjugate people by treating them as objects. This can assume several forms including control by, and dependence on, others. Foucault says that one must be liberated not only from the state and its institutions, but from the oppressive forms of subjectivity produced by their practices (McLean 1995). Sarup says that Foucault puts it in a technical and strategic framework and explains this in the following way:

Modern power operates through the construction of 'new' capacities and modes of activity rather than through the limitation of pre-existing ones (Sarup 1993, p.73).

Foucault maintains that power is always exercised at a cost. For example, one such cost of obtaining traditional power is by devaluing certain characteristics, such as what is labelled feminine in both women and men. When this devaluation occurs, members of the non-dominant group (those with feminine characteristics) often distance themselves from the dominant group and become marginalised (Falk Rafael 1996). Sarup goes on to say that:

In his view [referring to Foucault], complex differential power relationships extend to every aspect of our social, cultural and political lives, involving all manner of (often contradictory) 'subject positions' and securing our assent not so much by the threat of punitive sanctions as by persuading us to internalise the norms and values that prevail within the social order (Sarup 1993, p.64).

People are not consciously aware that this process is occurring and as McNay (1994) says:

Even when individuals think they are most free, they are in fact in the grip of an insidious power which operates not through direct forms of repression, but through less visible strategies of normalisation (McNay 1994)

Foucault identifies three ways (dividing practices, scientific classification and objectification) in which people are made into subjects and hence become objectified. He describes the process by which this happens as a mode of objectification (Danaher et al. 2000).

Dividing practices are described as those practices which differentiate one group of people from another. The most effective dividing practices result in the confinement or exclusion of a group based on their differences. This is most often seen in the labelling of people as mad/sane, sick/healthy, bad/good, alcoholics/non-alcoholics, for example. This dividing practice has been instituted in the oppression of races, classes and other groups. People or groups of people are characterised according to their differences rather than their similarities.

Scientific classification refers to the modes of inquiry that give themselves the status of science (Falk Rafael 1996). Foucault suggests that scientific evidence is generated to support and legitimise dividing practice. This scientific classification may refer to the generation and institutionalisation of knowledge that accentuates, exaggerates or mythicises the differences between the groups that provide evidence of supremacy of the dominant group. Boncenne explains:

It is, literally, a power that forces you to say certain things, if you are not to be disqualified not only as being wrong, but more seriously than that, as being a charlatan. Science has become institutionalised as a power through a university system and through its own constricting apparatus of laboratories and experiments (Boncenne 1988, p.106).

Foucault sees a person as occupying a position of truth by virtue of being attached to an 'apparatus of truth,' such as a university. Truth is linked in a circular fashion with systems of power which produce and sustain it, and to effects of power, which it induces, and which extend it (Strawbridge 1993).

Subjectification refers to the concept that individual thoughts and actions are shaped by, and reflect, social power relations (Doering 1992). This can be described as a process of

self-formation in which individuals internalise social power relations. It is an individual's sense of self and understanding of the world which involves the active participation of individuals in their process of self-formation. Typically, it is mediated by an external authority figure through a variety of influences on people's own bodies, souls, thoughts and conduct (Falk Rafael 1995). In other words, it permeates every aspect of life. This process has been identified as a characteristic of oppressed groups who assimilate the characteristics, practices and values of the groups that dominate them, including the normalcy and inherent superiority of the dominant group.

Foucault used the notion of governmentality in an attempt to avoid over emphasising the involvement of the state in the processes of political subjectification (Foucault 1991). Political subjectification can be constituted in various locations within and beyond the state (Rose and Miller 1992). Scholars influenced by Foucault realise continuity between government of self, government of family and government of state or community. To be successful in governing others one must be able to have the capacity to govern one's self (Hazelton 1998). The close relationship between power and knowledge can be seen in the connection between governance and the discourses of human sciences such as medicine, psychiatry and law. Governmentality implies all the tactics, strategies and programs that authorities use to shape the beliefs and conduct of the population (Cheek 2000).

In his mature work Foucault stressed the instability and productive nature of power relations (Foucault 1980, p.119). Power is thus understood to operate as a kind of network, government is directed towards the 'conduct of conduct', and power is

approached in relational terms in seeking to affect the actions of individuals by working on the way in which behaviour is largely self regulatory (Hazelton 1998, p.568).

Resistance to power means that one has acknowledged what the power is forbidding. This acknowledgment then leads to a new discourse about what is forbidden, and new knowledge results. This demonstrates how power can be viewed as an essentially positive phenomenon and:

to understand power, therefore, it is necessary to analyse it in its most diverse and specific manifestation rather than focussing on its most centralised forms such as its concentration in the hands of a coercive or ruling class (McNay 1994, p.3).

Foucault believes that power should be seen as being productive rather than repressive, as he explains in the following statement:

We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses' ... In fact power produces; it produces reality; it produces domains of objects and rituals of truth (Foucault 1977, p.194).

Discipline is an important force in maintaining power and limiting or producing knowledge. Foucault coined the term 'disciplinary technologies' to explain how procedures are used to manipulate or control. Their aim is to forge what he refers to as a 'docile body' that may be subjected, used, transformed and improved (Henneman 1995).

Foucault says that disciplines such as psychiatry, criminology, medicine and human sciences, which arose in institutional settings such as hospitals, asylums, prisons and schools, constitute their own power systems to control and discipline their inmates. He

goes on to say that subjugation is achieved 'not by violence or by aiming at the minds of the inmates in order to deceive and conceal (ideology), it is the docility of the body that they aim at' (Larrain 1994, p.395).

Foucault described three disciplinary mechanisms used by organisations, including professional organisations or disciplines, to maintain power: namely examination; normalising judgement; and hierarchical observation (Danaher et al. 2000).

Examination refers to the process of measuring competence, knowledge or skill, and by doing so compares one individual to another. Judgement is normalised by using the technique of 'little punishments' to maintain standards and achieve conformity (Dzurec 1989). Those who fail to meet the criteria are ostracised. Hierarchical observation is the process by which those at the top view all others below them. All three of these disciplinary methods serve the same function, which is to maintain the status quo.

With regards to AOD treatment within health services, the medicalisation of alcoholism allows consumers to be observed, categorised and treated by medical and related health professionals. The focus of staff on ways that they can help consumers regain control implies that there is a recognition that the consumers have a deficiency that needs to be 'fixed' and the goal for them is to become like the rest of society and be normalised.

Discourse

Much of Foucault's work is centred on the notion of discourse. A discourse is a certain way of thinking and talking which is unified by common assumptions. Various discourses occur at any one time, and these may overlap, complement or oppose each other. Discourse is used primarily to refer to language, but may include images and

gestures. The term discourse is used instead of language because discourse connotes the active political and strategic role of words and how they are connected to form sentences and construct meanings. 'This differs from understandings of 'language' that is simply universal and fixed linguistic awareness and meanings for words' (Grace 1991, p. 330). Discourse is a common sense belief that escapes scrutiny and sustains certain worldviews (Taleff and Babcock 1998). A multiplicity of discourses are in operation at any one time and it is by moving fluidly between these many discourses that ideas and practices are spoken into existence. As Weedon explains:

Discourses ... are ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and the relations between them. ... They constitute the 'nature' of the body, unconscious mind and emotional life of the subjects they seek to govern. Neither the body, nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which discourse constitutes the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases (Weedon 1987, p. 108).

Individuals' understanding and experience of their social identity, the social world and their place in it, are discursively constructed (Frazer 1990). In this sense, 'discourse' plays a similar role to the notion of 'conceptual schema', as it is by this means that meanings such as being male or female are made determinate. However, there is one important difference between these two terms. Conceptual schemes are static repertoires located in the mind of (usually) the researcher, and as such can be perceived as a personal possession, whereas discourse is a multifaceted and public process through which meanings are progressively and dynamically achieved (Davies 2000).

Davies (2000, p. 89) says that 'the constitutive force of each discursive practice lies in its provision of subject positions'. By this she means that an individual adopts a subject position which incorporates both a conceptual repertoire and locates them within a structure of others who use that repertoire. Once the person has adopted the position as his/her own, the world is inevitably seen from a vantage point of that position and in terms of the particular images, story lines and concepts that are made relevant within the particular discursive practice in which they are positioned. The individual emerges through the processes of social interactions as someone who is constituted and reconstituted through the various discursive practices participated in, rather than emerging as, a relatively fixed end product.

An analysis of discourse is concerned with discovering how and under what conditions words and phrases have specific meanings and what can be learnt about the politics underpinning the structuring of a particular discourse at a given historical moment (Crotty 1998). Discourse analysis represents an important development within the critical tradition and is closely associated with the writings of Foucault. A fundamental feature of discourse is that it is social and the words that are used and their meanings depend on whom they are used by and between. Therefore, words differ depending on the social settings and the institutional settings in which they are produced. 'Discourse is the means by which people communicate and they include moral norms or imperatives for behaviour' (Jupp and Norris 1993, p.49). That is, discourse is a certain way of thinking and talking. There are a number of discourses operating at any one time in society and often the discourses are competing with each other as they offer different ways of 'conceiving and explaining the world' (Cheek, Shoebridge et al. 1996, p.174). Foucault does not consider that discourses are in themselves true or false and, in

relation to truth, each society has its own mechanisms for deciding which counts as truth. 'Truth is not outside power' (Foucault 1980, p.131).

Foucault argues that there is not one focus of knowledge and power, but several. He increasingly questions whether the formation of discourses needs to be analysed in terms of ideology (Barry, Osborne et al. 1996) and whether certain forms of knowledge can be reduced to ideology. He is particularly critical of Marxism because it gives to ideology too much importance as a vehicle of power. The state is only one of several points of control and while he does not deny the importance of state power he posits that very little will change in society if the capillary mechanisms of power are not changed (Larrain 1994). He also has no notion of the inevitability of history and thus offers a form of analysis different to Marxist theory. He is, in fact, saying that it is a mistake to think that individuals submit to power because they are either deceived or convinced by ideology, but rather than look at the effects of power on individual consciousness, one must study the effects of power on the body:

Power does not seize the consciousness of a pre-given subject, but the subject is the product of a relation of power which affects the body of individuals (Larrain 1994, p.295).

The most powerful discourse in Australian health care is scientific/medical, which is built on the tenets of empirico-scientific rationalist thought. This scientific/medical discourse dominates other discourse in the health arena and as a result there is much scepticism about 'things' that cannot be proved scientifically. Brown and Seddon (1996) refer to doctors when they say, 'they claim the right to be seen as authorities as they understand the disease process better than anyone else does' (Brown and Seddon 1996, p.31). Consequently, this results in marginalisation and exclusion of alternative

ways of conceiving and providing care. Knowledge and authority are used to 'exclude from, control, legitimise and define the parameters for contemporary health care provision' (Cheek, Shoebridge et al. 1996, p.177). The power of scientific/medical discursive frames in contemporary health care is evident in that:

Not only can these experts define the objects of their study, such as for example what constitutes a sick or insane client, but they also determine the limits of possibilities for the study, treatment and management of the objectified client. The power and control exercised by 'experts' over clients-as-objects thereby constrain the types of discourse that are able to be developed about the client's condition (Cheek and Rudge 1993, p.276).

Consumers of health care are also part of the discourse. They are discursively constructed, through the provision of subject positions, as both objects of study and subjects of powerful discourses in their dealings with the plethora of 'specialists' in the contemporary health care system.

Surveillance

Individuals are also subject to examination (surveillance) which has become a ritualised, prescriptive act, designed to identify, classify and categorise individuals (Foucault 1982). The purpose of surveillance is to restore the 'normal' as defined by the appropriate expert, in this case, usually the medical professional or other health professionals under the 'guidance' of doctors.

Foucault (Foucault 1977) uses the metaphor of the panopticon to explore the notion of surveillance. The panopticon is a prison building designed by an architect, Bentham, where all the cells are built in a circle around the central guard tower. The cells are open and faced inwards, thus enabling the prisoners to be scrutinised by the guards at any

time. Further, the governor can watch the guards from above. The guards can also be scrutinised by the prisoners, other guards and by the governor of the prison. As a consequence of this, a network of scrutiny emerges. As it is impossible to tell precisely when one is being scrutinised, individuals develop compliant, self-policing behaviour. This is what Foucault refers to as surveillance techniques and he argues that the result of the application of surveillance techniques is the production of the 'docile body' (1977). He uses this metaphor to point to issues such as the concurrent advance of techniques to scrutinise populations through compulsory collection of statistics on fertility and morbidity while, at the same time, stressing individual rights.

The health arena is also subject to surveillance. We get the expert scrutinising the expert as well as experts scrutinising consumers, consumers scrutinising consumers and consumers scrutinising experts. There has become a plethora of experts such as the doctor, social worker, psychologist and the nurse. These 'experts' are scrutinised by more senior experts and so layer upon layer of 'expert gaze' is built up. The rhetoric of all this surveillance is that it is being done for the good of the consumer (Cheek and Rudge 1993).

Criticism of Foucault

Foucault, of course, is not without his critics. There is, for many academics, a tension between the philosophical assumptions of critical social theory and those who draw on the work of Foucault. The realm where critical social theorists challenge Foucault's assumptions is in his epistemology of power. They argue that although Foucault acknowledges power, he fails to challenge the political intent and therefore impedes political action and change (Manias and Street 2000). Habermas, a critical theorist,

claims that Foucault is a 'neoconservative'. He claims that Foucault's work on power offers no theoretical reason to move in any chosen direction (Habermas 1986).

Habermas criticises him for explaining who was currently getting and using power and for what purposes, while omitting to suggest ways others might get it and how they might use it. He goes on to say that rather than power and knowledge being inseparable, it is in fact the philosophy of subjectivity that makes us think that truth and power are separable and in fact, knowledge is power (Rorty 1985). Giddens, a contemporary social theorist, is also critical of Foucault and rejects the Foucauldian idea that power has primacy over everything else. He argues that by adhering to the notion that power is everywhere, this results in reductionism, which in itself is faulty (Davis 1991).

Sam Porter (1996), a nursing academic in Belfast, Northern Ireland who works and writes in the arena of health, also suggests that there are weaknesses in Foucauldian notions of power, and in particular with the notion that power is omnipresent. He finds that this notion of power is 'unhelpful', explaining that:

A word, which covers everything, possesses no explanatory usefulness. If power is found in all interactions, it becomes impossible to differentiate between instances of the application of power (Porter 1996, p.1).

Porter also challenges Foucault's assertion that power cannot be possessed. He argues that it is possible for it to be possessed, and that as a function of social structural position, some groups possess more power than others do. By viewing power in this way it becomes possible to compare the amount of power enjoyed by different groups. To illustrate this point, Porter compares nurses' lack of coercive power over consumers to the coercive power of British soldiers in Northern Ireland. He suggests that if consumers do not want to give information to nurses, then nurses are unable to force them to and,

consequently, nurses have little coercive power. Soldiers, however, do have coercive power and are able to 'persuade' people to give them the information they require. He summarises his argument by suggesting that in many instances power comes from above, and the amount of power that an individual can exercise is dependent upon the position occupied within social structures.

Porter criticises the preoccupation with panopticism which has 'led to an exaggeration of the degree to which surveillance and control animate the activity of health care workers' (Porter 1996, p.6). Porter argues that there is a danger of accepting Foucault's conception of power which could lead to a 'praxical paralysis' (Porter 1996, p.11). He proposes that if we accept that there is power everywhere then there is little point in striving to improve the world.

Many feminist writers are also critical of Foucault's work because he questions many of the conclusions which feminists have concerning the nature of social life; and in doing so, he disintegrates collective political strategies for transforming gendered power relations (Ramazanoglu 1993). Hartsock says that Foucault's conception of power is seriously limited because it 'fails to provide an epistemology which is useable for the task of revolutionising, creating and constructing' (Hartsock 1990, p.164). She also refers to Foucault's statement in his book, '*History of Sexuality*', where he says, 'The nineteenth century family should be understood as a network of pleasures and powers linked at multiple points' (Hartsock 1990, p.54). Hartsock declares that this definition fails to take into account the power differentials, and in doing so reinforces the male dominated perspective. Braidotti (Braidotti 1986), another feminist writer, argues that the world is a world for and about men. History has been conjugated in the male, masculine and virile mode. Foucault is viewed as a male who brings out the highly sexed

rules governing philosophical discourse. She says that philosophy posits the primacy of masculine sexuality as a site of social and political power and that Foucault elaborates a critique which emphasis sexual sameness.

Although there are criticisms of the usefulness of Foucault's work, it is his perspective of power which offers more possibilities for framing and analysing this research.

Foucault has better explanatory power because his work paves the way forward to investigating power at its peripheries in a way that other perspectives do not. His notion that power relations are immersed in discourse offers possibilities to explore the conscious and unconscious ways in which discourse is applied to AOD treatment.

Clinicians appropriate and use 'regimes of truth' in different ways to explain their practices. By exploring and unravelling these realities it allows both the dominant and marginal discourses to be exposed, and allows the possibility for clinicians not to close their minds to the possibility that there are alternatives to their current practice. Other viewpoints tend to concentrate on power as a central force and are more interested in power at a macro-level. Consequently, these may be useful in exploring how one group (clinicians, men) holds power and control over another (consumers, women).

Although it is the work of Foucault that will be used in this research, other perspectives on power as outlined in the introduction to this chapter will be presented. The authors presented in the following section have all been cited as saying that thinking about power is crucial for critical social thought and philosophy, and that they recognise the significance of power in the lives of contemporary society. Although the precise effects of power remain a subject of debate, it is acknowledged that power is one of the

fundamental realities of human social existence and this reality (power) explains the conditions, which can be both oppressive and demeaning, of human life.

Amelie Oksenberg Rorty

Rorty (Rorty 1992) sets the scene for this section on power. She describes an imaginary dialogue on the nature of power between two characters called Buff and Rebuff. Buff is portrayed as a nominalist septic who argues that the standard social theoretical concept of power depends on an outmoded metaphysical framework. Rebuff is portrayed as a social theorist who analyses power with a set of conceptual distinctions that Rebuff feels is sufficient to make sense of power. Rebuff claims that Buff's failure to address these distinctions has led Buff to the skeptical position of denying the usefulness of power as an analytic tool for social theory. On the one hand, power is described as the ability to control and define one's environment so that things will go in the direction of one's interests. On the other, power is described as the invention of those who cannot exercise their potential (those without power), and who then project this idea onto others as an explanation of their inability to get what they want. (The generally accepted position that it is those who hold senior positions in management, government and big business who hold power over others.) Rorty continues on to suggest that in order to understand power we need to understand how societal structures both constrain and direct individuals. Power is often invisible because it is not lodged in any individual person or institution but rather has to do with the relationship between them. Rorty identifies the need for a number of important distinctions in conceptualising power as well as illustrating the contested nature of the concept of power itself. She also argues that theorists' defence of their own conceptions of power depend on their particular

interests and beliefs and because of this she questions whether it is ever possible to reach a consensus in theorising power.

Thomas E. Wartenberg

Wartenberg (1992), who is an Associate Professor of Philosophy in New York, puts forward a model that conceptualises the presence of power in a social relationship as being the result of a broad social field. He believes that other theories of power fail to take into account the importance of a broad social context to the creation of a power relationship. Wartenberg suggests that social power exists within a dyad consisting of a dominant agent who wields power over a subordinate agent. He describes social power as being ‘situated social power’, where:

... the power dyad is itself situated in the context of other social relations through which it is actually constituted as a power relationship
(Wartenberg 1992, p.80).

These other social relations form a social field that both structures and conveys power between the two agents who form the central dyad. For example, when an AOD clinician emphasises the importance of abstinence to a consumer, it is the fear of hospitalisation, the fear of physical complications and the fear of losing a job that helps to strengthen the clinician’s domination in the power dyad. Wartenberg’s conceptualisation of situated social power provides a means to understand the power individuals have in certain social roles, and the power they may lose in other roles. It further explains how individuals can come to have a social being which transcends their own individual existence, and raises issues regarding situated social power and its effects on the lives of AOD consumers and clinicians. Wartenberg, like Rorty, is subscribing to the notion that power is conceived as a capacity to act.

E. R. Wolfe

Expressing power differently, Wolfe (1990), whose interest in power comes from an anthropological perspective, describes power as having four modes. These are personal, interpersonal, organizational and structural. He defines personal power as a 'potency or capability' (Wolfe 1990, p.218), and interpersonal power as the ability to impose one's will on another. Organizational power is described as an ability to control the energy flow that makes part of another's environment, and structural power as organizing and orchestrating the distribution and direction of this energy flow. Wolfe's conception of power differs from Wartenberg's (1992) and suggests an infusion of different amounts and types of power into different layers of society. His ideas about structural and organizational power may help us to understand how the forces of society (mores, judgements and beliefs) might limit or enhance the personal power of an individual such as an AOD consumer. Although Wolfe may describe power in a different way, he is still subscribing to the view that power is conceived as a capacity to act.

Anthony Giddens

Giddens (Giddens 1984; Giddens 1996), who has been described as 'one of the most prominent and prolific sociologists living today' (Kaspersen 2000), has developed an eclectic approach to power through the development of his own theory of 'structuration' - a grand theory. He suggests that power occupies a central role that cannot be tacked onto other concepts such as functionalism, where power is secondary to norms and values, or as in Marxist theory where class issues are central, and power is conceived as an adage which will disappear when class differences cease to exist.

He brings to the forefront of his analysis of power what he calls 'administrative power' and uses the term 'power containers' (Dean 1994, p.147), which are arenas for the generation of administrative powers. Government officials, universities and hospitals are all examples, but Giddens also identifies castles, cities and nation states as power containers (Dean 1994).

Giddens treats power as one of several primary concepts, each essential for the analysis of social life. 'All of these concepts are clustered around relations involving action and structure and cannot be explicated without reference to this relationship' (Davis 1991, p.71). He calls this 'duality of structure', where human action and social structure do not stand in opposition, but support each other. The generation of power is crucial to the timing and spacing of activities.

Giddens' conceptualisation of power has five dimensions (Giddens 1984; Giddens 1996).

1. Power is integral to social interaction.

Power exists at all levels of social life. Power is not limited to institutions, but can take place in any interaction. Three elements are involved: its constitution as meaningful; its constitution as a moral or normative order; and its constitution as the operation of relations of power. These are all tightly interwoven. Power involves the skills and resources which members bring to the interaction. Members exercise power by enacting or removing sanctions.

2. Power is intrinsic to human agency.

Power is agency. It is the 'can' which mediates the desired or intended outcomes.

Giddens rejects the idea that social forces ever govern social actors. He sees compliance as the result of a rational assessment of the situation and alternatives. It does not automatically entail agreement. He rejects the idea that individuals can be completely powerless.

3. Power is relational involving relations of dependence and autonomy.

Giddens locates power in a relationship between actors, where it can be 'harnessed' to actors' attempts to encourage others to comply with their wants (Giddens 1976 cited in Davis, 1991 p.73). Resources are asymmetrically distributed in accordance with the structures of domination. Power is never a simple matter of haves and have-nots.

Investigating power will also involve uncovering the 'dialectic of control'; how the less powerful manage resources in such a way as to exert control over the more powerful in established power relationships (Giddens 1988, p. 374 cited in Davis, 1991, p.73).

4. Power is enabling as well as constraining.

Giddens suggests that people try to exercise control over others by sanctions and other means. Sanctions are not necessarily restrictive because a person always has the capacity to say no.

5. Power is processual.

Power is exercised as a process. Structured relations of domination and subordination are produced and reproduced. This concept of power does not focus on the outcome, or who has more, rather it focuses on the 'how' of power; how it is constructed, maintained and transformed. Power is not viewed by Giddens as authoritarian or

repressive. Power can be viewed as enabling or productive. In this perspective, his viewpoint is similar to that of Foucault:

Power is regarded as mundane, processual and multi dimensional, whereby relations of power involving domination and subordination are constructed in the course of interaction. It is suited to a microanalysis of power (Davis 1991, p.75).

Giddens presents power in a different way to the previous theorists by positing that power is central to everything, rather than being an appendage.

Steven Lukes

Lukes (1974) offers a different perspective on power from Giddens. He stresses that power is both 'infinite and positive' (Ryles 1999, p.602), and, therefore, has a positive role to play in the freedom from oppression. Lukes maintains that while the concept of power is 'essentially contested' by different investigators holding different social values, the alternative views of power which those values entail may all be reduced to one underlying concept, that of power in the sense of a simple quantitative capacity.

Ryles (1999) explains that Lukes addresses the issues that he views as inherent in the 'reductionist approach by proposing a three dimensional view of power with each successive stage expanding the analysis to arrive at a positive view that is potentially liberating. Ryles describes the model as 'radical in both the theoretical and political sense' (Ryles 1999, p.604). According to Hindness (1996), Lukes' (1974) work bases a significant part of his analysis of power on the following premises:

The model of the individual as a creature of social conditions;
An image of the autonomous individual which provides an ideal against which the present can be measured; The claim that such an ideal could

be realised in a realm of social existence that is not structured by the illegitimate effects of power (Hindness 1996, p.95).

The first dimension, the one-dimensional view, views power as a quantitative capacity. Often this is referred to as the pluralist view of power. This liberal view implies that possession of power can be identified with confidence in cases of overt conflict; whoever is the victor holds the power. This one-dimensional view of power:

... involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of (subjective) interests, seen as express policy preferences, revealed by political participation (Lukes 1974, p.15).

The criticism of this view is that it accepts the bias of the political system under observation and does not address the ways in which the political agenda is controlled.

The second dimension, the two-dimensional view, looks at both the public face and the private face. The public face is where power is overt, while the private face is seen in the covert exclusion of the interests of particular individuals and groups from the legislative arena. Lukes explains that this dimension examines the way decision and non-decision making is important in the analysis of power:

A decision is a choice among alternative modes of action; a non-decision is a decision, which results in suppression or the thwarting of a latent or manifest challenge to the values or interests of the decision-maker (Lukes 1974, p.18).

Non-decision-making means that demands for change can be silenced or kept covert before access to the decision-making area is gained. The two-dimensional view critiques the behavioural focus of the one-dimensional view of power, and focuses on

the subjective interests which are seen as policy preferences or grievances (Lukes 1974). The two-dimensional view partly examines the issues of bias and control of the political system, but it conceives of them too narrowly. It 'lacks a sociological perspective within which to examine decision and non-decision-making power and the various ways of suppressing latent conflicts within society' (Lukes 1974, p.57).

The third dimension, the three-dimensional view, adds another perspective to include a political arena. There is a critique of the behavioural focus of the one-dimensional view of power, and the focus incorporates decision-making and control over the political agenda. It also focuses on issues and potential issues, observable (overt or covert) and latent conflict, and on subjective and real interests. Lukes (1974) says that there may be instances of the exercise of power in which 'victims' fail to recognise that their real interests are at risk, and consequently make no attempt to defend them. Power is viewed as insidious and this conflict is reduced (Hindess 1996; Ryles 1999). Power then operates:

... to produce and shape the perceptions, cognition and preferences of people in such a way that they accept social practices, and their role, as the natural way and therefore beyond question. Conflict, within this model, does not arise because people fail to consider alternatives to the present order of things (Gilbert 1995, p.867).

With this model, if domination were complete, power would have no role. By using three-dimensions, 'a deeper analysis of power relations is possible' (Lukes 1974, p.57).

Lukes' view of power supports Foucault's (1980) description of power as 'capillary', that is, operating as a network of power relationships extending throughout society. In such an analysis:

One should not assume a massive and primal condition of domination, a binary structure with ‘dominators’ on one side and ‘dominated’ on the other, but rather a multiform production of relations of domination (Foucault 1980, p.142).

Alvin Toffler

Toffler (Toffler 1990), who is a well-known contemporary social thinker, has a series of what he terms ‘assumptions’ of power. His interest in power grew out of a desire to understand the rapid and expansive changes during the 20th century. Toffler contends that the high-speed changes are not random or chaotic, but rather there are identifiable forces that shape change. He describes power as being inherent in all social systems and in all human relationships. It is an aspect of any and all relationships among people, and hence it is inescapable and neutral, intrinsically neither good nor bad. Everyone is included in the power system. For one person to lose power does not mean that another person has gained it.

The power system in any society is subdivided into smaller and smaller power sub-systems nested in one another. Feedback links these sub-systems to one another and to the larger sub-system of which they are part. Individuals are embedded in many different sub-systems, and hold differing amounts of power in each sub-system, for example home and work. Power relationships are in constant process because of the changing nature of relationships. Because people have needs and desires, those who fulfil them hold potential power. Social power is exercised by supplying or withholding the desired or needed items and experiences. As people’s needs and desires are highly varied, the ways of meeting or denying them is highly varied. There are, therefore,

many different 'tools' or 'levels' of power. Among them, however, violence, wealth and knowledge are primary. Most other power resources derive from these.

Toffler posits that violence, which is chiefly used to punish, is the least versatile source of power. Wealth, which can be used both to reward and punish, and which can be converted into many other resources, is a far more flexible tool of power. Knowledge, however, is the most versatile and basic since it can help one avert challenges that might require the use of violence or wealth, and can often be used to persuade others to perform in desired ways out of perceived self-interest. Knowledge, therefore, is supremely powerful.

Fluctuations caused by simultaneous shifts of power in different sub-systems may converge to produce radical shifts of power at the level of the larger system of which they are a part. This principle operates at all levels. Intrapsychic conflicts within an individual can tear a whole family apart; power conflicts among departments can tear a department apart; power struggles among regions can tear a nation apart. At any given moment, some of the power sub-systems that compromise the larger systems are in relative equilibrium, while others are not. When power systems are far from having equilibrium, sudden, seemingly bizarre shifts might occur. This is because when a system or sub-system is highly unstable, non-linear effects multiply. Big power inputs may yield small results. Small events can trigger the downfall of a regime and 'a slice of burnt toast can lead to divorce' (Toffler 1990, p.469).

Toffler also discusses the notion of chance when investigating power. He considers that the more unstable a system, the more chance matters. Equality of power is an

improbable condition. Even if it is achieved, chance will immediately produce new inequalities. Inequalities at one level can be balanced out at another level. For this reason it is possible for a power balance to exist between two or more entities, even when inequalities exist among their various sub-systems. He suggests that it is virtually impossible for all social systems and sub-systems to be simultaneously in perfect balance and for power to be shared equally among all groups. Radical action may be needed to overthrow an oppressive regime, but some degree of inequality is a function of change itself.

Toffler also discusses his moral or philosophical beliefs when he suggests that perfect equality implies changelessness, and it is not only impossible, but also undesirable. In a world in which millions starve, the idea of stopping change is not only futile, but also immoral. The existence of some degree of inequality is not, therefore, inherently immoral; what is immoral, is a system that freezes the maldistribution of those resources which give power. It is doubly immoral that those maldistributions are based on race, gender or other inborn traits. He suggests that knowledge is even more maldistributed than arms and wealth. Hence a redistribution of knowledge (and knowledge about knowledge) is even more important than, and can lead to, a redistribution of other power resources. He explains that an over concentration of power resources is dangerous (Hitler, Stalin et al.), but an under concentration of power resources is also dangerous. He uses the politics of Lebanon during the civil war as an example. He suggests that the absence of strong government in Lebanon turned that nation into a synonym for anarchic violence where scores of groups were in power without reference to any agreed conception of law and justice, or any other enforceable constitutional or other restrictions.

The problem of finding an adequate theoretical vocabulary to describe power and its manifestations presents a challenge. The precise manner in which power structures human social interaction is complex and there are many ways and many answers to how the concept of power is conceived of and operationalised.

Theories of power applied to the health setting

Surprisingly, there is a paucity of literature investigating how theories of power are applied to the health setting in the behavioural sciences, there is more written from a sociological perspective. AOD literature rarely addresses these issues. Historically, theories of power in health settings have predominantly been applied to investigating the relationship between doctors and nurses. The authors who write about power relationships have chosen to view the relationship between nurses and doctors as that of a subordinate one of the nurse to the doctor. Typically, they note that the medical profession exercises considerable control over the knowledge base of nurses; that nurses assist with rather than initiate diagnosis; and that much nursing work tends to be performed at the request of, or under the supervision of the doctor (Stein 1967; Freidson 1968; Freidson 1970; Roberts 1983; Whitehouse 1991).

More recently, the body of literature has expanded to include the consumer and the interactions between the consumer, the clinician and the health care setting. Most of this recent literature is structured within a postmodern and poststructuralist perspective and uses the strategies of discourse as techniques of power. Cheek and Gibson (1995) for example have undertaken a literature review of the nurse's role in medication administration. The authors argue that that the practice of medication is discursively

constructed, which they say is evident from an analysis of the procedures that nurses develop and institute to guide nursing practice. The authors argue that these procedures reduce nursing work to a series of rituals, to which patients are expected to comply. Fox (1993b), a health sociologist, discusses the application of postmodern thought to the sociology of health and includes a discussion on the way in which scientific and medical knowledge results in a particular way of viewing the body. In a 1997 publication he describes an ethnographic study in which he deconstructs negotiations between surgeons and patients regarding being discharged from hospital. The interactions can be seen as acts of power which limit choice and alternative understandings of the situation. Julianne Cheek (1997), who is currently Dean of the Research Division of Health Sciences at the University of South Australia, explores the way in which assumptions about health and health care by health care professionals and their consumers contribute to power relationships. This study contains an analysis of a conversation between a consumer and a health care professional, and shows the way that assumptions about health and health care affect the positions adopted when communicating about health. Thompson and Hirschman (1995) use data from 30 semi-structured interviews to identify ways in which the body is socialised by dominant discourses about health and beauty. This is discussed in relation to 'norms' about the body and in relation to Foucault's notion of the gaze.

These studies are important as they offer other ways of viewing health such as using Foucault's (1975) notion of the gaze where Foucault refers to the act of seeing, or the way in which disease, illness and health care are thought about and viewed. The act of examining the body is a central tenet of the construction of health care around the locus of the clinic. In the examination, the body is made the object of the health

professional's gaze and is scrutinized within the parameters of the medico-scientific discursive frame. This objectified body is then subjected to the regimes of truth and to the technologies of power through various tests and procedures. Foucault (1975) suggests that the resultant disciplined body becomes a docile body, which is both the subject and the object of the clinical gaze, and its underlying premise of the authority and legitimacy of scientific/medical discourse. In the AOD area the same process can be seen to occur when consumers first seek treatment or are viewed by others as having problems with their use of substances. Therefore studies undertaken in other health areas by clinicians and researchers from a variety of disciplines form an important link with my study.

This section shows that the concept of empowerment, and themes of power, do not belong to any one disciplinary area. However, they offer potential theoretical insights to many disciplines and research areas including health.

By using a poststructuralist perspective, such as that developed by Foucault, power relationships can be explored, identified and explained in a manner that focuses on what is happening within the health care setting beyond the dominant discourse. The intention is to begin investigation of this area in nursing and AOD treatment because, the few studies available in health show this approach has the potential for reflexivity, improved services and development.

Conclusion

This chapter has explored the concept of power and its manifestations from a variety of perspectives. It has shown that understanding power, and finding a theoretical

vocabulary for it, can present a quandary, as power is a complex and highly contested notion. However, the goal of a theory of power is to understand the ways in which the lives of people are constricted, as well as to reflect upon the possibilities for eliminating some restrictions. It seems opportune at this point to reiterate that theories of power are influenced and defended by the personal perspectives of the theorist and by those who use them. It is Michel Foucault's perspectives on power which underpin the analysis of this thesis.

CHAPTER FOUR

METHODOLOGY

Introduction

The research method used for this qualitative study fits within the methodological approach or paradigm known as non-positivist. Non-positivist research is concerned with seeking to know the social world by interpreting or inducing hypothesis from field research (Silverman 1993; Cresswell 1994). The purpose of qualitative research is to gain insights through discovering meanings while the intent of research is to give meaning to the whole (holistic) (Burns and Grove 1995). It is conducted to generate knowledge concerned with meaning and discovery. Holloway and Wheeler summarise the reasons for adopting a qualitative approach when they write:

The professional develops understanding of human experiences, which is important for health professionals who focus on caring, communication and interaction. Through this approach, nurse and midwife researchers gain rich knowledge and insight into human beings, be they colleagues, patients or professionals. Researchers generate an in-depth account, which presents a lively picture of the participant's reality [discourse] (Holloway and Wheeler 1996, p.2).

A qualitative method was chosen because it offers a way to enhance understanding of the concepts of power, control and empowerment in AOD treatment from the perspective of clinicians and consumers. In-depth interviewing using a semi-structured format was chosen as the primary data collection method. A modified grounded theory approach was used as

indicated in Chapter 1, because it allows a rigorous and systematic analysis of the data. A Foucauldian analysis was also undertaken.

As mentioned in Chapter 1, there are different schools of thought about the use of a theoretical framework when using a grounded theory approach to research, but there are numerous examples of researchers who do not develop a full grounded theory and who consider that a theoretical framework is entirely justified. The literature is full of different approaches to grounded theory, from researchers who closely follow either the school of Glaser (1992) or the school of Strauss (Strauss & Corbin 1990), the two founders of grounded theory who subsequently disagreed, to those who continue to develop this approach and who consider that a theoretical framework is entirely appropriate (Rosenau 1992; Morse 1994; Charmaz 2000; Cheek 2000). These latter researchers use grounded theory to collect and analyse data because of its systematic approach in these stages, but then undertake further types of analysis or interpretation and do not develop a full 'grounded theory'. It is acknowledged that this is acceptable to some and an anathema to others. According to Charmaz (2000), those who find it an anathema have their positions embedded within traditional positivism and its objectivist underpinnings with its assumptions of "an objective, external reality, a neutral observer who discovers data, reductionist inquiry of manageable research problems, and an objectivist rendering of data" (Charmaz, 2000, p. 510). On the other hand, a constructivist grounded theory, to which I subscribe, assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the researcher and participant and aims toward interpretive understanding of participants' meanings (Guba & Lincoln 1994; Schwandt 1994). As Charmaz (2000) confirms, constructivist grounded theory of subjective experience can bridge the empirical study of meanings with current post modernist critiques. She says:

... researchers starting from other vantage points-feminist, Marxist, phenomenologist can use grounded theory for their empirical studies. These strategies allow for varied fundamental assumptions, data gathering approaches, analytic emphasis and theoretical levels (Charmaz 2000, p. 513).

Any research approach takes a particular position from which to view and/or describe the reality in question (Cheek 2000). Discussion or analytical endeavour from a poststructuralist perspective (frame) is explicit about the ability of any research to capture only partial realities and partial understandings. Those who contrast a constructivist approach acknowledge the researcher's existing understanding of the topic, including a theoretical framework, to the traditional objectivist approach to grounded theory.

Researchers who subscribe to a constructivist approach also argue that the role of literature in qualitative research is to enable the researcher to recognise the leads without being led (Rosenau 1992; Morse 1994; Charmaz 2000; Cheek 2000).

This chapter is structured in the following way. First the ethical considerations and entry issues are addressed, thence an explanation of my preparation for interviewing and the process of obtaining a theoretical sample. Following this, the theory and process of data collection are discussed. The subsequent section discusses the dependability and adequacy of the research process, and finally, the process of thematic analysis is described.

Ethical considerations and entry issues

Ethics in research are viewed simply as the most socially responsible way of eliciting data. Ethics underpin the responsibility that researchers have to the people being researched as well as to the wider society. Action must be taken to ensure that no harm befalls participants as a consequence of their involvement in the project. Confidentiality and privacy must be maintained (Munnall 1988; Robley 1995). The participant must give permission or consent before taking part in any research. This consent must be given freely without any coercion from the researcher or others. The participant must be able to refuse to participate in or to withdraw from the research without any fear of recrimination. Reasons for the undertaking of the research must be explained to and understood by the participants.

Informed consent was obtained and each participant signed a consent form. Prior to meeting with participants I met the Director of Drug, Alcohol and HIV Prevention Services to explain and obtain his approval to conduct the research. I then attended a combined meeting of agency managers and presented my proposal, answered any queries and obtained approval to undertake research in their agencies.

Approval was sought from the University of Wollongong's Human Research Ethics Committee (HREC). Approval was contingent on receiving a written letter of consent from the Director of Drug, Alcohol and HIV Prevention Services, which was duly forwarded to the University Ethics Committee. A condition stipulated by the HREC was that AOD staff initiate the initial approach to consumers to see if they would be interested in participating in the study and after the staff had explained my request, I could then approach consumers directly.

Preparatory interviewing

To practise and refine the interview method, preparatory interviewing was undertaken prior to commencement of the research. The preparatory interview sample comprised two consumers and three staff members of a psychiatric rehabilitation unit. The interviews lasted from 25 minutes to 80 minutes. As a result of this interview I felt more confident in interviewing participants. I confirmed that the language used was understandable and I was able to refine my questioning technique. I also took the opportunity of asking for feedback about my style of interviewing, the questions and probes I used, and the appropriateness of my language.

Process of obtaining sample

At each agency I attended a staff meeting and explained my research in detail to the staff, explaining informed consent and the conditions of approval expected by the Ethics Committee. (See appendix 1) In addition, I left written information about the project and ensured that contact details were available if there were any additional queries after I had left the premises.

Clinicians discussed my proposal while I was present, gave approval to conduct the research and indicated convenient times to conduct interviews. The clinicians undertook to present the proposal to consumers at the next 'house meeting' in residential agencies, or in the case of outpatients, staff undertook to approach consumers directly. Once approval was obtained this way, I would contact the senior staff member on duty at the agency who would recommend a suitable time for

attending, together with a list of potential consumers who had indicated that they were interested in participating.

Clinicians who chose to participate in the study either contacted me directly to organise a suitable time to be interviewed or the manager of the service provided me with a list of staff members who had indicated interest and I then contacted them directly to clarify that they did want to participate and to organise a suitable time for the interview.

Prior to the commencement of every interview I read and explained the consent form to the participant before asking him or her to sign it. All the participants were willing to participate in the study and were informed of their right to withdraw from the study at any time. I also provided them with an information sheet that contained contact details if they wanted further information or wished to withdraw from the project at a later date. In addition I offered participants a copy of their transcript for member checking (Lincoln and Guba 1995), a process which allows participants to check for accuracy. Two participants requested a copy of their transcript be posted to them at their home addresses. This duly happened with an offer of follow up if desired, but no further contact was made.

The rights of confidentiality and anonymity were upheld by both the use of codes to refer to each participant throughout the research report and through the use of pseudonyms. Throughout the study a master list of participants' names, with their respective codes, was kept in a secure locked place, away from the interview transcripts. The rights of dignity and self-respect were upheld by honouring all the previously mentioned rights and by treating each participant with dignity and respect.

Data collection

The primary technique of data collection was in-depth interviewing. Participants were grouped into a clinical category (nurse, psychologist, AOD counsellor) or consumer. Demographic data were also collected. Data collected from clinicians were: gender, age, ethnicity, qualifications, length of registration (if applicable), length of time working in AOD treatment, reasons for choosing to work in this area and whether they identify as 'recovering'. Data collected from consumers were, gender, age, ethnicity, age at commencement of alcohol or other drug use, drug of choice, length of involvement with the alcohol and other drug treatment service and length of time elapsed since last AOD use.

Demographic information was collected at the beginning of the interview and formed part of the relaxing process. I checked with participants that they felt comfortable about revealing this information. I also checked with a cross section of them to ascertain if they would have found it better had I asked these questions at the end of the interview. All of them responded that the questions helped them to relax and that they felt quite comfortable with answering them.

In-depth Interviewing

In-depth interviews are defined as face to face encounters between researcher and participants for the purpose of understanding participants' perspectives on their lives, or situations as expressed in their own language (Minichiello, Aroni et al. 1990; Minichiello, Aroni et al. 1997). The interviewer takes a conversational approach rather than relying on a questionnaire to direct the interview.

The interviews were conducted in each of the AOD treatment clinical setting. The clinical setting was chosen as the majority of consumers were in residential care. Interviews were conducted in a quiet place, free from interruptions and lasted from between twenty and one hundred and ten minutes. Each interview was audiotaped with the consent of participants as permitted by the University of Wollongong Human Research Ethics Committee.

Advantages of using semi-structured interviews

Interviews rely on the respondent's verbal report of experiences, attitudes, perceptions or whatever phenomena are relevant to the study question. A semi-structured interview begins with at least an outline of the topics that the researcher intends to address:

... but both the interviewer and the subject are free to deviate from the prepared agenda and introduce thoughts or observations that are particularly relevant to their personal perspective as the conversation unfolds (Wilson 1985, p.382).

The semi-structured interview allows the interviewer more latitude in seeking clarification and elaboration on cues given by the respondent (May 1996) and in varying the amount of time spent interviewing each respondent (Wilson 1985).

However, all of the predetermined topics must have been covered in some form with each participant.

The relationship of the researcher to the respondent is a collaborative one and the issue of rapport is an important consideration in the interview process (May 1996). This is in contrast to positivist research where the interviewer must remain objective and 'detached' from the participant (Mishler 1990).

Listening to people discuss their experiences and perceptions has advantages. People are often more willing to participate in face to face interviewing than responding to a mailed questionnaire (Wilson 1985). Listening allows data to be collected from people who have literacy problems or some other communication disability and it is more effective at getting at the complex feelings or emotions of people by asking searching questions or for clarification and examples. Another advantage is that it can allow the researcher to discover the unexpected in a way that a structured questionnaire does not. Through the use of semi-structured interviews, the participants speak of their experiences and understandings, feeling more empowered by this type of interview process. Viney and Bousfield (1991) have stated:

Telling our stories can also empower us. People, whose narratives are heard within a community, may be better able to contribute to constructing how that community sees itself and its problems (Viney and Bousfield 1991, p.758).

Telling stories of experiences can also be empowering in that it provides catharsis, freeing up emotional energy for other tasks (Hutchinson, Wilson et al. 1994).

Sampling Procedures

A non-probability or purposive sampling technique was used. 'In non-probability sampling, not every element of the population has an opportunity for selection in this sample' (Burns and Grove 1995, p.238). Purposive sampling 'involves the conscious selection by the researcher of certain subjects or elements to include in the study' (Burns and Grove 1995, p.243). A modified grounded theory approach was used for analysis. This was discussed on page 83.

The sample chosen in my research were current clinicians or consumers in AOD treatment in various treatment facilities in a large urban area. Purposive sampling was used to capture the richness of a wide range of perspectives. Participants were selected on their personal history of AOD treatment, or because they were currently employed as AOD clinicians.

The criteria for selection were:

- Current consumer or clinician in AOD treatment;
- 18 years of age or older;
- Ability to provide valid consent;
- English speaking.

After performing the initial four interviews with consumers and staff in the AOD Detoxification Unit (Detox), I waited for the transcripts to be typed before doing any more interviews. I planned to do the substantive coding of transcripts before continuing with further interviews. At this level of coding, phenomena is conceptualised and compared and categorised. From the preliminary interviews with consumers it seemed that people in the early stages of detoxifying were less able to translate their experiences to other areas, while those who were well advanced in the process of detoxification were much better able to focus on their experience. I decided I wanted more of the second subgroup in the study and therefore would need to look at consumers in rehabilitation services as well as Detox.

In the next set of interviews a tentative theory was formed that gender may have an influence on how people perceive their treatment or how they respond to consumers. I

had planned to interview equal numbers of males and females, but this was not possible as fewer women than men presented for treatment during the time I was interviewing. With clinicians, I was restricted by who was currently employed. Another factor that seemed to be significant in consumers' experience of their current treatment was their previous attempts at detoxification. I decided it would be important to have as wide a cross-section of AOD consumers as possible and wanted to interview consumers who had had little experience with AOD treatment as well as those who had had a long relationship.

I decided to continue collecting, coding and analysing the data as the study progressed. Unfortunately, this was not always possible due to delays in receiving the typed copies of the transcripts on a regular basis, which meant that saturation of the categories occurred before the interviews were completed and analysed. The term 'saturation' when used in conjunction with theoretical sampling, refers to a process:

...where no additional data can be found that would add to the categories being developed and examined. That is, you have reached saturation level (Minichiello, Aroni et al. 1995, p. 162).

A total of 57 interviews were carried out ranging from 20 minutes to 110 minutes with the average interview lasting approximately 60 minutes. The sample consisted of 31 clinicians and 26 consumers.

Description of clinicians and treatment agencies

The thirty-one (31) AOD clinicians in this study comprised nurses (n=9), psychologists (n=7), AOD counsellors (n=14), of whom 3 identified as 'recovering', and one doctor.

See Table 4.1

TABLE 4.1

PLACE OF EMPLOYMENT AND NUMBERS OF CLINICIANS

INTERVIEWED IN EACH AGENCY

	Detoxification Unit	AOD Outpatients	Methadone Clinic	Rehabilitation Unit (CBT)	Rehabilitation Unit (12-step)	Total
Nurses	2	2	5			9
Psychologist		5		2		7
Doctor			1			1
Counsellor	8	1			2	11
Recovering Counsellor	2				1	3
Total	12	8	6	2	3	31

TABLE 4.2

CLINICIANS

Category	Number	Age in years	Years in AOD
Nurses	9 (F)	25-57 (mean 42)	2-13 (mean 10)
Psychologists	7 (3M, 4F)	24-38 (mean 31)	0.5-15 (mean 5)
AOD counsellors	14 (5M,9F)	19-50 (mean 34)	0.2-18 (mean 4)
Doctor	1 (M)	48	20

Agency Organisation

Five agencies were accessed. These are discussed in detail in the following section.

Methadone Clinic

The methadone clinic is part of the area health service. One doctor is employed on a part-time basis for the assessment of consumers' suitability for admission to a methadone program and for on-going counselling. Registered nurses form the remainder of the work force and they are responsible for dispensing and administering methadone, assessment, monitoring and counselling of consumers and the general day to day organisation of the unit. One nurse in the study was currently on secondment to a youth service which is a non-government organisation. Methadone is administered over a two-hour time slot each morning and consumers attend the clinic to receive it. Some consumers who have been assessed as being suitable may receive up to three take away doses each week. These consumers are expected to provide regular urine samples.

Detoxification Unit

The detoxification unit offers 24 hour residential care and is part of the Area Health Service. It offers a medicated detoxification service which means that consumers may be prescribed medication to assist them with detoxifying from AOD. One registered nurse is employed as the unit manager working Monday to Friday for the standard 40-hour week. Another registered nurse is employed for Saturday and Sunday. These two nursing positions were created in the months prior to my research. Before this, the nurse

unit manager was employed in a management-designated position rather than a nursing position and the other nurse worked full time as an AOD counsellor. With restructuring, the nurse was given the choice of remaining in the position as a full-time counsellor, or as a registered nurse working part-time. The remainder of the clinicians were all employed as AOD counsellors. Two of these identified themselves as 'recovering' counsellors, but the remainder did not. Seven of them were undertaking or had completed an Advanced Certificate in AOD Studies.

AOD Outpatient Services

Two nurses were employed as Clinical Nurse Consultants with AOD outpatients, a service which is run by the Area Health Service. Four of the clinicians interviewed were working part-time and either studying or working part-time in another position. Of these four, three were psychologists who were working to obtain clinical hours to be eligible for registration as clinical psychologists, and one was a counsellor who was undertaking a psychology degree. Two clinical psychologists were employed full-time in this unit.

CBT Rehabilitation Unit

The rehabilitation unit where cognitive behavioural therapy (CBT) is practised is a non-government organisation (NGO) and is funded by the NSW Department of Health, rather than directly by the Area Health Service. The two clinicians who consented to be interviewed were psychologists; one working full time and the other working part-time. The majority of staff in this unit were employed on a part-time basis and were completing their training as clinical psychologists.

Twelve-step Rehabilitation Unit

Three AOD counsellors were interviewed from the rehabilitation unit which adhered to a 12-step philosophy. One of these identified as a recovering person. This unit is also a NGO and receives funding from the NSW Department of Health. Two staff are on duty during a day shift; an afternoon shift has either one or two counsellors; one staff member is on duty at night. The manager is on 24-hour call. Clinicians are all AOD counsellors.

Description and demographic data of consumers

Twenty-six consumers participated in the interviews. Of these, eleven were interviewed while they were resident at the Detoxification unit, eight were resident at the rehabilitation unit which used CBT, five were resident at the rehabilitation unit which used a 12-step philosophy and one was an AOD outpatient. For seven consumers (27 per cent), this was their first experience with AOD services, but the other nineteen (73 per cent) had an on-going relationship ranging from three months to twenty-five years. The length of time they had been AOD free prior to being interviewed ranged from one day to three months and although the ultimate goal for all consumers, it was an expectation that they would be abstinent throughout their residential treatment. The only exception was those consumers who were currently enrolled in a methadone treatment program. For the purpose of this study, they are included in this number. See Table 4.3. Consumers were not asked if this was their first attempt at being AOD free.

TABLE 4.3
CONSUMERS

	Number and sex	Age Range (years)	Time with service	AOD free (days)	Age of commencing AOD use (years)
Detox	11 10m, 1f	23-67 mean 40	2d-10y mean 2.7y	1-60	7-21
12-step rehab	6 5m, 1f	19-36 mean 25	1d-30y mean 4.9y	1-90	5-15
CBT	8 6m, 2f	28-46 mean 37	1y-25y mean 0.6y	8-90	13-18
O.P.	1 (f)	35	2y	120	18
Total	26 21m, 5f	19-67 mean 35	1d-30y mean 4.4y	1-20 mean 13	5-21y mean 13

Process of Interviewing

Initial contact with each participant was made in person, except in one case where contact was made by telephone. In the initial conversation I explained the purpose of the study and what would be expected if they agreed to participate. This process took approximately fifteen minutes and allowed me to build rapport with each participant prior to interviewing. I also gave an information sheet to those participants who did not have one.

When interviewing in a residential agency I would spend between a few hours and a whole day or evening over a period of approximately one-month. During this time I would eat meals with the residents and staff, and participate in informal discussions. This had the added benefit of potential participants and participants becoming used to my presence and feeling comfortable with me in their environment. Another unforeseen benefit from this was that it enabled participants to talk to me about issues that they had

thought more about *after* the interview. This indicated that many of the participants were interested in the research and were reflecting on their participation and/or on their clinical practice. Some spoke of how they would try to do things differently as a result of the issues being raised. These reflective statements and musings by participants were not used in the research.

Each interview commenced with some initial informal conversation to put participants at ease and to set the tone of the interview. The audio tape recorder was explained and the participants were read and asked to sign a copy of the consent form. I then collected the demographic data in a relaxed and informal manner. The tape recorder was activated and the interview commenced. The first step was to ask each participant a broad question asking him or her to elaborate on the reason for being in AOD treatment, either as a consumer or as a clinician. The use of a broad question is what is described as a ‘grand tour question’ (Polit and Hungler 1995, p.271). From this point on the respondent predominantly drove the interview, with some guidance from me, towards the direction of their experiences in AOD treatment.

I relied on my semi-structured interview schedule to remind me of the areas I wanted to cover (See appendix 11). The interview schedule was used as a guide to the topics to be covered, plus possible prompts, as is commonly the case in semi-structured interviewing. The schedule outlined in appendix 11 is therefore not a replication of the wording used in the interviews. The questions were open-ended and focused on the topic area, but the wording varied depending on each participant’s language comfort level and the dynamic of the interview. As a result each interview was different in the

way it unfolded. There were also differences in the material covered by each participant, as each participant's experience was unique.

Each of the interviews was recorded on audiotape. Minichiello et al. (1995) describe the benefits of tape recording interviews in the following way:

Tape recording is one means of obtaining a full and accurate record of the interview. It can enhance greater rapport by allowing a more natural conversational style. The interviewer is free to be an attentive and thoughtful listener. The raw data remains on the record. Therefore, all the material is available for analysis when the researcher has the time to concentrate fully (Minichiello, Aroni et al. 1997, p.134).

Tape recording allowed me to concentrate on the interview without having to write notes. The flow of the conversation was preserved, allowing me to reflect on my interview style and content and to constantly revise and refine my technique. For example, I quickly became aware that I would pause mid way through a sentence, which sometimes was confusing for participants. I also became aware that my interviews with women were longer and flowed more easily than with men, and that interviews with clinicians tended to be longer than with consumers.

The disadvantages of tape recording, which have been identified, include inhibited interaction, inability to record non verbal data and biasing of the data because the informant may feel a need to be interesting (Polgar and Thomas 1995, p.142). In my experience, I did not find that participants were inhibited by the use of a tape recorder. Most respondents appeared unaware of it once the interview commenced and in most cases the conversations flowed naturally.

As soon as possible after each interview I wrote an account in a field journal. Field notes are 'constructed representations of experience' (Clandinin and Connelly 1994, p. 422), and are a 'reflective account of what was said, or not said, as well as observations made during an interview' (Minichiello, Aroni et al. 1990, p.251). This reflective account included speculation about possible themes, reflections on ethical issues and comments made that were not captured on the tape recorder. In addition, I kept a record of the body language of each participant, the ease of relationship between the respondent and me, the interview environment, subjective feelings, observations, methodological considerations and comments made to me by other people. These data proved invaluable during the advanced stages of data analysis. For example, when data were not captured clearly on audiotape I was able to make fairly detailed accounts of what was missed.

To enable analysis of the data collected in the interviews, the conversations captured on audiotapes were transcribed. After each interview, I copied the audiotape onto a back-up tape and couriered the original tape to an experienced transcription typist for typing. I then checked the accuracy of the transcriptions by comparing them against the tape recording. This process also ensured that I listen several times to the recording of the interview, thus keeping the interviews fresh in my mind. On the transcripts I included descriptions of any non-verbal responses that I thought might have accompanied the response, or added intensity to the response that would be missed in the transcription.

The interviews were conducted in a variety of rooms ranging from offices, staff rooms, counselling rooms, kitchens, bedrooms, activities room, and in one case in a garage,

depending on the availability of space, and where the respondent felt comfortable being interviewed.

Dependability and adequacy of research

The terms dependability and adequacy are used to describe rigour in qualitative research. Dependability can be ascertained by examining the ‘methodological and analytical ‘decision trails’ created by the investigators during the research itself’ (Siebald, Richards et al. 1994, p. 399). Adequacy encompasses the notions of reliability and validity and implies that research processes and outcomes are well grounded, cogent, justifiable, relevant and meaningful (Hall and Stevens 1991).

Each interview was tape-recorded and transcripts were offered to participants for ‘member checking’. Understanding of the environment was enhanced through informal contact with the clinicians and consumers and through participant observation during group meals. These observations were not directly used in analysis. These activities created an extensive audit trail, which, as Lincoln and Guba (1995) suggest, is one approach for establishing the trustworthiness of research findings. Another measure used for ensuring trustworthiness was the use of the constant comparative method, which is a component of a grounded theory approach where data are constantly compared. This was undertaken during analysis, when the data were constantly compared with and against each other and any negative cases identified and pursued.

The principles of theoretical sampling were followed and saturation achieved (Glaser and Strauss 1967; Strauss and Corbin 1990). The process of analysis, (which is described in detail in the following section) used in this study is consistent with the

process described by Corbin and Strauss (1996). By rigorous data analysis concepts have been generated and categorised. One core category emerged from the data and other categories have been further developed, refined and related to the core category.

Data Analysis

Data analysis is the process of systematically arranging and presenting the data in order to search for ideas and find meaning in the information collected. The process of data analysis which was undertaken can be described as a grounded theory method. With this method, the interview transcripts are coded for themes that arise out of the data rather than being imposed on the data. Data analysis begins early as emerging data are coded. Through coding, the data are defined and categorised (Silverman 1993; Morse 1994; Charmaz 2000). This process begins by line by line coding which sharpens the use of sensitising concepts and provides a starting point for building analysis. These concepts are further developed into categories which are constantly compared to each other (Wilson 1985; Strauss and Corbin 1990; Strauss and Corbin 1994). The process of data analysis is divided into three phases: substantive or open coding; selective coding; and theoretical coding which are described in more detail in the following section.

Substantive coding

Coding at this level is a matter of conceptualising phenomena in order to ‘compare, categorise, examine and eventually build theory from the data’ (Strauss and Corbin 1990, p.63). This means deconstructing the observation and reading through the data line by line, naming each discrete incident or idea. After I finished this initial phase of coding for each interview, I drafted lists of the concepts generated to enable

comparisons between them. Drafting lists of concepts from each interview facilitated the genesis of categories.

Selective coding

‘Selective coding requires that the analyst note what is similar and what is different about the codes on the list and to create categories that relate to one another’ (Wilson 1985, p.419). This is a more abstract consideration, as the concepts within a category must have similar properties and characteristics. For example, all the concepts clustered in the category, ‘making changes’, which is discussed in chapters five, six and seven, are psychological or social mechanisms identified by the participants as necessary to implement and maintain change. They are all connected with dissonance, which is a key factor in facilitating change (McMahon and Jones 1992).

Theoretical coding

This phase of coding involves identifying ‘how the substantive categories are related to one another’ (Wilson 1985, p.419); in other words, formulating propositions about relationships and attempting to verify them. The primary activity of theoretical coding is developing the storyline (Strauss and Corbin 1990). The central phenomenon identified from this study was control. Control was selected as the core category as it underpinned the entire participants’ accounts of empowerment. Participants talked about ‘wanting control’, ‘needing control’, ‘being out of control’ and ‘having control’ as a central pivot to the empowerment process in AOD treatment. The other categories all relate to control in one way or another.

Analytic ordering

Corbin and Strauss (Corbin and Strauss 1996) use the term analytic ordering to make explicit the linkages between interaction and the conditions that affect both it and the consequences flowing from it. These authors contend that conditions affecting the interactions may have their sources in quite different areas than the actual interactions around the phenomena. For example:

The interactions may concern gender relationships, whereas the conditions stem from the market or local politics or organisational or sub organisational relationships. [In addition] Significant consequences seem to get overlooked because of the relatively restricted gaze of the researcher, not necessarily because of a major research focus (Corbin and Strauss 1996, p.143).

There are many lines of connection which are termed connectivity paths and analysts are faced with making choices about which consequences are significant in relation to which particular conditions. Choices must be made among different levels of scale (scope) and located in different areas. Corbin and Strauss (1996) suggest the use of a matrix (see Appendix 111) which they say is a:

pictorial device for reminding researchers not to foreclose on conditions, consequences and interactions germane to understanding a given phenomenon. Built into it are several kinds of connections. (a) Some will characteristically run within the same level, i.e. the same scope. (b) Other lines of connectivity can be either upward, or downward or both. The goal is not to trace every path, but only those which are most patterned or seem most relevant to the study's purposes (Corbin and Strauss 1996, p.146).

While categories were being developed, the matrix paradigm was found to be useful in thinking about concepts and the connections between them and the conditions which

affect them. I used the matrix in the same way that I used the interview guide as a memory aid to check that certain concepts or ideas were covered.

The purpose of the matrix, which is not meant to be deterministic, is to focus the researcher on the level of explanation being sought while at the same time reminding the researcher of ‘the greater range of potentially significant conditions, consequences and interactions than might be noticed’ (Corbin & Strauss 1996, p. 145). For example, this study looks at empowerment and collaboration in AOD settings and the interactions where these phenomena are potentially located. However, these interactions are influenced by the treatment philosophy of the institutions where they take place, the marginal position of these institutions, the clinicians and consumers in the health care system as a whole and the negative and often moralistic view of addiction held by the general public and fuelled by some sections of the media, conservative religious groups and politicians. By using the matrix as a guide, it was a useful tool in reminding me continue to expand my thinking about the concepts that were being generated.

Conclusion

The methods explained and discussed in this chapter are part of a qualitative study designed to explore the concepts of power, control and empowerment in AOD treatment. In-depth interviewing was the main data collection technique used because interviews of this type provide an enriched picture of the perspectives of both staff and consumers in AOD treatment. Data analysis was governed by processes and procedures cognisant with grounded theory. The process was rigorous; each interview was coded on a line by line basis in the first phase of coding. Then the initial codes were rationalised, categorised and reconfigured in terms of a specified coding paradigm.

Finally, a core category emerged from the other categories and its relationships to the other categories were explained as the theory developed from the process of analysis. Explanations were undertaken using Foucault's conceptualisation of power (see Chapter Three). The adequacy of the research process has been discussed and an extensive audit trail (Lincoln & Guba 1995) explained.

The aim of this study was to explore the perceptions of consumers and clinicians on issues of power, control and empowerment in AOD treatment. The methods used to achieve this aim allowed me to explore the experience of fifty-seven participants in detail. The result of this intense exploration has enabled the development of significant categories, which should be useful to a range of health professionals working in AOD treatment. These categories are discussed in the following three chapters.

The data chapters, which follow this chapter, are divided into three entities. The first data chapter, ***Institutions***, is organised around three major categories, *Treatment philosophy*, *Discourse* and *Service provision*. The other two data chapters, ***Clinicians*** and ***Consumers***, are organised around categories that emerged during data analysis. These have been named *Change*, *Control*, *Empowerment*, *Empowering others*, *Being disempowered* and *Working against empowerment*. Data presented in all the chapters are supported and illustrated by the use of quotes from clinicians and consumers, and simple counting is used to add weight to support the evidence presented.

Simple counting is used as a means to survey the whole body of data and to gain an impression of the data as a whole. Counting assists the crucial step of interpreting the pattern that is found in the codes. Pattern recognition implies seeing something over

and over again in one case or across a selection of cases and simple counting displayed numerically can make patterns emerge with greater clarity. While simple counting may be considered by some to be a quantitative technique and therefore out of place in a qualitative analysis, these authors have argued that it does indeed have a place and can assist in pattern recognition. (Morgan 1993; Silverman 1993; Sandelowski 2001). Silverman in particular recommends its use for the reason he explains in the following quotation.

Instead of taking the researcher's word for it, the reader has a chance to gain a sense of the flavour of the data as a whole. In turn, researchers are able to test and revise their generalisations, removing nagging doubts about the accuracy of their impressions in the data (Silverman 1993, p. 163).

CHAPTER FIVE

INSTITUTIONS

Introduction

This chapter is concerned with the institutional impact on issues of power, control and empowerment in AOD treatment. The institution is not just the physical building where AOD treatment takes place; it encompasses institutional practices and beliefs such as AOD treatment philosophy, discourse and service provision.

The philosophy of each treatment centre determines the advice and treatment given to consumers and both clinicians' and consumers' views are affected by the ideology operating in each centre, whether it be total abstinence or a harm reduction approach. Consumers and clinicians may refer explicitly to the philosophical perspective through discourse and/or in printed matter, or it may be implied through their discourse.

This chapter explores the question of how the dominant ideology of the 12-step program is maintained and perpetuated in AOD treatment, in spite of the fact that many of the clinicians practise in an environment which subscribes to a harm reduction model. It also investigates why consumers also maintain this ideology (abstinence), yet are critical of its effectiveness and voice support of a harm reduction model, even though they may be resident in non-abstinence-based programs.

This chapter also shows that the clinical imperative that consumers need to change their AOD use is increased by the treatment philosophy emphasised in individual facilities, and this pressure for change is further strengthened by the 'carrot and stick' approach

imposed by the overlapping routine activities of the health system and the criminal justice system.

It is argued those institutional practices and beliefs are disempowering not only for consumers, but also for AOD clinicians. Participants identified the 12-step philosophy as being disempowering for consumers and even more so for women consumers.

Consumers are treated by clinicians as a homogenised group (AOD problems/addicted), irrespective of individual differences and needs. Consumers (and clinicians) view the rules imposed by treatment services, specifically those imposed by the detoxification unit, as inflexible, not serving any purpose and disempowering. In addition, these rules serve to reinforce the dominance and control held by clinicians.

Empowerment does not appear to have an active role in institutional practices although the concept may be documented in mission statements and in AOD literature. The move towards a harm reduction approach to AOD treatment supports the notion of consumer empowerment; however, the data show that AOD treatment is still dominated by the 12-step approach which may well work against empowerment.

Finally, the impediments to empowerment are explored. Residential treatment programs protect and shelter consumers from the routine of their day to day lives and may actually work against consumers in their attempts to gain empowerment and/or control over their AOD use.

These three domains (treatment philosophy, discourse and service provision) are used to structure the chapter. Although each domain is extrapolated and discussed as a separate topic, they intertwine and each influences the others.

Treatment philosophy

Specific treatment modalities are viewed by participants as supporting the right to individual choice, or conversely, as taking away choice from the individual. The philosophy of Alcoholics Anonymous/Narcotic Anonymous (AA/NA) was viewed by sixteen of the clinicians (52 per cent of clinicians) and five consumers (19 per cent of consumers), as being controlling and lacking in options and choice because of its reliance on the disease process, and its emphasis on abstinence from all AOD use for ever. They felt that AA/NA dealt with issues in a simplistic manner with their emphasis on ceasing AOD use, but without an equal emphasis on exploring the underlying reasons for its use in the first place. One participant suggested that consumers may simply replace one behaviour (drinking or drugging) with another (going to meetings), which results in them not making the changes necessary to sustain the decision not to drink or use other drugs:

I don't believe just stopping taking drugs or drinking is the answer. There's plenty of recognition of that problem in the past, through AA/NA. Just because they're not drinking they've stopped one behaviour. In fact, they often get addicted to going to meetings, developing co-dependent relationships. It's just not the answer, but I mean eventually they'll end up in a relapse anyway.

Grant, psychologist, CBT Rehab.

This philosophy is in contrast to the harm minimisation approach to AOD treatment such as CBT, where the underlying principles are the acquisition and maintenance of

interpersonal and intrapersonal skills in order to cope with life's stressors without resorting to AOD use. By using this approach, individuals choose for themselves whether they want to reduce, control or abstain completely from AOD use. By encouraging choice and self-responsibility, consumers are perceived to be able to control their AOD use. If they resort to previous levels of AOD use (lapse/relapse), it is viewed as simply a setback, rather than a failure, as labelled by the 12-step (AA/NA) approach. Consumers feel they now have a choice:

I was still in the old system of re-education and you pick up a drink, you drink. Lapse relapse! I didn't agree with lapse, relapse. I'd been educated from other rehabs and that there's not such a thing as a lapse, but you pick up a drink again, you lose. So this fear that was instilled in me through the other rehab [AA] gave me no choice. But here I can ... this time I did have a choice. I don't have to keep on drinking to oblivion because of feeling guilty and the shame and embarrassment and stuff like that.

Hamish, consumer, CBT Rehab.

Many consumers feel out of control and recognise this by saying that the drug controls them. They feel powerless and they don't like feeling that way:

Well because the power that alcohol has over me. It's ruined so many things in my life, and I've got to the point where I don't like it any more.

Ralph, consumer, Detox.

This particular way of describing the notion of being out of control and powerless is reinforced by the AA and NA philosophy where the first step is to admit being powerless over AOD use (A.A 1939).

The 12-step philosophy also supports the power imbalances between consumers and clinicians by reinforcing that the consumer lacks control, while clinicians are in control and ultimately have control. The underlying message is that if consumers are compliant

and do as clinicians direct, then they too will be able to have control. It creates a dependency on individuals to support the AA/NA fellowship, by giving the message that consumers need to follow the 12-step program to its completion, because they will falter in their resolve if they do not attend meetings regularly and do not maintain contact with other members of the 12-step fellowship. If people lapse in their resolve, they are viewed as failures, adding further to their disempowerment.

For many women, the 12-step philosophy compounds the disempowerment they experience in relationships, occupation and income. Gender has been rendered invisible in most of the literature on substance abuse (Hamilton 1991; Ezard 1998). Historically, women have been excluded from research into AOD use, and gender issues have not been included in reports of research outcomes. Feminism's entrance into the AOD field has been instrumental in reformulating the questions around AOD use to accommodate issues of gender. Added to this is the negative way women with AOD problems are often viewed by both women and men who hold a moral perspective on AOD use, which may be evidenced by their acceptance or tolerance of legal drug use (alcohol and tobacco) by men, and their intolerance of illegal drugs by both genders. Drugs are divided simplistically into good and bad kinds.

The 12-step philosophy was seen by five clinicians (16 per cent of all clinicians, 26 per cent of female clinicians) as disempowering to women because it was originally designed for men. Many authors have criticised AOD treatment services for being inaccessible to women because they have been designed for men, partly because they rely on research based on men's AOD use, rather than on women's experiences of problematic AOD use (Broom 1994a; Broom 1994b; Copeland and Hall 1995). The 12-

step program was developed when it was less acceptable for women to drink alcohol. It was the common practice that a woman with a drinking problem be hidden by the family and her drinking be kept secret. Although there have been some minor alterations to the wording of the 12-step program, it is still viewed as a patriarchal model. It is seen to intensify the powerlessness that many women feel as it encourages women to remain separate from those who do not have problems with AOD use. In addition, it discourages women from discussing their AOD use outside their 12-step support group, thus bolstering their invisibility and further marginalising them. All of this underlines the necessity for them to remain within the AA fellowship and further suggests that without the support of their group they are likely to once again lose control. One clinician who described it in this way was also a ‘recovering’ person:

I’m heading away from the twelve steps. I don’t want to use drugs or anything at the moment, but I’m starting to see it as very limiting and it keeps me separate from society. It doesn’t empower me; it keeps me locked into a belief system where we have to keep a secret. It’s held me safe and protected in its loving arms for six years and I’m eternally grateful for that. ... I also give a message because the wording of the steps is very limiting and disempowering, especially for women...

Jenny, AOD counsellor (recovering), 12-step Rehab.

The first step of AA or NA is to encourage individuals to admit powerlessness over the drug and to convince them to remain abstinent, not just from the preferred drug but from all drugs. People with AOD problems are often described as having ‘addictive personalities’. It is assumed that if a person has problems with the use of one drug, then it is a given that he/she will have problems with all others; therefore, the individual is unable to use any potentially addictive substances. The ultimate goal is to remain completely drug free.

CBT on the other hand, does not subscribe to the notion of an ‘addictive personality’. Consumers who have problems with specific drugs are not automatically categorised as having problems with all drugs. This notion can be quite liberating for some consumers who, for the first time during AOD treatment, are offered choices. For example:

I don’t have a drinking problem ... I can go and have a couple of beers or a glass of wine with my dinner and that’s all and I’m fine. They were saying to me at the other rehab, that I could never drink again, whereas here they’re saying, well, only you know if you can or you can’t, and you may be able to drink. But my drug of choice is heroin and that’s what I have a problem with; and being told that you’re not allowed to drink alcohol ever again, I didn’t agree with that. Whereas they’re accepting of that here.

Cameron, consumer, CBT Rehab.

The philosophy of each treatment centre influences the care and treatment given to consumers. Although services may subscribe to a harm reduction model and consumers and clinicians speak about the negative aspects of the 12-step program, it remains dominant and works against the principles associated with consumer empowerment. The philosophy of the 12-step program influences discourse and service provision which are discussed in more depth throughout the remainder of this chapter.

Discourse

Consumers who spoke about the drug controlling them used the language, or discourse, of abstinence to explain this occurrence. The use of phrases such as ‘hitting rock bottom’ is associated with the 12- steps program, where it is widely held that in order to ‘fully recover,’ the individual who is controlled by the drug must experience ‘rock bottom’ (cannot fall any further) before being able attempt change and gain control.

Consumers attribute personal characteristics to the substance and describe how it has held them powerless. Like something out of a science fiction movie, I am left with images of a dark, sinister being undertaking a battle with the consumer:

Well, alcohol's destroying me mentally, physically, emotionally; it's cunning, baffling and it's a beaut. You can't beat it, you've gotta take it head on, you can't play games with it you know, it's a fact. Whenever you're feeling down, it'll sneak up on ya. You can't play with it; it's no joke. The only way to go is down. You can't go any further, you just, you hit rock bottom that way. Well you lose your kids, you lose your wife, you lose your self-respect. I've already lost that. I've got no self-esteem whatsoever.

Dave, Consumer, Detox.

Clinicians also use the language of the 12-step philosophy to describe their experiences and views. The use of this particular discourse occurs irrespective of the treatment philosophy at the clinicians' place of employment. Phrases such as 'co-dependent relationships', 'addiction to meetings' and 'only one needle away from a junkie' are phrases that are commonly used.

The term 'dosing,' which is used to describe the dispensing of methadone, is commonly used, and can be seen to depersonalise consumers. The term 'dose' is frequently applied to treating animals rather than people. The use of this term further categorises consumers into a distinct category (dividing practices¹) and by doing so, reinforces the dominance of the clinician and the power held. Although methadone maintenance programs support a harm reduction philosophy, many clinicians there are still influenced by the 12-step framework which encourages a power differential between

¹ A Foucauldian term which is used to describe the way people are categorised into distinct groupings and is one way which leads to people becoming subjects. This is explained in detail in chapter three.

consumers and themselves. The dominance is further perpetuated through the use of jargon, which becomes part of the dominant discourse as illustrated by the following example:

I mean that's the other thing, you know, you're supposed to have one urine before a takeaway [a dose given to the consumer for consumption the following day] but what's the point of telling someone, well we've got to do a urine before you get dosed, if you'd rather say to them, what's happening, are you planning to score? and they are much more likely to do an extra urine and get a clean one [uncontaminated by using non-prescribed drugs] in.

Jean, RN, Methadone.

Consumers also take on board the message that they are powerless and unable to control their drinking or drug use. To counteract this, they need to be guided by and comply with the 12-step doctrine. Consumers use the discourse of the 12-step program (praying to a higher power, hitting rock bottom) to explain their efforts to alter their AOD use:

Just praying to a higher power and a higher self. And just handing my life over and it gradually happened. Now a few months down the track, and I was feeling good and I didn't want to use any drugs any more. But you know I still have days where I want to use, but I know I don't have to use.

Scott, consumer, 12 step Rehab.

With increasing attention being given to the relationship between AOD use and its harmful consequences through reported research and other means, there is a slow move towards supporting harm reduction strategies in treatment (Laslett and Rumbold 1998). Clinicians may initiate change in AOD treatment in an attempt to address consumers' needs. Regardless of discussing the benefits of harm reduction, they may be unaware of the influence of the 12-step model on their clinical practice. They unwittingly

perpetuate the philosophy in the discourse that they use, such as ‘one drink equals one drunk,’ ‘hitting rock bottom’ or ‘alcoholic thinking’:

I’m an alcoholic, coming up to seven years sober now. I was drunk every day for 26 years and then I finally hit rock bottom.

Ron, ‘recovering’ counsellor, Detox.

The use of the term empowerment has been integrated into AOD discourse and clinicians use the word freely when discussing the treatment philosophy and program implementation. The concept of empowerment as a goal or outcome, forms part of a political move in industrialised countries aimed at encouraging consumers to take more responsibility for their health. Hence, as a concept it is written into mission statements and clinicians are familiar with the term. Consumers, on the other hand, do not consciously think about empowerment. Many are unaware of its meaning and unless it is brought to their attention, they may not be aware of how it can apply to them. For example:

Coming to detox is, I think, the last ditch attempt for a lot of people when they think they are at the bottom of the line. When people put themselves into detox they really want to get well and, in the first stage, you’re not really thinking about empowerment. They’ve got a lot of words in their head but they just want to get well.

Johnny, consumer, CBT Rehab.

But I had to have someone show me, too, point it out to me, cos I was forty when I got clean, and I’d been running amok for a lot of years. I was really tired by the time I crawled in the door and I had to be shown. I had to have it shown to me that everything I had done had been myself. I put it in a sense to my counsellor at the time at the rehab I was in, she just said, ‘well darling, I didn’t drag you in the front door’. Oh that’s right you didn’t. That’s as simple as it was, and from then on that was,

where my empowerment and my choices came and that I could keep on making them.

Jenny, 12 step Rehab (Recovering person/AOD counsellor).

However, although the term is used, empowerment plays little part in institutional practices and philosophy. While clinicians may be familiar with the concept, consumers are not. Clinicians who discussed consumer-clinician collaboration may be aware of the power imbalances that occur between them. Individual clinicians may work in a collaborative way with consumers, but there is a paucity of data to support the notion that this actually occurs as a central tenet of AOD practice. The concept of empowerment may in fact be masking the notion of compliance. This position is explored in chapter six, which presents clinicians', perspectives.

One discourse that was identified as prominent in AOD treatment is that to be one (a counsellor), you have had to have been one (an AOD user). This belief is the cause of many debates and the subject of much research in AOD treatment (Miller 1985; West and Power 1995; Marcus 1998; Bacchus, Marsden et al. 1999). Consumers feel that a recovering person will make a better counsellor than a nurse will. Nurses are viewed by consumers as 'textbook' counsellors. Consumers divide counsellors into two distinct groups – ex-addicts or never-been-addicts. Clinicians who come from a professional background (nurses, psychologists) are categorised into the latter group:

They're both here to help me so I don't differentiate between either nurses or drug and alcohol counsellors. One thing I do think is the drug and alcohol counsellor, most of them are recovering alcoholics or addicts themselves, and I can talk to them probably more easily than I can to a nurse who's more or less a textbook counsellor. The people who haven't recovered just read from books and they don't really know how you feel when it comes down to certain things. It's hard to explain, they tell you

things you already know, where as a recovering addict who's a counsellor or something, he's been there and he can sorta [sic] understand where you're coming from and he won't sorta [sic] jump down your throat so much. Maybe it's psychological with me but I feel that they would understand me better than a nurse, who's only learnt through textbooks.

Mick, consumer, Detox.

Well the way I look at it, I'd pay less attention to a trained nurse than what I would to a counsellor that's lived my life. They've been there, done it, and got out of it, so they've got more of an idea of what I'm going through. I suppose that's probably a pretty stupid way of looking at it, but the way I see it, the nurses only lived it through a textbook. Whereas they've [AOD counsellors] actually gone out and lived it on the street, and all that sort of stuff like I've had. A normal everyday counsellor would probably get through to me a lot easier than what a nurse would.

Andrew, consumer, Detox.

Consumers also assume that all AOD counsellors are recovering people and, consequently, better able to understand them and then to explain their perspective. They, like clinicians, also tend to use jargon, or discourse, specific to the abstinence philosophy. This serves to maintain the dominant discourse and reinforces the 'rightness' of this approach:

Unless they've recovered, they've walked the walk and talked their talk, the rest of it's bullshit. What you get out of a book is not life, you can read all you like, but you can't really know until you've been down, got better, and then turned around and then started to perhaps even work in that field yourself because you know how much help, how much care is going to be needed, how much frustration is coming from the people such as myself, how much *anger* here, [points to heart] erratic emotions, you can't get knowledge from a book. Not the real guts of the matter.

Dave, consumer, Detox.

In reality, only three out of the fourteen AOD counsellors interviewed, identified themselves as 'recovering'. It would seem that consumers make this assumption, but do not ask questions to ascertain its truth. It is not known if counsellors reinforce or deny this assumption. When one AOD counsellor was asked about this aspect she explained that consumers like to think that the staff are recovering counsellors, but they were not encouraged by management to discuss this issue with consumers, and if questioned, were to rationalise their position. Counsellors may unwittingly or even consciously encourage and perpetuate this perception and thereby reinforce the view that to be one, you had to have been one:

I think the clients like to think there is. I don't think so. They don't have to stick their hand in the fire to know that it's going to hurt, and I think it depends on the quality of care that you give them.

Joanne, AOD counsellor, 12-step Rehab.

Most things are thought to have the potential to be addictive, and although clinicians implement programs to benefit the consumer, they also unconsciously continue to reinforce the concept of the addictive personality. They discuss every day activities in terms of positive versus negative addictions, thereby perpetuating the belief that consumers will become addicted to whatever they do or take, a point highlighted in the following script:

There are workshops here they have on relapse prevention. Because when clients leave and they just go home or go back to their same environment or same group of friends or whatever, it's gonna be difficult to say no to them, and so you try and encourage them to do maybe other things like positive addictions like jogging or sport.

Paula, AOD counsellor, Detox.

Although consumers generally preferred recovering counsellors and used phrases which support the 12-step philosophy to explain their preferences, sometimes they experience doubts that the counsellor can easily revert to his/her previous AOD using behaviour. These phrases reflect assumptions that if individuals ever use AOD, they must again classify themselves as ‘alcoholics’ or ‘addicts’ rather than ‘recovering alcoholics’ or ‘recovering addicts’. The use of these terms supports the belief that the ‘affected’ individual has an addictive personality and, hence, can never use any substance again in any situation:

The difference between someone who is a recovering addict who’s a counsellor, they’ve been there, they understand better I find. But then again, on the other hand, I’ve got this thing about ‘oh he is, he was a junkie’ or ‘he was an alcoholic’. He may pick up tomorrow, he or she might’.

Hamish, consumer, CBT.

Clinicians use professional jargon (therapeutic alliance) to explain their perceptions and experiences in AOD treatment. While jargon has the advantage of offering clinicians a mutual language, it, in effect, does highlight the differences between them and the consumer, as consumers do not have access to the specialised language, and serves to preserve the power that clinicians hold:

When I work with a client I tend to be quite similar to how I am normally and I find that works incredibly well because the skills allow therapeutic alliance that I think are paramount.

Kim, psychologist, AOD Outpatients.

The words used by consumers when discussing skills and attributes further perpetuate the dominant philosophy. As discussed earlier, the dominant discourse in AOD treatment supports the belief that to be an effective AOD counsellor, you need to have

been there and have ‘walked the talk’. Clinicians wittingly or unwittingly support and perpetuate this discourse.

Service Provision

The data suggest that although some consumers may enter treatment reluctantly and may not consider that they are out of control, the aim of AOD treatment is for the consumer to regain control over the use of AOD. This aim is bolstered by institutional practices, specific treatment philosophy, norms and mores of acceptable substance use held by AOD clinicians (and by the wider public), and by the language (discourse) of AOD treatment. The 12-step philosophy reinforces the belief that individuals are powerless over their AOD use and the only way control can be gained is by permanent abstinence. The legal system overlaps the health system and compounds and strengthens this belief that the consumer is out of control and needs to gain control. Rewards and punishments are implemented to ensure compliance. Added to this is the perspective that only when the person hits ‘rock bottom’ and cannot sink any further can that person be perceived as ready to attempt to gain control.

Individuals may not want to change their AOD use for a variety of reasons, but institutional practices are geared to ensure that the individual behaves in ways that are acceptable to the wider population. The mandate of institutions entwines and the philosophy and practice of one institution can impact on, and reinforce, the philosophy of another. While clinicians may perceive AOD treatment as a health issue, the purchase and supply of drugs come under the sphere of the criminal justice system and Customs and Excise, both of which are concerned with maintaining law and order and ultimately, regaining control. This, in turn, impacts on the way AOD treatment is

perceived and viewed by the wider population as well as clinicians. If individuals are willing to admit that they are out of control and need help, the criminal justice system will show leniency if they agree to enter AOD treatment. A reduced gaol sentence or even no gaol sentence is the incentive offered. They may not want to change their behaviour or be prepared to put in the work necessary to attempt change, but undertaking AOD treatment is perceived to be a better option than incarceration. If consumers are coerced into seeking treatment, it may be that they are left believing that self-control can be learned by control imposed on them from external sources; a dichotomy in itself:

...I'm not sure he [referring to a specific consumer] would actually say 'I want control'. He is not owning, not identifying. He still wants to hand it over for us to try and fix it for him, as opposed to him doing it.

Maree, RN, AOD Outpatients.

The ultimate aim of clinicians is to encourage and assist consumers to initiate and maintain change in their AOD use. Institutional practices are geared towards ensuring that this occurs. Consumers are encouraged to become compliant and accept and follow institutional rules and practices in order to make the changes that clinicians see as necessary for them.

Institutional processes influence service provision and play a large part in the disempowerment of consumers. In particular, the 12-step philosophy is disempowering because of its tendency to homogenise consumers and its rigidity in promoting abstinence from all types of potentially addictive substances. This can disadvantage consumers who want to substitute methadone, which is prescribed medically and consumed orally, for heroin, which is obtained illegally and injected intravenously. In addition, not all consumers want to abstain from all drugs. For example, a consumer

may want to abstain from using illegal drugs, but may want to consume alcohol socially. One exception though, is tobacco. Paradoxically, AA/NA does not actively discourage the use of this substance, yet the 12-step philosophy is underpinned by the belief that the person must be completely drug free, and is opposed to the harm reduction model. When methadone services were originally established there was a lot of opposition from those who subscribed to the abstinence philosophy. This philosophy can create problems for consumers who want to substitute methadone for heroin, as well as for clinicians when establishing services:

Well, it was hard because at the time the drug and alcohol service in that area was very AA oriented and they totally disagreed with methadone. They wouldn't give us any assistance.

Kaye, RN, Methadone.

One consequence of this abstinence philosophy was that the 'dosing' of consumers (dispensing of methadone) was rigidly controlled, consumers not being given any options or choices; they had to abide by the rules or go back to using heroin. The disempowering aspect of the philosophy of abstinence is further reflected in the rules imposed on consumers, such as not allowing those in detox to have coffee or making them go to bed at set times throughout the day and at night:

You've got more rights in jail than you've got in here. At least in jail you can go and make a cuppa when you want, they supply all the stuff for you to go and do it. They don't even let you drink coffee here. How ridiculous. Because there's caffeine in it. There's just as much caffeine in coffee as there is in tea. Like some of their ways of doing things really make me wonder like what are they actually trying to do.

Andrew, consumer, Detox.

Clinicians think that the 12-step approach disempowers consumers because it encourages a power imbalance between consumers and clinicians. This is particularly evident in therapeutic communities where consumers may reside for extended periods of time. The daily program is governed by often seemingly rigid rules, imposed by clinicians as a means of creating some sense of structure in the consumer's life. If consumers do not obey clinicians and do as instructed they will not be allowed to re-enter again for a set period of time:

Another time I think a client can feel disempowered ... is people living in therapeutic communities that have a disease model, and are told, 'you should do it this way', 'I know how to speak to you', 'I know how you should get better', 'you don't [get better] therefore you're wrong', 'I have all the power and you don't'. And in that sense that can be a real problem.

Ruth, psychologist, Outpatients.

Clinicians acknowledge that although the 12-step program offers some positive aspects for consumers, it is not the only way. They feel that it fails to address some of the deeper issues, such as lack of self-esteem, and the development of specific strategies for dealing with difficult times. In this respect it is seen as limiting and restrictive. They acknowledge that while it might be useful for some consumers, it certainly does not address the needs of all consumers. There needed to be other options available for them.

In addition, clinicians also feel that because of the dominance of the 12-step philosophy consumers are not necessarily aware of other programs. This lack of information inhibits their choices and further adds to disempowerment. For example:

Yeah, the twelve steps are good but I think you need more than that and that's why I don't think it's good to have a narrow view, and just think that AA's the only way, or NA. Because there's so much more that needs to be addressed. There's self esteem issues and I keep harping on about that, but

it just seems to be the big thing you know, and like problem solving skills and learning conflict resolution and co-dependency and all that kind of stuff. There's heaps of different things besides just the twelve steps and that they've got a choice.

Wendy, RN, Detox.

Consumers' responses support this lack of knowledge about available services and options. Only one consumer in this study talked of telephoning various places to ascertain their treatment philosophy. Most relied on the advice of their AOD counsellor or on bed availability and they do not appear to realise that they have choices.

All the consumers interviewed were currently in facilities, or had previously attempted treatment in facilities, that used the 12-step approach, and while they spoke about some of the limiting aspects of the rules and program, no one spoke directly about any positive impact of the AA or NA philosophy on their treatment progress and determination. Consumers who were resident in the treatment facility which used CBT had previously undergone treatment in centres which subscribe to a 12-step abstinence model and this was their first attempt at trying a different way. When interviewed they voiced how they find aspects of the 12-step program limiting, punitive and rigid compared to the program that they are currently undertaking:

It was amazing. The program here's taught me something different, cognitive behaviour therapy. I'd say it's a total contradiction to any sort of recovery that I'd ever come across in my many attempts and at respective times...But this thing, it takes a whole different approach because it looks at all areas of addiction. Although the twelve steps have improved, it's still sort of black and white attitudes [but] there is that sort of community back up. What this program has done is given me a different outlook on the twelve steps, I see it in a different way. Like example, right now it's obvious to me the first step [of AA] is a cop out. Now in the old days, the

emphasis was on total abstinence at all costs. If you slipped or relapsed it was very bad. Bad is the only word I can think of.

James, consumer, CBT Rehab.

Women also feel disempowered by the treatment provided for them. Although most treatment centres cater for women as well as men, there are fewer women than men entering treatment. Most treatment services simply admit women without making any specific changes to the treatment program. Very few services offer childcare facilities or allow children to remain with their mothers while they undertake treatment. This can deter women from entering treatment, and for those that do, there are a lot of arrangements that need to be made to ensure that their children are looked after. This places an extra burden on women consumers as they are concerned about their children's well being. If there are any problems with the childcare arrangements, then often the woman consumer will cease her AOD treatment to return home to care for the family. Furthermore, if she is not compliant and does not succeed in altering her AOD use, she has the added threat of having her children removed from her care:

Apparently Tom [son] had a fight with the people in the house last Saturday night and he stormed out the house. He's ten years of age. The police picked him up; they took him back to the house. They [the people staying in the house] said they didn't want him there. The police took him to DoCS [Department of Community Services]. The police rang here and DoCS rang here to notify me of what had happened. My first instant reaction was I've got to get out of here, I've got to go and get this sorted out. Never had any dealing with DOCS but from what I've heard, they take your children away, you'll never get your children back. Panic attack! He went into foster care... That's what we need. Somewhere our children can go to be looked after... They say that they're there to keep families together, but I've seen what DOCS done to other people, but maybe that depends on me and my recovery and how I stay clean

Jan, consumer, 12 step Rehab.

Men also feel disempowered by the rules imposed by AOD services, such as when to go to bed and when to get up, which are seen as rigid and restrictive. The imposition of such rules reflects a treatment philosophy which believes that consumers need to have order and structure in their daily lives in order to develop routines, which will assist them in breaking their desire for AOD. The imposition of the rules also reflects the power differential between clinicians and consumers. Consumers are viewed as needing to be told what to do and not capable of thinking for themselves, which in turn reinforces the belief that the clinician knows what is best. For example:

Well I'm forty years old and being told to go to bed at eleven o'clock on the dot and you get up at six o'clock on the dot, and you're showered by seven o'clock and it sort of makes you feel a bit like a sheep at times. I know it's not a holiday resort, I know those rules have to be there but it makes me feel like a child again.

Mike, consumer, Detox.

Although people being forced to change their lifestyle and behaviour might be seen to have negative connotations, this is not always the case. Sometimes the forced circumstances are the catalyst for change to occur. Consumers may think about making changes and even put strategies in place, but for a myriad of reasons may not achieve their goal. When consumers are directed to undertake AOD treatment, this may provide an opportune moment for them to take advantage of the enforced treatment and initiate change. This change may occur in attitude to treatment, attitude to the service or may simply be 'the right time and place':

At the beginning of the year I detoxed myself and my girlfriend, who's now my ex-girlfriend, and I came back in to Sydney. I started using again with her and everything fell to bits ... I was going to rehab, one last shot, and I did some crime to get the money for that and ended up being locked up in

jail. And that's how I detoxed and then I got out of there and got sent to rehab. So it sort of forced me to. Even though I did want to stop anyway the legal pressures helped with that.

Cameron, consumer, CBT Rehab.

Well I was actually bailed to here, I went to court from jail in January of this year and before I came here, I rang up here and got assessed as suitable for the program and then it was up to the actual courts to let me come here and they just said okay we'll give you a go. When I first come here, I come here four weeks to do the program, and then go back to what I was doing before but something changed along the way.

Peter, consumer, 12 step Rehab.

In methadone maintenance programs, as in other areas of AOD treatment, alterations have been made to the way the treatment is delivered. These changes are reflective of the gradual shift away from the 12-step philosophy. A harm reduction philosophy does not dictate any 'one right way' and as such is more flexible and sympathetic to individuals needs:

In retrospect what we did was really dreadful, but that was what we did at the time, and I guess what we have done over the last few years is empower the clients bit by bit. We've actually given more and more of the decisions regarding their treatment over to them. The difference is noticeable. Very rarely do we get attacked by a client and we can measure it by the number of Christmas cards we get.

Jean, RN, methadone.

However, within the wider practice of AOD treatment, harm reduction is slow to gain acceptance and the 12-step philosophy remains foremost. Although it is a stated aim in harm reduction, the concept of empowerment does not appear to have a large role in any institutional practice. There is no evidence to suggest that even if harm reduction becomes dominant it will result in more empowerment. Consumer empowerment and

collaborative practices are not always obvious in routine activities, and programs, which subscribe to the abstinence philosophy, will often remain unchanged. This reinforces the perception of the rigidity of the 12-step approach.

The concept of consumer empowerment is not fully accepted or implemented by AOD clinicians. Institutional philosophy, discourse and treatment result in the absence of practices which encourage its implementation and may, in fact, actively discourage it. One nurse who spoke of supporting consumer empowerment did not support empowerment for her nursing colleagues, because she perceived a conflict between caring and empowerment. For her, if nurses were empowered then they would not be able to 'care' adequately for consumers:

I would have concerns that if the empowerment of nurses means that they move away from caring for the very people that they came into the profession for in the first place...

Barbara, RN, AOD outpatients.

Ten clinicians (32 per cent of all clinicians) expressed the view that not everyone is capable of becoming 'empowered'. Some individuals are seen as not being able to manage independently and be 'empowered' because they do not know how to strike a balance between powerlessness and power. In addition, it was expressed that only a select few of the general population are capable of managing the balance. This serves to perpetuate the quantitative notion of power; that those with power have the right to act for those who do not (Rorty 1992; Wartenberg 1992; Wolfe 1990).

This perspective has parallels with the underlying belief of the 12-step program, where it is held that some people (alcoholics and addicts) are unable to limit their own

drinking and/or drug use and the only answer is for them to resist temptation and remain abstinent. They are perceived as incapable of managing power:

Well there can be some drawbacks. I would think that you can have too much empowerment in someone with too little experience in a subject. And it can tend to run to people's heads. What I'm trying to say is that before you empower somebody to do something, you've got to consider where their abilities are, or how far their abilities can take them.

Ralph, consumer, Detox.

Another factor that can inhibit empowerment is that consumers in residential treatment facilities are cushioned from everyday life where alcohol (and other drugs) play an everyday part. Removal from usual day to day activities can add to their disempowerment, particularly if they are in residential abstinence based treatment programs such as therapeutic communities, or residential detoxification centres.

Removal can create a false sense of security, confidence, and shelter from stress for consumers; however, when they leave the treatment facility and are faced with their daily routines they may, within a very short time, return to their previous levels of AOD use. Residential units are predominantly abstinence based. Eight clinicians (25 per cent of all clinicians) believe that long-term residential treatment is detrimental to the consumer and they voice support for ongoing treatment and counselling on an outpatient basis. This enables the consumer to learn to cope with the everyday stresses while undergoing AOD treatment:

I guess sometimes you can be a little overconfident in yourself. It's certainly something you see a lot of in people coming out of rehabs or detox is that they have a sense of invincibility. That often falls over because there's something they haven't paid attention to or it's often easier to walk out of an environment where you haven't had to worry about the phone bill, the landlord, the pets, the partner, the dog, the unemployment, those sorts of things. You have dealt with them in a

sense in a theoretical sort of way or in a therapeutic exploration and then the practicality of meshing what I know with what my life is like is sometimes too difficult.

Dennis, psychologist, OP.

They might go out and it might hit them all of a sudden and they're sort of, they're on a crest and they're stumped. I think that that probably happens a lot, but I don't see that as a negative aspect of empowerment, I think that that's a negative aspect of detox.

Tim, AOD counsellor, Detox.

Five consumers (19 per cent of all consumers) also feel sheltered and protected in residential treatment. They are anxious about leaving the residential treatment facility to return home without relying on AOD to help them cope with stressful situations. This was a new experience and they often feel ill prepared for it:

Trying to take control of things where you don't have the expertise to do so. Trying to take control of your life, when you've never been able to do so. Bloody scary, I'm shitting myself. So to be given the reins to run your own race, because you don't have that fall back, the cushion. When you fall off you hurt hard, there's nothing to stop the fall, so you're sort of missing a bit of back up.

Dave, consumer, Detox.

Although the concept of empowerment has entered the philosophical ethos of service provision, its implementation is not without difficulties. There are tensions between the empowerment of health professionals and consumer empowerment which may be antithetical as it can create difficulties for clinicians if and when consumers do become empowered. Consequently, institutional processes and practices can work against consumer empowerment.

Conclusion

Institutional philosophy, discourse and service provision all impact on the way power, control and empowerment are viewed, dealt with and reinforced in AOD treatment. In particular, the rationale of the 12-step abstinence program of AA or NA, which is still dominant in AOD treatment in Australia, is singled out by both clinicians and consumers as actually working against consumer empowerment. The ethos is perpetuated through jargon such as 'hitting rock bottom', 'walk the talk', and 'only one drink away from an alcoholic'. Although the 12-step philosophy is seen by many as being rigid, advocating a power differential between clinicians and consumers, and disempowering to women, its dominance continues.

The data show that the belief that AOD consumers are out of control is supported by the 12-step philosophy. In addition, the notion that control can be learned externally is first enforced by the routine activities of the health system and then reinforced by the criminal justice system, with added input from religious organisations such as the Salvation Army and the Catholic Church. One institution can impact on another. The legal system is actively and routinely involved with the health system; some consumers being directed to undergo treatment, thus reinforcing the perspective that the individual is out of control and needs to gain control. This raises the question of whether self-control can be imposed.

The 12-step philosophy reinforces the belief that individuals are powerless over their use of alcohol or other drugs and, therefore must remain abstinent to regain control. Individuals are expected to permit a 'higher being' take control of their lives as they have demonstrated that they are incapable of controlling themselves.

AOD treatment is concerned with encouraging and assisting consumers to change their AOD use. When consumers accept that they need to change, clinicians use a variety of incentives and disincentives to assist them. Institutional practices reinforce the need to change and consumers quickly learn that if they comply and follow the rules, they have a chance of becoming empowered as defined by clinicians, though they have never heard of empowerment. Thus the position of power and control held by the clinician is perpetuated.

A harm reduction approach to AOD treatment is becoming more popular, but its general acceptance by many groups is slow. This is in part due to the dominance of the 12-step approach. Clinicians and consumers who support the harm reduction model also unwittingly promote the dominant 12-step approach by the language they use to describe AOD treatment, that is, they reinforce the dominant discourse of the 12-step program.

In practice, the 12-step philosophy does not encourage the concept of empowerment although a harm reduction model potentially does. Clinicians feel that residential services which subscribe to a 12-step philosophy actually disempower consumers by protecting them from the day to day realities. Treatment facilities may support the notion of empowerment by writing it in their mission statements. Clinicians may articulate this perspective. However, practising in a manner that promotes consumer empowerment does not occur readily because of opposing and paradoxical situations.

Finally, this chapter has shown that institutional philosophy, practices and discourse impact on the way power, control and empowerment are viewed by clinicians and consumers in AOD treatment. In the next chapter, power, control and empowerment is explored from the perspective of clinicians.

CHAPTER SIX

CLINICIANS

Introduction

This chapter is about control and about how control is implemented and maintained in AOD treatment. It will be explained how empowerment is synonymous with compliance, how AOD clinicians have control and how they use a variety of mechanisms to maintain their control. Having self-control and being able to control individual AOD use are consistent with the clinicians' definition of consumer empowerment and, for consumers to gain self-control, they must become compliant with what the AOD clinician stipulates. The notion of change is paramount if clinicians are to achieve their goals. Consequently, clinicians implement strategies to assist consumers accept responsibility for their AOD use and to change their behaviour. These strategies are both overt and covert and, while they may be directed toward the stated aim of changing the individual's response to AOD they, in fact, encourage the consumer to conform and comply with the treatment regime. This reinforces the power and control that clinicians have.

If consumers do not want 'empowerment' as described by clinicians, rather than reflecting on the treatment program, clinicians place the blame of failure on the consumer, family or friends by suggesting that they deliberately sabotage the consumer's empowerment. Systematic rewards and punishment are implemented by

clinicians to encourage compliance. If consumers do challenge the clinician's authority, they are punished by being labelled negatively.

In spite of having control in AOD treatment, clinicians feel disempowered by health professionals from other disciplines and by those employed by other health services. This leads to self-doubt because their specific skills are not recognised by others. They say that they need to be empowered themselves before they can empower others.

This chapter is structured under subheadings around linked commonalities that have emerged through the process of data analysis. These categories have been named *Change, Control, Empowerment, Empowering others, Being disempowered* and *Working against empowerment*.

Change

AOD treatment is concerned with change. The emphasis is for clinicians to find ways to encourage consumers to change their AOD use. Clinicians speak about change from several perspectives. They discuss how they implement change in their own lives and the reasons for their desire to change. They also discuss the changes that they have made in the clinical area in response to an increased emphasis on consumer collaboration in an attempt to improve treatment. In addition, they discuss the notion that the consumer must take responsibility for making changes and explain the strategies that they use to facilitate acceptance of that responsibility. If consumers are compliant and accept the clinician's advice, the clinician is viewed as successful, but if consumers challenge the clinician, the consumer is perceived as not ready nor able to implement change.

Changes in the clinical area

Although clinicians spoke about the changes they had made in their clinical practice and programs to improve consumer treatment, they were aware that change did not happen overnight and that the process is important. How it is implemented is crucial to its success. Three clinicians (10 per cent of all clinicians) who were employed in either AOD outpatients or CBT rehabilitation thought that change should be a collaborative process rather than an imposed regime. Hence, they adhered to the broad principles of participation and empowerment:

I'll just get back to what we were talking about before in terms of changing, giving people different responsibilities to go away and do some thinking about writing and coming back and discussing things. So with the aim of restructuring our time so we can actually give that area the time that it requires, and in some respects I'm doing that role, but we're not doing it properly yet, we're just sort of getting towards that.

Grant, psychologist, CBT Rehab.

Some changes were made in response to the changing nature of the consumer population. Three clinicians from detox (25% of clinicians from detox) discussed the increase in the number of consumers who were diagnosed with a dual diagnosis (co-existing mental illness and AOD problem):

When we first did the stats [statistics] we had four per cent dual diagnosis; the last time I did the stats, which was probably a year ago, it was 74 per cent.

Michelle, AOD counsellor, Detox.

The increase in the number of consumers diagnosed with dual diagnosis was attributed in part to AOD clinicians gaining more knowledge about mental illness and improving their assessment and referral skills.

Changes, such as education sessions implemented by a sexual health nurse in the program of one treatment facility, were thought to specifically advantage women, as the numbers of women using the service had increased. Two clinicians felt that this increase could be attributed to women consumers feeling comfortable with the program offered to them. They felt that this happened through 'word of mouth', as they had not promoted their service in any way:

I used to do the stats when I first came in and we very rarely got women and now, our percentage of women is up. It was only, it used to be only five or seven, up to ten per cent and now it's quite a lot more, which means that women do feel comfortable, and word of mouth out there is, gets out more than pamphlets do, so obviously we're doing something right with the women, that we're getting more and more of them come back.

Michelle, AOD counsellor, Detox.

Clinicians did not discuss the probability that the increase in women consumers using the service could also be related to an overall increase in AOD consumption by women, nor that it could possibly be due to a societal change in acceptance of women using AOD.

Four nurses (44 per cent of all nurses) were ambivalent about change. This was particularly evident in the methadone unit where it had previously been a condition that all consumers undertake routine urine screening and be observed by a clinician during the process. If consumers were unable to provide a urine sample, they would be refused methadone. This has since changed and consumers are now randomly screened. If they are unable to provide a urine sample, they are assessed and offered a full or partial dose

of methadone, depending on the clinical judgement made by the nurse. On the one hand, clinicians felt that the changes allowed more flexibility and that consumers found it easier to access the service. With it being more flexible, consumers are less likely to return to their previous use of AOD or more likely to inform the clinician if they have used, rather than simply ceasing treatment. On the other hand, clinicians felt an underlying resentment towards those consumers whom they thought took advantage of the changes and abused them. For example:

We had a girl come in yesterday, I was shocked, at 12.30, do you think I'm sorry, I was in bed, I was at a funeral, Will you still dose me? Three and a half-hours late! You can't really ignore her, she could carry on a coherent conversation and her pupils were not really dilated. I said I could give her a half dose. She was fine with that because she was aware of the consequences and I mean that would never have happened in the past, so it is a lot better, people are much more likely to report themselves.

Jean, RN, Methadone.

While some clinicians appeared ambivalent about change, other clinicians were reluctant or even antagonistic towards change. For some clinicians the idea of change was both frightening and challenging and they simply liked things the way they were. Two nurses singled out other nurses for complaining about being disadvantaged in the clinical area, yet not attempting to proactively seek opportunities for their own development. They suggested that these nurses needed to examine and reflect on their practice. Some nurses are viewed as being unwilling to do this:

I should think it's too frightening for a lot of them. A lot of nurses like to clock in, do their shift, go home and not have to make any change in their routine or changes in what they've done. Empowerment is accepting that you can do things wrong or, ' God, I did that five years ago, why did I ever do that', and realising we make mistakes and making sure that we learn from them. Get time to read literature, and not expecting to be empowered

in the traditional way, but really get education whatever. Nurses complain all the time that they get nothing educational; they've got to go and get it as well.

Jeanette, RN, Methadone.

Strategies used to implement change

Clinicians use a variety of strategies to assist consumers accept responsibility for changing their AOD use. Five clinicians (16 per cent of all clinicians, made up of nurses and psychologists) used psychological jargon to explain their strategies. The phrase 'therapeutic alliance' was used to describe the relationship between them and the consumer. The establishing of a relationship is complex and involves clinicians having confidence and awareness of themselves and using their personality as part of the therapeutic relationship (use of the self as a therapeutic tool). If consumers like and trust clinicians, and a therapeutic relationship emerges, then consumers are more open to changing their AOD behaviour:

It's also about confidentiality - how do you prevent that information from leaking, how to keep that unique relationship you have with that client. How you use humour with the client; if you use sarcasm with the client; so there is a number of situations, some clients may say that that person's process fits with mine, and that is what it's all about, therapeutic alliance and what their eventual goal is, you know, and whether or not those two meet means a therapeutic relationship.

Barbara, RN, OP.

Three other clinicians (10 per cent of clinicians) spoke of using particular words or phrases to assist consumers make changes. These clinicians describe their roles as facilitators rather than directors. As prescriptive words and phrases are viewed as detrimental to change, it was thought that by not using prescriptive words, consumers could see that their opinion was listened to by clinicians. These clinicians acknowledge

that consumers have the answers to their problems, and the role of the clinician is simply to guide:

Yes, probably by not using words like *I think* when talking to someone or, *you should do*, just not using such direct terms as that. Using broader terms, like saying, *other clients have found this helpful*, and just asking them what they need, what do you need? When were your better days? What did you find to do in those days? What made you not want to do that on that particular day? That sort of thing. For them to have the say.

Kaye, RN, Methadone.

Not all clinicians hold the view that consumers have the answers to their problems, and this will be discussed in **Control** later in this chapter. One of these three also spoke about needing to make decisions for consumers as they could not be trusted to make rational decisions for themselves. Again, this serves to illustrate the contradictory nature and complexity of AOD treatment and highlights the dissonance experienced by some clinicians.

Other clinicians emphasised the need to offer positive feedback to consumers and to make consumers feel good about themselves. They accepted that consumers had often made a difficult decision when they decided to seek treatment and although consumers might feel ashamed of their dependency on AOD, this could be manipulated into something positive. The transformation of a negative situation into a positive one was one specific strategy referred to by clinicians:

... We had a fella the other day who'd been here 30 something times and basically we give him a short detox just to sober up. He went out the last time and stayed sober for eight months, and he came back a couple of weeks ago and he was so depressed. 'You know, I've stuffed it' [failed], and I went for the wire and I said You stayed sober for eight months, *how did you do that* ... instead of just going on, oh why do you think you picked

up? Just to ask him how did you stay sober, and he told me and he'd done things that he hadn't before.

Paula, AOD counsellor, Detox.

Although manipulating or rephrasing consumer's experiences was spoken about as a positive strategy, it could also be used in a negative way by clinicians:

Fran, who you've spoken to, talks about validation all the time. It's one of her favourite words, and it's *amazing* what the difference it can make. It can almost manipulate people into feeling bad or good by providing it or taking it away.

Helen, RN Detox.

Clinicians sometimes '*bend the rule*' if they think it will benefit the consumer, particularly if the consumer is perceived as being compliant with the treatment regime and demonstrates a commitment to change. Clinicians think some rules are restrictive, inflexible and even detrimental to AOD consumers, although in many instances they still insist on them being obeyed. In some residential treatment facilities, consumers are not allowed any face-to-face contact with family or friends until they have been in the program for a specified length of time. Family and friends are vetted and any visits that might be allowed are closely monitored to ensure that no AODs are smuggled in.

Surveillance can be difficult for some consumers, particularly for parents with young families:

We bend with that, because we also consider the child. If parent or children are stressing severely about no contact, we will organise contact. Half an hour visit under the tree, privately with the family, because children do stress out, and they warp it in their little minds, and think it's a hospital, and therefore someone's really ill, and worry thing. It's easier for the family if we allow that, we bend the rule there.

Michelle, AOD counsellor, Detox.

Although clinicians might '*bend the rule*' because they think it might benefit the consumer, it might result in consequences not previously considered. Clinicians may change the rules without thinking through the consequences for other clinicians and/or consumers and they can end up with an unforeseen outcome. If the bending of rules does result in an unwanted or unanticipated result, clinicians may feel that they have been let down by those they have tried to help. This process then tends to perpetuate the belief that AOD consumers cannot be trusted:

I open up the boundaries and the rules of the place a little bit... Sometimes I can see that although you do something that you think is nice, you lose. The repercussions down the line don't always work, so I can see that there's a very fine balance between absolute law and order and being able to have grey areas.

Joanne, AOD counsellor, 12 step Rehab.

Control

Some of the data in this section appears to contradict data that were presented in the previous section, and exposes the complexities of AOD treatment. There is a discrepancy between what clinicians do and what they say, and the research highlights this. This section explores what it is like not to have control and the process used to assist consumers gain it.

Out of control

As discussed previously, the 12-step philosophy reinforces the belief that AOD consumers are out of control and are not capable of controlling their substance use. Consumers perpetuate this perspective by discussing how they feel they are controlled by the drug and, therefore, do not have control over their lives or the choices they can

make. Twenty-six clinicians (86 per cent) also believed AOD consumers were out of control:

To me empowerment implies a control over your life, control over your behaviour and so many of the people who come here don't have control over that or they do have, but they don't see that they have it. They have loss of control a lot of the time so therefore because of that they do feel quite helpless, usually hopeless and sometimes and consequently not very empowered at all.

Kim, psychologist, AOD outpatients.

Although these clinicians thought that, six of them (23 per cent of this group) also thought that AOD use can be interpreted as one way of controlling others, usually the consumer's family. This is yet another example of the paradoxical nature of AOD use. Control, in this instance, is not seen as healthy or positive. Domination can result in family violence where the perpetrator has superior physical strength and becomes aggressive or violent if challenged about the use of AOD. The perpetrator might spend the family income on AOD and control the family financially. Physical or financial dominance creates dependence and fear:

I think even through my drinking I was a controller. I always had to control everything around me, and so when I got sober and started to become empowered I had to hand over the control to other people instead of me trying to control everything.

Alan, AOD counsellor (recovering person), Detox.

The 12-step philosophy was also seen by 16 clinicians (53 per cent of all clinicians) as restrictive in the way it encouraged the notion of being powerless. However, in spite of this view it was also felt that consumers had a choice whether they wanted to have control or not and again it was seen as being up to individuals as to whether they wanted to accept responsibility for their own behaviour. This notion of choice links to

the moral perspective on AOD use as outlined in Chapter Two. Four of these clinicians, (25 per cent of this group), suggested that consumers could turn the powerlessness perspective around, and instead of being powerless they could actually choose to gain control over their AOD use, and possibly realise that they do have some power. These four clinicians analysed the merits of the 12-step program, and although they found it predominantly restrictive, they accommodated its dominance and found a way of using the philosophy as a positive strategy:

It's about giving them back control over their lives, because the first step in AA says their lives become unmanageable and their power over their addiction [has also become unmanageable]. I think they have to move on from that. I always say yes it's important to address that and acknowledge that, but you have to then move on because you don't start recovery until you move on from that. Actually, a lot of people think they don't have a choice, they think well I'm an alcoholic, I can't, I'm powerless over it, well yes, to a certain extent, because your life's become unmanageable but you have to make a choice, and you have to take the power back.

Wendy, RN, Detox.

Learning control

The process of learning control was also discussed by clinicians. Not everyone was seen as able to learn self control at an early age. Four clinicians (14 per cent of all clinicians) thought that some consumers came from families where they had not had the opportunity to learn control because of no role modelling in the family and because of family dynamics which were perceived as being non supportive and unhealthy. For example:

I think some people just come from such dysfunctional families that they've never ever thought for themselves and they just want people to tell them what to do and when to get up.

Alan, AOD counsellor, Detox.

Learning control was seen as a matter of trial and error. If consumers did not have the opportunity to practise control, they would never learn it. In addition, it was suggested that consumers needed to find a balance between a lack of control and too much control. Both alternatives were seen as negative and outside the norm. Control is monitored both internally by the individual (internal locus of control) and externally by systems (external locus of control) specifically established for the purpose of maintaining social order; such as law enforcement, community services and/or corrective services.

Although some consumers have not had the opportunity to learn or practise control, it was still generally expected by clinicians and by the wider population that they should exercise it. If they could not they were sanctioned by these external controls and punished (loss of privileges, monetary fines, incarceration). Even if consumers did not know how to exercise control, they internalised the message that they should have control. This can lead to consumers feeling guilty about their lack of control and perpetuates their belief that they are powerless and unworthy:

It takes practice to be able to interact appropriately and sometimes people go over the top. It's a learning curve of what's appropriate. A lot of clients feel it's something they should have, which they deserve, and they blame themselves for being weak, and not in control.

Pete, youth worker.

Responsibility for control

Not all consumers are perceived as wanting control. These consumers are viewed by clinicians as accepting 'the easy way' and wanting to be told what to do, rather than thinking for themselves. This tends to validate the 12-step philosophy which

encourages consumers to follow the doctrine, and discourages them from independent thought. In addition, if consumers do challenge or question clinicians, then they may find themselves treated in a negative way, thus presenting an interesting conundrum:

I suppose it depends on what addiction they're coming from. I think a lot of the clients that come from a disease model and AA people. Like they're taking control but I still think that a proportion of clients, who would still like to have the power, they like to go along [with] not having to make choices, 'just tell me what to do and I'll do it'. Sometimes it's just easier to be told 'this is how it is' and 'I don't need to know, let me just get on with it'.

Jeanette, RN, Methadone.

Clinicians use the psychological theory of secondary gains (Bandura 1982) to explain why some consumers do not want control. These consumers are viewed as being unhappy or unhealthy and are portrayed as 'victims'. Psychological theory suggests that these 'victims' actually obtain some power by remaining in the same situation, and as a result do not want to make changes. In the same way that consumers use AOD as a means of control, 'victims' often use their circumstances as a way of maintaining power:

Well some of them, I think they're the ones who are the challenges, love being victims, love the poor me, and it's never gonna work and all that kind of thing; and they don't want to know about what they can do, or they just sit there saying yeah, yeah, yeah and they don't want to go out and do it, cos they like being a victim and they probably would never admit to that.

Wendy, RN, Detox.

It is thought that at times consumers are unable to attempt control of their treatment plan because of their physical or emotional state. This was specifically highlighted at times during the detoxification process or if someone with a dual diagnosis was

experiencing a psychotic episode. Both situations (detoxification and psychosis) compromise consumer safety and it is the safety of consumers and clinicians that was viewed as a priority. Clinicians felt that it was more important at those times for *them* to take control for the consumer:

... you can give an example of a parent with a child, that sometimes you just have to take their empowerment out of their reach for their own welfare, so basically you take control.

Kaye, RN, Methadone clinic.

All clinicians discussed the notion of self-responsibility. They felt that consumers need to take responsibility for their behaviour and that they should make changes to alter that behaviour. Consumers need to be aware of what they can control and, what is outside their control. They need to accept responsibility for the bits they can control. Clinicians also discussed the notion that for consumers to realise and accept that they had control could be frightening at times. Five clinicians (17 per cent of clinicians, made up of 4 psychologists and one nurse) referred to internal and external 'locus of control', an idea based on language linked to Bandura's (1982) psychological theory, to explain their perspective when discussing the acceptance of responsibility. According to Bandura, consumers are more likely to change their behaviour if they have a strong internal locus of control (acceptance of self-responsibility):

I guess my initial response is about a strengthening, and about resources and about knowledge, and about taking responsibility and taking action where possible for the situation for yourself. It becomes more an internal thing than I see as an external thing. So it's about okay, I'm in situation X and what can *I* do about this? rather than letting external things take control.

Tanya, psychologist, OP.

Maintaining control

Although clinicians and AOD services have attempted to adapt to the changing treatment philosophy and verbalise support of consumer empowerment, control is still maintained by clinicians in a variety of ways which may leave consumers feeling that they are being treated like children, as explained in the following example:

The biggest complaint that we've had here in the past is that we treated the clients like children. We decided if they didn't face us to do a urine, they wouldn't get dosed. We don't do that any more but that was the biggest thing ...

Jean, RN, Methadone maintenance.

If consumers questioned or challenged the rules they were negatively labelled. This labelling of consumers can take a variety of guises. For example, in one of the treatment facilities the program was altered and became highly structured. Some consumers objected to the rigid structure and felt that they were being treated like children without any right of recourse. If consumers complained or challenged the new routine, one way that they were punished was by being labelled as 'damaged', but if they praised the program they were viewed as being 'not too damaged'. Either way, it serves to divide clinicians (undamaged) from consumers (all have varying degrees of damage):

Recidivists who have come back and said, 'yeah the programs changed a lot, we really like it', well some of them who aren't too damaged really like it, the ones who are more damaged find it very difficult to cope with and really threatening, you know.

Alan, AOD counsellor, Detox.

Clinicians may also categorise others into distinct, exclusive groupings. Consumers are categorised by AOD clinicians as addicts, drunks, good boys, sick, and children, which may add to them feeling unworthy and marginalised:

I find that sometimes here they'll say, 'he's a good boy' and I think the *boy* is a very revealing term, and sometimes the good boys will get rewarded for being good boys.

Glen, doctor, Methadone maintenance.

It is interesting to note that clinicians are able to identify dividing practices in other people, but rarely do they identify their own usage, or see that their attitudes may contribute to the process. Clinicians refer to the attitudes of their colleagues or other health professionals, thus:

... the nurses up there, and the doctors as well, they see us as nothing, they see our clients as just old drunks who can't do anything for themselves, it is their fault and all that sort of stuff.

Ron, AOD counsellor (recovering), Detox.

In addition, clinicians refer to attitudes they assume are held by the general public:

Often you go up [name of street] and you see quite a lot of young people and alcoholics and they're just wanting a few bob for food, and a lot of people absolutely hate them, they hate them so much they have to make a comment about it....

Kate, RN, Methadone maintenance.

Four clinicians (14 per cent of all clinicians) claimed that four other clinicians provoked and goaded consumers. This goading was carried out as friendly banter but with an underlying negative message evident in the sub-text. For example, consumers are encouraged to take responsibility for their own treatment progress, but if they challenge the clinician's decision, they are punished and labelled as uncooperative. Two of these four clinicians felt that this was deliberate and that certain other clinicians would deliberately set up a recalcitrant consumer to fail. If the consumer responded and became abusive or aggressive, then this reinforced the clinician's position of being in control:

There's a kind of 'what are you doing here', you know, 'are you playing up again' with a tone of total disapproval and putdown and then the client would rise to the bait, and they would say the client's uncooperative.

Glenn, doctor, methadone.

Empowerment

Clinicians were asked what empowerment meant to them. All were familiar with the term but each described it in his/her own way, which initially appears to indicate that there is no collective understanding or use of the term. However, when data are explored, it becomes evident that the rhetoric of consumer empowerment, as described by clinicians, is consistent with that of consumer compliance. This section is concerned with the process by which this happens. If the consumers comply and follow the instructions of clinicians they will be able to achieve what the clinicians refer to as empowerment.

Empowerment is somewhat paradoxical. Although it was discussed as being worthwhile and practices that foster it should be encouraged, there was also a cautionary note attached to it. In some instances its implementation was actively discouraged because it was perceived that some consumers are not capable of being empowered. In fact, what is really meant is that some consumers do not want to change their AOD use, and these consumers resist clinicians' attempts to make them conform or comply. Although empowerment was a main thrust of the interview questions, clinicians did not talk about the factors associated with *empowerment* as readily as they spoke about *disempowerment*.

Clinicians discussed the ways that they saw empowerment occurring and how they encouraged empowerment in the clinical arena. They discussed the notion of working together through consumer empowerment, partnership and encouragement. One way that they facilitate consumer empowerment is by articulating a personal philosophy and encouraging empathy. When consumers were empowered, clinicians perceived them as being confident and having choices in their lives. Clinicians recognise that individuals need to take responsibility for their own empowerment, and there are strategies that they use to ensure that consumers alter their AOD behaviour (become empowered). Consumers sometimes need to be shown that they are empowered. Again, in this instance, empowerment is really about altering AOD use. Although clinicians discuss empowerment as a two way process, paradoxically, their role is inextricably linked with maintaining control and coercing consumers into altering their behaviour unknowingly.

Empowerment was generally viewed as a process. Clinicians feel that unless they themselves are empowered they cannot empower others. If they are not empowered, consumers can manipulate them and ultimately, clinicians will lose control.

Having choices

Empowerment is associated with having choices, as well as understanding that there are laws, rules and policies that need to be adhered to which individuals must accept or reject. If individuals do not abide by them, the consequences are the imposition of sanctions. These laws, rules and policies apply to all spheres, including AOD treatment. Understanding this was one way that clinicians used to describe consumer empowerment:

How I see empowerment is very much tied up as a concept with internal/external locus of control and I believe that everybody has a choice,

but there are some things that are regulatory. There are some things that I'm going to have power over and there are things that I see as out of my control, and for me, empowerment means to be able to control myself and my reactions to things that I see as out of my control. So it's about a sense of how I react, how I respond, how I perceive and view the world.

Ruth, Psychologist, Outpatients.

Twenty-six clinicians (86 per cent of all clinicians) felt that knowledge and choice go together. By having knowledge then the individual is able to make an informed choice. Knowledge is seen as possessing educational opportunities, having qualifications, information, being able to access services and understanding personal rights. Having access to information is viewed as empowerment. For example:

For clients, I think empowerment is letting them have choices to make. In drugs and alcohol in pregnancy, I think, it's being able to be an advocate for a woman which will then empower her to make some choices about where she delivers, how she delivers, what drugs she can choose to use in pregnancy if she wishes to continue to use, and to give her information and say, well this is what's going to happen.

Jeanette, RN, Methadone.

However, it is clinicians who have access and control of knowledge in AOD treatment. Knowledge is only shared with consumers when they are willing to demonstrate compliance. These 26 clinicians argue that it is important that consumers *feel* that they have choices. Allowing people to *feel* that they have choices is more important than *actually* having choices:

It's about creating [an] opportunity for people to feel informed or powerful enough to have the option of making choices, not necessarily making choices, but actually feeling in the position of being able to make choices.

Dennis, Psychologist, Outpatients.

This documents another paradox and another way that clinicians maintain control and encourage consumer compliance.

Finding a balance

Seven clinicians (23 per cent of all clinicians) emphasised the importance of treading carefully when working with consumers. They perceived that there is a thin line between having power and misusing it. There is an acknowledgment of a power imbalance between them and the consumer. Clinicians present options to consumers while at the same time recognising that some consumers need more direction than others. Maintaining the balance was one-way clinicians explained empowerment.

These same clinicians also spoke of the importance of not using their power or position to intimidate or compromise others, particularly opposite sex consumers. However, one of these clinicians also expressed his concern about consumers having too much power and the detrimental effect that this had on the clinician, thus serving to illustrate the paradoxical nature of AOD treatment and the difficulty clinicians have in finding a balance:

I myself have a lot of power in this job, to have people do what I choose for them, but also at the same time, a lot of people need to have empowerment to say yes to what sort of programs they're gonna go into, their relationships and how they're gonna spend the rest of their life. If I don't have any power, I see a lot of my clients not taking any notice of me. It's got to be carefully used because if you misuse it, there's *trouble*, you know, for both parties and then the person loses, especially on gender issues.

Alan, AOD Counsellor, Detox.

Closely linked with the notion of finding a balance is the idea of equality.

Empowerment is defined by seven clinicians (24 per cent) as the consumer and

clinician working together, with the clinician accepting responsibility for the process. Both the consumer and clinician need to feel empowered. Empowerment is seen by these clinicians as a two-way process, a partnership. Paradoxically though, the clinician is the one designated to be in control of the consumer's empowerment, and yet clinicians discuss empowerment as being the consumers' responsibility. It seems that the *real* challenge for clinicians is how to implement strategies in a covert manner so that the consumers are unaware that they are being coerced into complying. For example:

To me empowerment means equity, or even equality. I think maybe more equality not equity. It's not about giving people something or relinquishing anything yourself, it's just about accepting and making sure that the environment is such that all people within it are equal. I think because obviously in a professional worker-consumer relationship there are differences in power. If you can achieve that environment where both feel equally empowered in the situation, then I think that's empowerment, especially for a client. You need to make them feel like you're not over them.

Tim, AOD Counsellor, Detox.

Whose responsibility?

All clinicians speak about self-responsibility when exploring the notion of empowerment and discuss empowerment as accepting responsibility for their own actions. They see empowerment as a personal choice and individuals can choose to be empowered or not. This perspective serves to reinforce the moral perspective of AOD use, where it is believed that individuals can simply choose whether to use AOD or not. Clinicians also describe empowerment as consumers learning to accept responsibility for their actions. The clinician's role is to help them learn that responsibility (comply). Empowerment from this perspective is giving consumers the skills for them to become empowered

(change their AOD use). Consumers need to accept responsibility for their decisions, and if others do not reward the decisions they make, then empowerment means that they accept responsibility for the consequences of those decisions:

Empowerment to me would be to try and teach the client that they do have the right, to try and get some self respect and trust in their own judgement, to make a decision but wear the consequences.

Kate, RN, Methadone.

Needing to be empowered before you can empower others

Twenty clinicians (66 per cent) spoke about the need to be empowered before they can attempt to empower others. By feeling empowered they have confidence in themselves and in their decisions. Without this confidence they find it difficult to empower others. Clinicians believe they need to be empowered in their personal life as well as in their clinical practice, as these two spheres overlap and are difficult to separate:

Everything is linked, they do link and that's a fact. I think if you're empowered at work, if the doors are opened, all those things in your own life and at home ... I know that they trigger each other.

Kaye, RN methadone.

Five clinicians (17 per cent) think that if they are not empowered, consumers can easily manipulate them. This is in contrast to the view of the clinicians who spoke of being aware of the power imbalance between consumer and clinician and how they need to be careful that they do not use their power in a way that is detrimental to the consumer (although some clinicians gave both messages). These clinicians discussed the consequences for themselves if they were not empowered:

I believe everyone needs to be empowered in order to just get through life because if you haven't got some sort of empowerment, people just walk all over you, treat you like utter crap and basically you get

nowhere. And also in this line of work it's necessary in order to function effectively as a team and even on your own with the other clients.

Amy, AOD counsellor, Detox.

If clinicians themselves feel disempowered, it is difficult to work in a way that empowers others. This is one explanation for the imposition of petty rules with which consumers are expected to comply. For example:

I think it's very difficult to handle and very subtle to handle because you don't want to empower a client in terms of their destructive behaviour, but you're trying to empower them to more therapeutic approaches, but I don't see that managed. I think, unfortunately, compliance with the rules is seen as the goal and I see that as quite often antagonistic to a patient's recovery.

Glenn, doctor, Methadone maintenance.

Needing to be shown

Twenty-four clinicians (80 per cent) assumed that consumers want to be empowered and twelve of them (50 per cent of these twenty-four) think that consumers do not necessarily know that they want empowerment. The possibility of empowerment is something new for consumers and clinicians see it as their responsibility to show consumers that they can become empowered:

Whether they realise it or not, I think deep down somewhere, it might be a very dull little flicker, but sure, everyone wants to be able to say yes and no and do what they choose.

Alan, AOD counsellor, Detox.

Clinicians also thought that many of the consumers needed to be shown that they were, in fact, empowered. Empowerment is something that many of the consumers are unaware of because for so long they have been disempowered due to their need for an addictive substance(s). Clinicians feel that by consumers deciding to undertake a

treatment regime, they desire empowerment. Reinforcing their decision is one way that clinicians can show consumers that they can have some degree of empowerment:

They haven't got any opiate on board now, so giving them the empowerment to work. They've actually done that by making the decision to detox off it. They've actually got empowerment, but you have to keep telling them you're doing it, you're okay, you've done it and you should be really pleased with yourself. So they've actually gained empowerment by making that decision of I've had enough of methadone, I'm not using, I can do it. That's probably their first biggest empowerment and then after that they ... once they've cut the cord. I think it just gives them empowerment to know that they don't have to have an opiate on board any more. And that's what they tell us too,

Kate, RN Methadone.

Empowering others

Clinicians were asked to identify skills and attributes that they thought necessary in order to work in a way that is perceived to be empowering of others. Twenty-three clinicians (74 per cent) thought that the ability to empower others comes from the person rather than from their professional training. The ability of nurses, and to a lesser degree AOD counsellors, to empower others was discussed by the participants. This was related to prompts from me as it was my interest in nurses and nursing that initially led me into this research journey, but when I began the interviews, it became apparent that not many nurses were employed in AOD treatment. I then prompted discussion about nurses, AOD counsellors and 'recovering' people. Fourteen clinicians (45 per cent) feel that there are no professional differences between nurses and other counsellors. What is important is the knowledge, skills, ability and desire to empower others.

Who can empower consumers?

Clinicians feel that nurses can empower consumers for a variety of reasons. These include their approachability, knowledge of the physical and psychological effects of withdrawing from AOD, knowledge of the change process and the use of an eclectic approach to treatment. All the nurses feel that they are in an ideal position to be able to empower consumers. Nurses are seen as accessible and more in touch with the concerns of consumers than those from other disciplines, such as medicine or psychology. The ranking of disciplines are listed hierarchically, with the doctor at the top, followed by psychologists, nurses and finally AOD counsellors:

Through giving them choices, they're seen as more, a nurse is more reachable than a doctor, in drug and alcohol circles, not as scary as a psychologist [and] seen by clients I think as a little bit higher up the professional scale than a worker in detox, I reckon.

Jeanette, RN methadone.

Nurses thought that nurses working in methadone maintenance could empower consumers because of their clinical experience. Nurses (apart from one doctor who works there on a part-time basis) who work autonomously staff the methadone unit:

Nursing staff in the clinic are the ones who are there all the time. Our medical doctor is only here for one day a week. We have over a hundred clients, so the bulk of the decision making is in conjunction with the nurses.

Jean, RN, methadone.

Nurses are seen to possess specialised knowledge about anatomy and physiology. In addition, nurses are viewed as having empathy, caring and knowledge about psychological and physiological aspects of people. AOD clinicians make a distinction between nurses working in AOD settings and in other settings. Nurses working in AOD

are considered much more available and caring than other nurses are. These perspectives are supported by other clinicians as well as by nurses themselves.

I find that the real medical health knowledge that nurses naturally have, more awareness of because of their training, they have to pass that knowledge to clients, 'this will be best for you', or 'This will be doing ABC'. I think that's an empowering thing so that clients can take that away and whether it's just using clean needles and things like that. They're [consumers] taking control over their behaviour.

Kim, psychologist, OP.

Clinicians generally thought that nurses can empower consumers because of their skills, training and knowledge. On the other hand, the question posed by some is that although they think that nurses can empower consumers, do they in fact attempt to do so? Four psychologists (67 per cent of psychologists) view nurses as being controlling because they subscribe to a medical model of treatment. Motivation or desire to empower others is seen as an important component and it is suggested that not all nurses possess these qualities. It is also suggested that before anyone could attempt to empower others an awareness of the issues involved in disempowerment and empowerment is needed:

There's no reason why they can't. Whether they do or not is a different kettle of fish. No, I believe, I know that some do, whether they're in a drug and alcohol setting or in a hospital setting, if they've got an awareness of the issues, and I think that's probably the key factor, if they're aware of that stuff, then there's no reason why not. It should be happening anyway.

Grant, psychologist, CBT Rehab.

For two nurses (22 per cent of all nurses) there was a difference between nurses trained in a hospital and those who are university educated. These nurses thought that hospital-trained nurses are more aware of consumer issues than university-educated nurses, who

were perceived to have learnt theoretically. Both of these nurses were hospital trained and one had undertaken further education. One nurse thought that some nurses concentrate on negative issues rather than reinforcing positive aspects of the consumer and considered this disempowering.

Twenty-two clinicians (73 per cent) felt that other AOD counsellors can also empower others. (AOD counsellors were referring to all other clinicians.) The training and professional background are seen as of secondary importance to the personal skills or attributes of the individual. As with nurses, they felt that AOD counsellors can empower others, but whether they wanted to, or whether they did was a separate issue:

I think there's two questions there. Having the capacity to do it and having the motivation. I guess experience gives different ways to approach it. Some would want to empower and that would impact on their clients. It makes people able to, I guess having had experience, this way they're able to become empowered themselves. I guess confidence really must have something to do with it, patience and appreciation of someone you know, the support you feel and feeling empowered right now.

Pete, AOD counsellor, OP.

Clinicians generally thought that with education and training, recovering AOD counsellors are able to empower consumers, although they think that clinicians from a professional background are more suitable. Without additional training though, AOD counsellors are seen as having limited experience and narrow in their outlook and treatment perspective. Clinicians acknowledge that consumers can identify more readily with recovering people and that this is an advantage that can be used:

As a general principle, yes. I pretty much totally agree with that. I guess for me the key word here is *can*, I've certainly seen clients whose previous encounters with drug and alcohol counsellors would suggest

they've been disenfranchised or disempowered by the work that's been done so I guess as a statement of potential is there, yes.

Dennis, psychologist, OP.

Characteristics, knowledge and skills to empower others

Twenty-nine clinicians (97 per cent) emphasised that the ability to empower others or to practise in an empowering way depends on certain characteristics and skills of the individual clinician. One such skill is that of therapeutic alliance. Therapeutic alliance is a psychological term used to explain the relationship between the clinician and consumer (Frank & Gunderson 1990). The clinician is seen as responsible for finding a way to enable the alliance to occur:

I think it is the individual's approach and whether or not your approach is unique and meshes with that of the clients ... and how do you present your information to overcome that block in preventing that information exchange and inquiry into treatment. You're really talking about personal experience as well ... and some clients may say that that person's process fits with mine, and that is what it's all about, therapeutic alliance and what their eventual goal is, and whether or not those two meet, means a therapeutic relationship.

Jenny, RN, OP.

Self-awareness is perceived as a cornerstone to both the therapeutic alliance and as an attribute necessary to possess. Clinicians need to be flexible and adaptable in their approach to consumers, offering encouragement and positive reinforcement. This is necessary for building consumers' self-confidence. Once consumers feel confident in themselves and in their clinician, other strengths will emerge and consumers will be better placed to deal with their AOD use. Other attributes are compassion, understanding, tolerance, non-judgmental behaviour, patience and realising that there are many solutions to a person's AOD issues. These characteristics are viewed as being

more important and having more influence than the clinician's professional background:

Not being judgmental of the people that you're working with. I think perhaps being patient is important, particularly if there have been behaviours that are fairly well entrenched. And the change is physical for the person and they're used to letting other people, other things take control of their lives with changes, perhaps going too slow, and you think it's about being aware of that and sort of making things happen or talking about things and thinking about small parts and doing it slowly. Patience and just being supportive and positively reinforcing anything, any changes that do occur.

Tanya, psychologist, OP.

Being disempowered

Clinicians experience disempowerment in a variety of ways, from differing sources and with differing intensity. They experience disempowerment when working in a multidisciplinary team with other health personnel and they can experience disempowerment in a hierarchical team where the manager belongs to a different discipline. This can affect individual centre managers as well as clinicians.

Disempowerment can also occur horizontally across disciplines and between disciplines. In addition, it can be accentuated by age, gender, disability and employment status. Added to the disempowerment that clinicians experience from within their own service, is the disempowerment they experience from other service providers, in particular, from mental health services. AOD clinicians feel very disempowered.

When clinicians are disempowered they experienced a variety of feelings. These include feelings of self-doubt, powerlessness, frustration and anger. Clinicians vary in the way they deal with these emotions; some make compromises, while others sabotage

the process or even become so depressed and debilitated that they take leave from work or offer their resignation.

Another consequence of disempowerment is the roll-on effect, leading to clinicians disempowering consumers. Clinicians are not aware of their own complicity in the process, but they are able to see how other clinicians actively disempower consumers. This disempowerment takes the form of breaking confidentiality, of talking about consumers in front of other consumers and clinicians, and of speaking to consumers in a hostile and aggressive way: This is illustrated further on in this chapter under the subheading *disempowering consumers*. One service manager appeared to condone this behaviour. If consumers challenged their treatment, the clinicians joined ranks against the consumer and apportioned blame for what was happening. This added to the power and control held by the clinician and acted to further disempower consumers.

Hierarchical disempowerment

Clinicians felt disempowered in their clinical role for a variety of reasons. Two managers (50 per cent of managers) spoke about the disempowerment they experience in this role. The managers of AOD services are, in fact, on the bottom tier of the management structure. Local AOD managers are answerable to the regional AOD manager who, in turn, is answerable to the Regional Area Health Service manager. AOD service managers feel sandwiched between the regional manager and the consumers and clinicians for whom they are responsible. Both of the managers surveyed felt disempowered by the hierarchical management structure, although they did not feel disempowered in their relationships with their own team members:

With all the hierarchical bureaucratic stuff that goes on in some services that limits and restricts you, and of course we're restricted by clients, and

that has had a lot to do with disempowerment because there's a lot of ideas that you get that you can't go through with. For example, until recently I couldn't even sign for a packet of biscuits, something as simple as that, you feel really as though you're not really worth very much. And if I feel that as a manager of a unit I don't know how the other nurses must feel.

Kaye, RN, Methadone.

Sometimes the clinicians' disempowerment was attributed directly to the manager of a particular service. Disempowerment, in such instances, is interpreted by some clinicians as deliberate, emanating from the manager and clinician having different professional backgrounds. In the example documented below, the clinician feels the disempowerment is deliberate, as he is the only male working in a treatment centre, and in addition, he has a medical background whereas all the other clinicians are nurses. He does not feel disempowered by other clinicians; however, he does feel disempowered by the manager who is female and a nurse. This example is somewhat of a paradox as it is usual for a doctor to be at the top of the 'pecking order'. The female nurses working in this unit do not discuss being disempowered by the manager:

I find it interesting because it's difficult because [name] tries to denigrate everybody in a sense, tries to have everyone on a lower level than herself, clients and staff. And I feel that quite strongly. But, with everybody else, there's no difficulties I think there's quite a mutual sort of, there's a lot of fun, a lot of sharing and there's a lot of understanding of the different roles.

Glenn, doctor, Methadone.

Colleagues

Although clinicians discussed their disempowerment by those in a more senior position, nine other clinicians (30 per cent of all clinicians) felt disempowered by their colleagues irrespective of their professional background. Nurses identify peer disempowerment more than other clinicians. Although peer disempowerment is

rationalised as needing to happen², the clinician is left feeling hurt and deflated by these incidents. There is a sense of nurses wanting all nurses to be the same and not encouraging individual success. This happens covertly as illustrated in the following example:

You might think you've done something *really* good, and made a good decision, and then it'll just be taken right out from under you, you'll just feel yuk. 'No, but didn't you realise this or that?' 'They're just pulling the wool over your eyes', 'You're too naïve'. So your empowerment is taken away completely. They take it all away from you very quickly which is probably a good thing as long as you're not too sensitive.

Kate, RN, Methadone.

Nurses

Three nurses felt disempowered as part of a multi-disciplinary team (44 per cent of all nurses, and 100 per cent of nurses who worked daily with a multidisciplinary team). All nurses who work in services other than methadone thought that their professional skills were not recognised or valued. In addition, they felt that they were treated as commodities because nurses working in a community setting receive higher salaries than AOD counsellors and some psychologists. As a consequence of this, nurses were less likely to be employed. These nurses feel their skills are not recognised by management, nor by other clinicians working in the service. In part, they rationalised that this was because they had been initially employed as AOD counsellors and, although they have now been re-employed as nurses, they still feel that their specific qualities are not recognised.

I have felt quite disempowered working here at times and I suppose that my role wasn't, and I suppose it's probably not always completely understood,

² Success can go to your head, or others know better than you do

but it wasn't understood and I was probably not utilised to the best of my abilities in terms of what I had to offer.

Maree, RN, Outpatients.

When nurses employed as AOD counsellors were given the opportunity to be reclassified as nurses, the change presented other difficulties. The detoxification unit originally functioned as a ³non-medicated detox, although two registered nurses were employed as AOD counsellors. When it was decided to make the unit a ⁴medicated detoxification unit, allowances were made for a nursing position eight hours per day, seven days per week. The manager of the service, who was a nurse, chose to work five of those seven days. The other nurse then had the choice of either working as a nurse for two days a week, or staying as an AOD counsellor on a full time basis. This was a difficult choice. She felt dissatisfied with either choice and although she chose to work as an RN, she felt disadvantaged (disempowered) because of it. Having her qualifications recognised disadvantaged her, and she was left feeling marginalised from the rest of the team and unsupported by her manager:

It was really difficult, it took me months to decide whether I was gonna take up the position or not. It was good because I was a part, I had a different role, and I felt good that I was acknowledged for the fact that I'd done my degree and all that, and it was really good for here, because then we could say we've got registered nurses working here. But going just back to the weekends, I just felt left out. I just felt like I was left on the ledge, and nothing was asked of me, or I sort of felt like I'd just been pushed to the side. And that was really hard because this was where I wanted to be.

Wendy, RN, Detox.

³ Pharmaceutical support were not prescribed to assist detoxification and nurses were not seen as being essential to the service.

⁴ Medication regimes prescribed to assist with detoxification.

Two psychologists (33 per cent of all psychologists) spoke of the disempowerment faced by nurses and of a tension that exists, particularly in relation to other more dominant professions, such as medicine and psychology. Nurses belong to a predominantly female profession and, as one psychologist explained, nurses are perceived to have limited skills apart from the practical caring skills. Nurses are viewed as not being employed for their intellectual capabilities, rather for their capacity to care for people and to be practical, such as giving injections:

I think sometimes nurses sometimes face structural disadvantage from having been part of that overall, hopefully it's evolving, but that overall health factor of being not quite doctor's handmaiden, but certainly not seen as having skills other than patients, practical hands on patient management stuff.

Dennis, Psychologist, Outpatients.

AOD counsellors

Nine AOD counsellors (43 per cent of all counsellors) also felt disempowered. They felt that their skills were not recognised by other clinicians, and that other clinicians disregarded them because they do not possess qualifications which enable them to work in a particular discipline. AOD counsellors felt resentful of other clinicians and disempowered by them:

The only thing with Detox workers is sometimes they're underestimated as to what their abilities are with regards to assisting clients and stuff, just because they haven't got the piece of paper to say I'm a nurse whatever. Sometimes there's a lot of conflict of interests in dealing with clients and it's a bit heavy at times because someone's got a piece of paper saying I'm a welfare worker or I'm a this, or I'm a that. There's a bit of a clash of interests there because some people think 'I'm an expert in this field'.

Amy, AOD Counsellor, Detox.

Fitting in

Clinicians who worked part-time also discussed feeling disempowered. Clinicians who worked full-time were perceived as having more power than clinicians who work part-time. Four psychologists (57 per cent of psychologists) react to feeling disempowered by either deliberately not getting involved, or by speaking out and making sure they are noticed by other clinicians, as well as by their fellow professionals. These clinicians also sympathised with nurses, who they think are disempowered by other psychologists:

All the full-time staff tend to have more of the power and more of the say in things and because when you're just part-time you tend to get left out of things a little bit. I find it a little bit hard. We tend to make ourselves fairly well known professionally. In terms of roles the psychologists and the nurses, and I really don't like that very much because I don't think one is better than the other is. I'd like to have the knowledge that they have and I'm envious of that So that comes into crap between psychologists da da de da and I'm sure it happens, I think that's really bad. A power trip.

Kim, Psychologist, Outpatients.

Age or inexperience is also linked to disempowerment. One clinician related what happened with consumers to his own experiences. New people entering the group have to prove themselves and wait until the group accepts them. Until this happens, the older members of the group tend to dominate and sideline the newer members:

That's a process I'm going through at the moment. That takes a long time in a workplace, I think especially in this workplace because it's age, and inexperience and all those sorts of things, it takes a long time to become accepted.

Tim, AOD counsellor, Detox.

Other health services

Twelve AOD clinicians (40 per cent of clinicians) felt disempowered by other services, in particular by mental health services. They felt that their specialised knowledge was not valued and that they were treated as if they have no insight into mental health issues, even though they have undertaken courses and inservice education on mental illness and in particular, dual diagnosis. AOD clinicians felt hurt and angry at the way they are treated:

I mean, we've got to do mental health core working here which is an intensive program. It takes two years so we're not going off half cocked, reading a book and thinking that we know it. We are educated and to have A and E [Accident and Emergency] send her back saying she is in the DT's! [delirium tremens] A second year nurse would have been able to see this was not the case. We know our job and we don't get acknowledged for being credible in it.

Michelle, AOD counsellor, Detox.

Effects of disempowerment

Clinicians discussed their experiences of disempowerment and how this impacted on their clinical judgements and decisions. They revealed that if they felt disempowered in any aspect of their life then that impacted on all other aspects of their daily activities. The feelings associated with disempowerment arise periodically and most are linked to a specific situation. When clinicians felt empowered and valued they are able to deal with issues as they arise, but when they are disempowered they feel frustrated, confused and lacking in confidence.

Two psychologists and two AOD counsellors (14 per cent of clinicians) spoke about their feelings of disempowerment which stemmed from their family circumstances. These clinicians had experienced violence, substance abuse, racism, and sexism. One

was disabled and used a wheelchair. They now hold strong views on how being disempowered impacts on them:

Because I hate that, I hate the feeling of feeling powerless, feeling vulnerable, feeling vulnerable and feeling like I'm being intimidated by someone bigger than myself, someone with more power than me. I just think it's wrong, and it's weak They're weak. His or her way of getting power is by controlling someone else.

Gordon, AOD counsellor, Outpatients.

Clinicians reacted to disempowerment in a variety of ways. If clinicians felt unsupported they might leave their place of employment. Others might continue to work, but find themselves unable to function effectively. Some might even take disciplinary action against their employer:

I've had experience as a manager who has been disempowered and I've had experience as a manager of being empowered. What I mean by that is that my perception of what was going on was not acknowledged or validated, and my beliefs about what should have been done was not validated or acted on. As a consequence of that I crashed, much to my surprise, became very depressed and had to take time off work. I had to put in a compensation claim to take time off work.

Ruth, Psychologist, Outpatients.

Not all felt disempowered to an extent that they became depressed or resigned from their employment. Clinicians used different ways of dealing with the issues surrounding their feelings. One strategy used by a new staff member was to compromise her own values to gain acceptance by the other clinicians. Instead of directly confronting the more experienced staff member, she compromised by keeping quiet. This compromise is viewed as a temporary but necessary strategy undertaken in order to gain acceptance:

I've only just come in and I'm sort of feeling my way. Maybe more so with certain staff than others. I think at times that people who've been here a lot

longer might have a certain way of doing things and I mightn't like the way they do things. So I might cover up my own way for a while, not push it off. I wouldn't go along with the way they do their stuff differently.

Yolande, AOD counsellor, Detox.

Although clinicians might have felt disempowered in their working environment they did not confront the issues. The message given seemed to be one of resignation about the circumstances and conditions and of 'grinning and bearing it':

I don't think you can get on with the job if you don't feel empowered because I think it restricts you emotionally as well as professionally. I just don't think you can do the job if you don't want to be there and you don't want the responsibility of the job and if you don't want it, you don't feel like you're getting anything back from it. You're certainly not getting great wages, well it's better than some but sometimes some of the workers put in the hours they have to put in. So you tend to put it in and either feel miserable and depressed all the time or you don't put in or you don't get your work done on time.

Kaye, RN, Methadone.

Other clinicians spoke of how they sabotage situations when they feel disempowered:

If someone's telling me what to do, my initial reaction, if I don't agree with them, I might sit there like, you know, a higher position than me on a work level then I'll go along with it, but I'm not going to be happy with it, and something inside me will tend to sort of react to that anyway and some processes or sabotaging will happen, not intentional but a usually different sort of mood or something.

Grant, Psychologist, CBT Rehab.

Disempowering consumers

Eleven clinicians (35 per cent) discussed how clinicians disempowered consumers in a variety of ways. Sometimes clinicians are seen as being antagonistic toward consumers and aggressive in their interactions with them. This makes it difficult for consumers to

ask clinicians for assistance, and adds to the disempowerment consumers already feel. In addition, some clinicians discuss consumers in their presence, and sometimes they speak about consumers to other consumers. Consumer confidentiality is broken at these times. Furthermore, this behaviour is seen as having been sanctioned by the manager of one service because she did not stop these occurrences:

I hear it a lot. I think when the staff are aggressive towards the clients in their manner, and in the way they talk and the way they say things. They break their confidentiality by walking around the house saying, talking about the clients, in clear view of other staff and other clients. I think not properly addressing conflict in the house amongst the staff and amongst the clients, cos that's detrimental to the clients when there's conflict amongst the staff, and that comes from the director.

Wendy, RN, Detox.

Consumers are seen as being disempowered when clinicians themselves feel disempowered. This was especially so in relation to clinicians' experience with other health services, specifically mental health services. Clinicians feel that they deal with these disempowering experiences as best as they can, and although the experiences have a negative impact on them, they are aware that they have power vested in their position as clinicians. This knowledge assists them to rationalise and cope with situations. Consumers, on the other hand, have little power and, as a result, are further disempowered by service provision:

We're sending them there, they're bouncing back to us, and yes, we deal with our side of it, but we can't prescribe, we don't know how to. We just sometimes stumble along through it, but what's the poor client going through, getting shoved from pillar to post, and no treatment, or very little treatment?

Michelle, AOD Counsellor, Detox.

If consumers complain about these issues or about the way they are treated, clinicians close ranks and blame the consumers or punish them in some way for challenging the power that the clinician holds. This serves to reinforce the power differential between clinician and consumer, which leads to yet further disempowerment for the consumer:

I think their [referring to consumers] power was taken away from them when they complained recently. There was some complaints put in about some staff members, about the way they were treated on one of the shifts by both staff members, and it ended up being swept under the carpet. They [Director and other staff] came and had a group with the clients and addressed the clients. They said that the clients were told that they were lying.

Wendy, RN, Detox.

The disempowering of consumers by clinicians was thought by other clinicians to be an unconscious mechanism. Clinicians are not perceived as being aware that they are, in fact, disempowering consumers, or even of being aware that their own behaviour adds to the disempowerment. Although clinicians are the ones in power, they seem unaware that they use their power in a way which disempowers others:

Unfortunately I think a lot of the de-empowering stuff is unconscious, it's an automatic thing. I'll give you an example. One of the biggest things that I had when I came here was the anger in this unit, and I used to say 'well, look, the clients wouldn't respond if they didn't get so much denigration from you', and people would look at me like 'what are you talking about'? But I could feel it; I could feel the denigration responses and the statements, the automatic putdown statements.

Glenn, doctor, Methadone.

Working Against Empowerment

Sometimes clinicians are unsuccessful in their attempts to get consumers to alter their AOD use. When this occurs clinicians state that some consumers or circumstances work

against their efforts. They place the blame on others rather than reflecting on their own practice. For example, they suggest that some consumers are reluctant to change and to 'become empowered, because consumers obtain 'secondary gains' by continuing in the victim role. Clinicians describe being frustrated with these consumers.

Resistance to empowerment

Clinicians feel that not everyone wants empowerment. Some consumers, for a variety of reasons, are resistant to making the changes that are necessary for empowerment to occur. Sometimes consumers are satisfied with their current lifestyle, and some do not know any other life or are unaware of the choices available. Sometimes clinicians may make the assumption that all consumers want empowerment (as defined by the clinician). If consumers do not want to change their behaviour or life style, they will actively resist the clinician's attempts.

Four psychologists and one nurse who worked in AOD outpatients (63 per cent of outpatient clinicians) described how consumers receive 'secondary gains' by remaining disempowered. Such consumers are viewed as being resistant to empowerment and not wanting to change their AOD lifestyle. These clinicians feel that change is too difficult for some consumers, implying that certain consumers do not want to accept responsibility for their behaviours and actions:

I think some clients want to be empowered, but other clients are quite happy to be disempowered and be victims and carry on in their maladjusted junk behaviour because of the secondary gains ... Pure and simple to me, and I think in drug and alcohol that's a fair whack of the clients.

Kim, Psychologist, OP.

Clinicians thought that the process of empowerment was not easy. It forced consumers to look at other aspects of their lives, which was sometimes too difficult for them.

Sometimes the process was too challenging. In addition consumers may be ambivalent about making changes:

I don't think empowerment is necessarily an easy passage, and I think to some degree it may make them aware of other things that they're not happy with or they're not satisfied with. ... So there's the whole issue of secondary gains. Often the partner may not respond well, particularly if they have their own issues of a similar nature and they're not addressing them. Obviously that change is going to create something in the relationship.

Tanya, Psychologist, OP.

Two clinicians (7 per cent of all clinicians) suggested the assumption that one person can empower another is arrogant as it acknowledges that one group of people, (in this case clinicians), has more power than another (consumers). This is another paradox in AOD treatment, because on the one hand clinicians acknowledge that by attempting to empower consumers, the power differential between the two groups is reinforced because clinicians are acknowledging that they hold power, which the consumer does not; yet, on the other hand they talk about the process needed to be able to empower others:

The empowering I see is so subtle because my definition of directly empowering someone you're taking charge of their empowering. And you've got to be very aware of that and do it extremely subtly so they've got no sense that they're being empowered.

Glenn, doctor, methadone.

The literature addressing the conflicts for nurses who have trained in a 'caring' model and are expected to adapt to work in an 'empowering' model is quite substantial and I expected that this would emerge as a major theme. However, only one clinician, a nurse,

spoke about the potential conflict for nurses when it came to empowerment. She thought that the nursing profession was trying to reposition itself in the medical hierarchy and cited the changes made to nursing education, currently undertaken in universities instead of hospitals, the expectation that nurses in management be required to pursue further degrees and the expectation that all nurses continually upgrade their qualifications. She thought that as a consequence of the 'profession' becoming empowered, the consumer could actually be disadvantaged. She warned that nurses are in danger of forgetting that their primary goal is to care for the consumer:

I remind myself that I am here to empower somebody that comes for counselling, but I see that as a great difference between the professional body and empowerment and what that word actually means and what their requirements mean as opposed to empowering the clients.

Barbara, RN, OP.

This dichotomy between empowering the profession and empowering the consumer is also discussed by this nurse who thinks that there is also a potential conflict for the nurse traditionally trained in a 'caring' model, but expected to work in an 'empowering' one. She explains that although it is possible to manage the two philosophies, for some nurses it can create difficulties:

Caring is about the balance you have between offering a service and support. To encourage the person to change, or to develop and grow, or to open new treatment approaches. To have a balance between the two and to develop very much that internal support and the networking to achieve that is about caring.

Barbara, RN, OP.

Not everyone wants empowerment

Clinicians discussed the idea that not everyone wants empowerment. While twenty-five clinicians (80 per cent) thought that consumers wanted empowerment, (although they

might not know it), many of these same clinicians also discussed the difficulties and responsibilities that face consumers if they do become empowered. They acknowledged that some consumers found the responsibility and accountability necessary to undertake changes too difficult. This group of consumers was not necessarily viewed as wanting to stay in the role of victim, as described earlier, but rather that this group had tried to become empowered and found the process too difficult and the outcome unsatisfactory:

They may say that they want empowerment but when it comes to the crunch they can't deal with the empowerment once they've got it. Or they don't know how to deal with it, or they're not sure how to handle it, they don't know what to do with it, they can't feel it when they've got it, or when it's presented to them. 'Okay then you can let go of this victimisation, you can be empowered', but, 'I know no other role in life'. That's typical you know.

Gordon, AOD counsellor, OP.

Other consumers were seen as being honest about their reasons for accessing AOD treatment and returning to AOD use on discharge (not wanting to become empowered). These consumers were in the minority and only two clinicians raised this perspective:

Others will tell you they're here to get a meal, to get better, to go on the drink again. I don't see those people as wanting it [empowerment]. They want a rest, they want a safe time out, places where's they'll get a meal, they want a bit of TLC [tender loving care], and they want to go out and drink again. But they're honest they'll tell us that. And I don't see that they would want it or ask for it [empowerment]. I think they'd actually see it as intrusive if we tried to push something onto them that they weren't asking for.

Michelle, AOD counsellor, Detox.

One AOD counsellor spoke about the impact it had on her when consumers did not think they could become empowered:

Sometimes it's easier ... for the client because they see the situation as too hard to get out of anyway. ... That really saddens me. They see that their situation isn't going to change so I may as well stay like this. ... I was nearly tearing my hair out this afternoon because he [referring to a consumer] just cannot see that there is any hope for him, and it doesn't matter what strategies that I put forward ... 'I'll show you're quite normal', ... and that's really sad when you come across clients like that.

Fran, AOD counsellor.

Sabotage of empowerment

Clinicians talked about the sabotage of empowerment that can occur for consumers.

They discussed that others (family, colleagues and significant others) might not like the confidence and empowerment that a consumer gains while in AOD treatment, and try to sabotage their empowerment for a number of reasons. One such reason could be that other people in the consumer's relationships feel that they are losing any control that they have had over the consumer:

In the case of violence, that's something that I think that affects our clients, because the more power they gain, the more the perpetrator [is] going to try and control them and relinquish the power from them in that situation.

Gordon, AOD counsellor, OP.

Clinicians felt that empowerment could create some difficult situations and stress for consumers because they might choose to relinquish contact with some of their previous acquaintances. Sometimes consumers decide to leave their partner/spouse or other family members:

The more empowered that you become the less friends you have. The more empowered you become the more personal barriers you have. The better sense of self you have, the less people you end up having in your life. So that could be seen to be a negative thing because a lot of people

... would find it difficult to go back to people they interacted with in their addict life.

Sue, AOD counsellor, 12-step Rehab.

Another negative outcome that can occur as a consequence of consumers becoming empowered is an increase in domestic violence. If the consumer is in a violent relationship, as she/he changes and becomes more assertive, the potential for violence will escalate unless the other person in the relationship makes change at the same time. Clinicians think that consumers need to be made aware of these potential consequences and suggest strategies to deal with them:

They mightn't have been empowered all their lives and they don't know what it is. And then you start letting them make decisions, or take responsibility, or learning how to say no, and stuff like that, and they're scared of it. Especially in domestic violence situations. They'll just say no to their partner and cop a hiding and that's no good. They need to get out of that situation first and then start putting it into practice.

Ron, AOD counsellor, Detox.

Some consumers find that when they do become 'empowered' the consequences are too difficult to deal with; consequently, clinicians think that consumers deliberately sabotage the gains they've made. Some clinicians believe this is inevitable because some consumers do not, in fact, want to change their lives, and are only saying what they think the clinician wants to hear:

And then there's others that just like being victims. I see it as that and they'll sabotage their own recovery.

Wendy, RN, Detox.

Other clinicians are more sympathetic to the reasons a consumer would sabotage 'recovery' (empowerment), and speak of the complexity associated with consumer empowerment:

Sometimes the client will become empowered and they stop drinking and stuff like that and their partner doesn't like it because the partner's lost the power. Sometimes the [partner] will walk out on the client, and then they [client] think their whole world's fallen down around them. They don't want this empowerment any more; it's destroyed their lives and everything else.

Ron, AOD counsellor, Detox.

Not all clinicians think that consumers are able to cope with being empowered or able to respond in a way that is seen as appropriate. Four AOD detox counsellors (50 per cent of detox counsellors) described a tension between empowering consumers and wanting to maintain their own position of power. If consumers challenge clinicians, their perspective is often ignored or negated by clinicians, who may even rationalise that consumers are unable to make intelligent decisions. They are viewed as needing protection from themselves and incapable of making decisions. It is the clinician who knows what is best for the consumer, and the consumer is labelled as being brain-damaged:

Because they start arguing, start trying to control their own, what they see their needs are. But most people that come in here who are chronic alcoholics have a lot of the isms of alcoholic brain damage, so they really have limited choice at the time, you know.

Alan, AOD counsellor, Detox.

Clinicians are clearly the ones who have control in AOD treatment and they want to maintain it. They think that if the consumer gains empowerment, then the logical consequence is that the power held by clinicians will be loosened, which some

clinicians see as a threat. Some clinicians find the thought of this challenging to their power and position and they actively resist implementing strategies that foster consumer empowerment:

If someone has empowerment they're not about to just accept whatever they're told as gospel. They want to know the ins and outs, the hows the whys and the wherefores, so it takes some nous and patience and more input from myself as a worker to provide them with that, or facilitating them in finding their answers. It means several things like, if I do something out of line, they can put in a complaint against me and if they're empowered they *will*. They will do that and I'll have to be answerable to my actions. It means that they maybe want more.

Sharon, AOD counsellor, Detox.

Sharon seems to be suggesting that this is to do with accountability, however this is not evident in other interviews.

If consumers do challenge clinicians about their attitudes or behaviours, or even go as far as to officially complain, AOD clinicians 'close ranks' and stick together to portray a united front against them. (Refer to the comment from Wendy who is quoted on p.165.) Consumers are then caught in the middle. Not only are they dealing with their own issues associated with AOD use, but they are also enmeshed in the treatment philosophy and program which often works against the conditions necessary for empowerment to occur. In addition their family and friends as well as AOD clinicians use rewards and punishments to entice them to conform:

Once a patient starts to express their real power or their real self I think they get tremendous negative feedback. I feel like it's almost like a family or a dual family or a substitute family and it's like they're held by a series of elastic bands and they're hooked right in the middle and whenever they move one way there's great pressure for them to go back

to where they were. I think that they're quite threatening to probably their families, probably less threatening to us, but there is still that you be good and we'll reward you and you not be good and we'll punish you.

Glenn, doctor, Methadone.

Conclusion

This chapter has presented and explored how clinicians perceive, experience and effect power through the rhetoric of empowerment. The complexities, contradictions and paradoxes associated with AOD treatment have been highlighted. The main themes that emerged from the study were used to structure the chapter.

Making change is necessary, but it is complex and occurs at many levels. However, not all clinicians want to make changes, and are content with the status quo, and some clinicians are even viewed by their peers as being fearful of change. Change is implemented in the clinical area to improve treatment programs and also in an attempt to respond better to consumers needs.

Clinicians discussed changes that the consumers needed to make in order to be able to control their AOD use. They acknowledged that it was difficult for consumers to make the changes that they (clinicians) viewed as necessary. Clinicians also feel that change is the responsibility of the consumer and that their role is to assist the consumer make changes. This they do by a variety of strategies including the use of interpersonal counselling skills, positive reinforcement, practical sessions such as role-plays and workshops, and by also changing or bending the rules which can be seen to result in both positive and negative outcomes. However, change is often imposed on consumers as clinicians work with them. In addition, the goal of every clinician is to work to change the consumer's behaviour and by discussing self-responsibility in relation to

change, they are effectively distancing themselves from any responsibility if the consumers do not change their behaviour. Consumers are blamed for failure if they do not want to accept responsibility and practise self-control.

Clinicians spoke about control in a variety of ways. They concentrated on their perception of the consumer being out of control, and discussed why they thought this had happened. In addition, they discussed the notion that not all consumers are able to take control, and at these times clinicians need to take control for the consumer. Clinicians ensure they maintain control by an overt and covert system of rewards and punishments.

Clinicians are aware of empowerment as a concept and it is part of their everyday discourse. Empowerment as described by clinicians is code for consumer compliance. If consumers are to achieve empowerment (ie. alter their AOD use), they need to make changes. If consumers follow the instructions of the clinician, empowerment (compliance) will be possible. If consumers resist becoming 'empowered', they are negatively labelled.

Although it is assumed that consumers want to be empowered, discussion revealed most consumers were not aware of its meaning. Empowerment (compliance with the clinician and changing AOD use) is seen as an individual responsibility with consumers needing to accept the consequence of their actions. Advocating self-responsibility is part of the moral perspective of 'addiction', where it is held that individuals are responsible for their own AOD use, and they can choose whether to use or not.

Clinicians also feel that they need to be empowered before they can begin to empower others. While some clinicians feel that they must be careful that they do not abuse the power that they hold, others feel that if they are not empowered themselves, they could be manipulated, and walked over by consumers. If this occurred, it meant that the clinician had lost control, a situation to be avoided at all costs. One way clinicians discourage this from happening is by emphasising the importance for consumers to *feel* that they have choices rather than actually having choices.

While nurses, a specified subgroup of AOD clinicians, are generally thought to possess the necessary skills to empower others, the data suggest they do not always attempt to do so. Although nurses have the knowledge to empower others, AOD clinicians believe empowerment is dependent on the individual concerned. Only *some* will *attempt* to empower others. It is an individual's skills and attributes, rather than professional affiliation that are perceived to be the common factor in attempting to empower others.

Clinicians experience disempowerment in many facets of their work and on many levels. They discussed being disempowered as AOD clinicians by other AOD clinicians, by their employment status, by peers from their own discipline, by other service providers, and of how clinicians disempower consumers both overtly and covertly.

Clinicians express the thought that not all consumers want empowerment. Furthermore, the choice of whether to be empowered or not needs to be the consumers', rather than clinicians imposing their beliefs and desires on them. This effectively removes any feeling of failure on the part of the clinician.

Clinicians discuss the consequences when some consumers gain ‘empowerment’, explaining that others may sabotage the process and describing how it can result in domestic violence and isolation. In some cases, it is perceived that consumers feel more disempowered and will then end up sabotaging their own empowerment.

Clinicians’ description of empowerment is equated to consumers changing their AOD use. This can happen if consumers are compliant with the treatment regime and follow the guidance offered by clinicians. If consumers question the clinicians’ authority or the treatment regime, they are viewed as not being ready to change, or unwilling to change. Therefore, they are seen as being neither ready nor capable of empowerment.

A minority of clinicians speak about their reluctance to empower consumers because of the impact that an empowered consumer can have on them, forcing them to be more accountable for their actions; They believe many consumers have brain damage from their AOD use and are unable to accept or deal with empowerment. Thus, it appears that some AOD clinicians may be actively stopping consumers from gaining empowerment.

CHAPTER SEVEN

CONSUMERS

Introduction

This chapter presents consumers' perspectives of power, control and empowerment and the surrounding issues. This study identifies that consumers feel out of control, but they want control and want to *feel* in control of their AOD use. They desire to be 'normal' and want what other people have, such as a job, car, house and to be in a satisfying relationship. For women consumers, being out of control has an even greater impact as they feel disadvantaged by societal and family expectations, as well as by being women in AOD treatment.

All of the consumers who participated indicated that they wanted to change their AOD use and lifestyle. This desire for change occurred whether they had voluntarily sought treatment or had been directed to undertake treatment by the court system. Some consumers had desired change for some time, while for others, change was precipitated by a dramatic or life-threatening event. Most consumers felt responsible for implementing and maintaining change and had strategies in place to enable this to happen.

Consumers express a desire to be empowered although they do not fully understand what this entails. They associate empowerment with changing their lifestyles and AOD using behaviour. In addition, they want to feel in control of their AOD use and to feel

valued in their interactions with AOD clinicians. They express a desire to work together with clinicians in planning and implementing their treatment program.

Being disempowered is a recurring theme for some consumers. Over half of the consumers interviewed feel disempowered by AOD clinicians and this happens by a variety of mechanisms. Disempowerment occurs more often when consumers are resident in the detoxification unit than in other treatment centres.

Consumers generally think that recovering people are best placed to be able to empower others because they understand what consumers have been through and are currently experiencing. Clinicians are viewed as being able to empower others as long as they have the desire to do so, are trustworthy, are caring and are capable of building a rapport with consumers. These attributes are viewed as being more important than the professional training and education of clinicians.

Finally, empowerment is viewed as a positive outcome. However, it is acknowledged that there are difficulties associated with gaining empowerment. For women this relates to the way that others might view them as they gain confidence and become more assertive. In addition, when women feel in control and empowered they become aware of the impact that their AOD use has on their children. Male consumers discuss the need for a balance between power and empowerment and how difficult they find to maintain it. They feel that it is easy to become over-confident which can impact on their 'recovery.' They may end up either not being successful in gaining self-control or in trying to manipulate and control other people.

Control

Two major themes dominate this section. The first is that consumers want to be 'normal'. They want to be like other people; they do not like their AOD lifestyle, although they may pursue it for a long period of time before they change it. Consumers desire what they perceive other people have, that is, a job, a house, good health, intimate relationships, being able to deal with their feelings and not feeling driven to commit crime to gain money for drugs.

The second major theme is the impact that being out of control has for women AOD users. Women feel disadvantaged in AOD treatment because of their role as nurturers of children and societal expectations about women's behaviour in relation to AOD use. This impacts on the way they think others perceive them. It impacts on their desire to be good mothers. It impacts on their reasons for seeking treatment for AOD use.

Wanting to be normal

The desire to be normal was an emotion described by all consumers. Being normal meant doing what others do, that is, not spending all their time planning and obtaining drugs, or having a drug based and drug focussed relationship. The desire for 'normality' is highlighted by the fact that consumers, in these circumstances, feel out of control and may have been out of control for a long time. The consequences of feeling out of control have a significant effect on the individual and the family. Respondents talked about the impact that their drinking or drug use had on their family and personal life. The consequence of their behaviour is always present when they discuss being out of control. Consumers express self-loathing, lowered self-esteem and worthlessness. They

feel controlled by their AOD use and dependent on others. Feeling out of control triggers their desire to be normal:

If I've got some control over my life, which I don't have in any respect at the moment it might start to give me some self esteem back ... As a human being I rate minus five and as an individual, I've got nothing. I'm just completely a piece that someone else has got; I don't have any ownership of me, mentally or physically, at the moment.

Dave, consumer, Detox.

Participants who use narcotics describe their life as 'driven' by having to work out how to 'score' [obtain] enough drugs to get them through the day. This may involve trips to numerous doctors in order to obtain prescription drugs, although consumers may want to spend time differently. For example:

... We were always on buses going to this doctor, or that doctor.

Lindsay, consumer, Detox.

Some consumers spoke about theft and related criminal acts that they had committed in order to obtain goods that could be sold for cash, in order to purchase illicit drugs. They do not like what they do to other people in order to obtain money for their habit, nor do they like their own behaviour, which they often describe as being out of character. The fear of being caught is outweighed by the need for the drug:

I've always ended up in prison, and for quite serious charges. They're always armed robbery, cos I can't do anything else, I don't normally steal a chocolate bar from Woolies [supermarket] I haven't got the nerve. It doesn't make sense does it, but you can commit serious crime.

Jan, consumer, 12 step Rehab.

The importance of feeling healthy and not having to rely on drugs is another aspect of consumers wanting control of their lives. Narcotic users confess to often feeling sick and wretched. They feel sick when they are in need of another 'fix' or sick from the effects

from each 'shot' they have had, as there is no way of knowing the purity of the drugs they use. They are also fearful of contracting HIV/AIDS from sharing needles. Consumers are blasé about their Hepatitis C status and accept as a foregone conclusion that they have already contracted it:

Not just me having control, just having a good life, being healthy, being able to do what I want to do without having to use drugs or whatever to get by each day, or have relationships or whatever, just being, normal, just to be the real me and not have to put up [with] all that stuff, to [be able to] adapt to different situations I'm in.

Travis, consumer 12-step Rehab.

All consumers feel that the drug controls them, that drug use blunts emotional responses and, although initially the drug is used to block out painful or uncomfortable emotions, many realise that as a result of use, they do not have the skills to deal with emotional situations. When difficulties arise, they will use AODs rather than face the problem:

I don't want to be controlled by drugs. I want my feelings and emotions and all that so I feel I can handle them.

Cameron, consumer, CBT Rehab.

Although consumers may want to be normal and to have choices, this is not straightforward nor easy. Often their families suffer and whilst consumers feels 'bad' about this and they understand the consequences of using, they still feel powerless to stop:

I've got a lot of guilt I feel I've really let them down, I hate all the time it's taken from me. I should have known better. I know what you've got to do to stay clean. ... I knew from the very first time that I got on and I picked that first shot up, I had the next day planned while I was mixing up that shot in the spoon, I knew that I would go the next day and it would be continuous.

Jan, consumer, 12-step Rehab.

Eleven consumers (42 per cent of all consumers) described the impact of AOD use by expressing a desire to possess material belongings and to live their lives the way that other people do, having a job, having relationships, owning possessions and budgeting their income to meet life's requirements:

Out of the last ten years I've spent eight years in jail, and I'm getting sick of that way of living, and every time I use drugs, use heroin, that's how I end up and I've just had enough of it. I'll be thirty in a few months and I'm not getting any younger and I'm just sick of living that way, being totally consumed by my addiction. So it's wanting a *normal* life, a so called normal life, whatever you may call that but just being able to pay the rent, and having food in the cupboard and having a car and being able to maintain a stable job and stuff like that.

Peter, 12 Step Rehab.

Another aspect of being normal is having choices. Consumers thought that when they use AOD their choices are restricted to obtaining drugs because their daily activities centred on that pursuit. The idea that they could have choices about how to spend their day, where to go, where to live, what to wear, what to eat and so on became exciting and something desirable:

Basically what we're talking about now, getting my life in control. Having choices. Substance abuse takes away a fair amount of your choices. I suppose basically it gives you the choice of how you're going to supply yourself with your drug of choice. That's about the only choice you have.

David, consumer, CBT Rehab.

Having choices enabled consumers to see that there are different ways of dealing with setbacks. For many, this is a new experience, as the only way they had dealt with difficulties previously was to use alcohol and/or other drugs. They spoke of the increased self-esteem they experience when they are in control and have options other

than scoring drugs. They spoke of increased confidence when they realised that if one strategy is not successful, they can try again using a different approach:

You have self-esteem and feel confident in your life. If you have setbacks, well you don't get down in the mouth about it, you just see if there's different ways around it.

Peter, consumer, 12-step Rehab.

When consumers feel in control and feel they have the same things as others, they express positive feelings about themselves. They like having choices about their plans for the day and they like the way others perceive them. They feel that *they* are in control, rather than in the control of AODs:

You know today I can deal with things that happen, issues that take part of my life, I'm prepared physically and emotionally for situations. I don't wake up today hanging out, wondering who I'm going to rob next, you know, I've got self pride, I've got self worth. Before, when I used, I didn't have any of those things.

Scott, consumer, 12 Step Rehab.

Women and control

Being controlled by others was discussed by some women consumers in their description of being out of control. This encompasses the feelings that they are not able or not permitted to be responsible for their own life choices. Instead they feel that they are being manipulated by others and doing what they think others want or expect them to do, rather than doing what they want to do:

... I've been spinning out of control for so many years I want control of my own life and I want to do what I want to do and not what everybody is wanting. I spent my life time doing what everybody else wants me to do, so if I'm in control of my own feelings, I can tell *them* what I want, instead of them telling me what I want.

Bronwyn, consumer, CBT Rehab.

Three women AOD consumers (60 per cent of women) discussed that previous attempts to alter their AOD use, undertaken because other people desired them to. They felt pressured into trying to change their AOD use because of their families, rather than because *they* wanted to. No male consumers discussed this aspect, although some indicated having been given an ultimatum by their spouse or partner many months prior to them seeking treatment:

I've done it for years for other people, for my family, for my kids, any other reason but for myself, but this time it's for myself, it's not for the kids, it's not for the family, it's for myself.

Bronwyn, consumer, CBT Rehab.

Women in AOD treatment often have the added burden, or incentive, of caring for children, and cited the changes that they saw in their children's behaviour as a factor in seeking treatment. They also spoke about the impact that *their* behaviour and lack of control had on their children. They wanted to be 'good mothers', and give their children security and stability:

I become more healthy and I see how it affects them. I mean it's really not bad, but I can just, those things, and that's how I can see that I have changed, but how my previous behaviour has affected them [her children].

Helga, consumer, Detox.

Women also felt disadvantaged in AOD treatment as they need to make additional arrangements when choosing residential treatment. There are very few residential units in Australia which offer facilities for children, so mothers need to make alternative arrangements with family or friends to care for them. If this is not possible they can place their children with the NSW Department of Community Services (DoCS), but for most women this is not acceptable, as they fear losing custody of their children. In

addition, many referring counsellors do not consider the impact that being away from the family has on both the mother and the children. Often, residential units are a long way from where the consumer resides, which adds further financial burdens:

I wasn't given much in the way of options and it was either here or the [other] option that they gave me was over eight hundred kilometres from my home and they knew that I have three children. 'Not... there's one three hours away'. We managed to find [it] on our own.

Bronwyn, CBT Rehab.

It appears that women are poorly served in AOD treatment because they feel that there is a lack of choice in AOD treatment facilities. In addition, their specific childcare needs are not addressed and they feel guilty because although they want to be good mothers, and feel afraid of being judged as poor mothers because of their AOD use:

The most important thing for me is getting out and getting a job, getting my children back. I'm going to court; hopefully the court will view my case positively. That's the biggest problem for me.

Sian, consumer, CBT Rehab.

Moreover, if a crisis arises at home when women are in treatment, their initial reaction is to cease treatment before it is completed and return home:

... My first instant reaction was I've got to get out of here, I've got to get out of here, I've got to go and get this sorted out.

Jan, consumer, 12-step Rehab.

Change

The actual decision to undertake change is an important one for all consumers.

Consumers discussed the factors that led them to attempt to change their drinking or drug taking lifestyle. For some, the decision to change was in response to a specific situation, but for the majority of consumers it was a gradual realisation that they were

addicted occurred over a period of time. They gave reasons for wanting to change, such as their age, not having any friends, being sick of hurting others, wanting some sanity, being given an ultimatum and being directed by the legal system.

Consumers discussed the process of making changes and of not knowing that they needed help or where to go to seek assistance. They spoke about their own responsibility for change although some talked of making changes for their children's sake. All consumers felt that they needed to have specific strategies if they were to succeed.

Decision making

Feeling out of control is the driving force behind consumers' decisions to seek AOD treatment. Even those consumers who were sentenced by the courts felt out of control and were in fact glad to be referred for AOD treatment. In each instance the immediate precipitating factor varied, but all were linked to being out of control. Some consumers had a list of reasons that they gave for deciding to seek treatment:

I wish to keep my family, so maybe that's the ultimatum part. ... Wanting to sort myself out. I'm lost. Sanity. I need it. I think everybody's own idea of sanity is what they perceive it to be. To me, sanity is to be rational, capable, be able to deal with day to day muck that they throw at you, to be able to come out on top instead of saying there's no other option but to hit the bottle again. Crawl inside it and pull the cork down on top of ya. Sanity to me is *sober*.

Dave, consumer, Detox.

All consumers spoke about wanting to make changes long before they attempted to implement change. Sometimes it took a dramatic event before they committed

themselves for treatment, despite knowing that they were at risk of a relationship breakdown or ill health if they did not make changes:

My partner gave me an ultimatum to the point that she left me four months ago, and threatened to do so twelve months ago.

Ralph, consumer, Detox.

For others it is a collection of events that finally leads them to seek treatment. For these it appears more as a gradual realisation rather than any one dramatic event that triggers their decision. This gradual realisation is linked with wanting normality:

Because I'm killing myself ... I'm just sick of it ... I can't function, I'm just robbing people ... hurting my family through stealing ... Sick of just not being me. I wouldn't have a clue what's going on. I blow relationships all the time. I've just had enough. It's no way to live. Always hanging out, wondering where you're gonna get money for drugs or what you're gonna have to do to get money for drugs. I've had enough.

Travis, consumer, 12 step Rehab.

I've gotta get off drugs, they're killing me. I've gotta stop cos I don't want to see my girlfriend die. I don't like seeing my mum and dad when I'm all stuffed up [crying] and I want to sort myself out. Having to shoplift every day. Get up, get out of bed, sick as a dog and gotta go and get it. It's too much; it's just a bad drug. I use with my dad. I started using with him and watching him use. It upsets me you know.

Paul, consumer, 12 step Rehab.

Sometimes the decision to attempt change is prompted by a specific incident, and when consumers realise that they are unhappy. Sometimes the specific incident forces them into making changes:

I just woke up one day and realised nobody likes me and the only time people come to see me or visit me [was] when I had drugs that they want to buy. There's always an ulterior motive; there's never any motivation to ring

me up because they want to know how I am. I really didn't realise that, until Christmas Day when nobody called me. Everybody disappeared. I wasn't invited to go anywhere and I realised people didn't want me around. I was just somebody who had totally lost the plot.

David, consumer, CBT Rehab.

Women consumers may be reluctant to talk about their experiences, and admit that they feel unable to control their AOD use for a variety of reasons, many of which relate to physical and sexual abuse. Many women who are the victims of abuse still feel that it is their fault and somehow they deserve what has happened to them. As a result, they are often reluctant to seek assistance. Sometimes the shame that women feel about being abused stops them seeking treatment:

I was too embarrassed and too ashamed in a small country town. There'd been a girl who'd been raped not long before me and they'd virtually persecuted *her*, you know. So I didn't tell a single soul until the day that I had the baby. So I sort of dealt with having the baby and the rape and everything come flooding out at once, and it was like starting another dam. Whoosh, just everything came, you know. I was right as long as I'd kept it in there but when I had the baby I had to let it out. When I let it out everything else come rushing out too.

Bronwyn, consumer, CBT Rehab.

Taking the plunge

Eight consumers (31 per cent of all consumers) spoke of not knowing that they needed help although they knew that there was something wrong with their lives. They did not know what to do or where to go for assistance. It was only when someone that they trusted suggested that they sought treatment that they acknowledged they were out of control:

My girlfriend wanted me to get help because I got to a certain stage of my addiction where I had no control. I couldn't think properly, suffering severe

paranoia. I was getting very aggressive and violent ... and *she* left me. ... Everybody abandoned me. They could see that I was a stick of dynamite just about to go off. I was referred here by my girlfriend's mother. She said you know what you have to do, and I said no I don't, I've got no idea. So she gave me help to find a detox to go to when I had my head together enough.

David, consumer, CBT Rehab.

Two consumers (8 per cent) were referred by the courts and it was only when they realised that the options were gaol or an AOD treatment centre that they chose treatment, considering it to be the easier undesirable option. However, during the time in AOD treatment, they realised that they needed to make some changes and were glad that they had undertaken treatment. The overlapping 'carrot and stick' approach of the criminal justice and health systems can thus sometimes assist consumers to implement changes in their lives:

Well I was actually bailed to here, I went to court from gaol in January ... I came here four weeks to do the program, and then go back to what I was doing before. But something changed along the way.

Peter, consumer, 12 step Rehab.

Responsibility for change

Twenty-four consumers (92 per cent) felt that the decision to change needed to be their own. They felt it would not be successful if someone else made the decision:

If I do it for someone else they're gonna feel good, I'm not. So I've gotta do it for myself.

Darryl, consumer, Detox.

One consumer who had previously attempted change, but had not continued spoke of attempting change for the wrong reasons. The change was attempted to please others, her partner and parents, rather than herself. She felt coerced into attempting change.

This time she had chosen to undertake treatment because she wants a more stable life for her family, but is adamant that the changes need to be for *her*, and when she makes the changes, her family will benefit as well from them:

Because when I gave up before I was just doing it for somebody else and I didn't really want to do it. I wanted to do it but I didn't want to do it for the right reasons.

Bronwyn, consumer CBT Rehab.

Some consumers spoke of making changes for the sake of their children rather than themselves. The following consumer discussed wanting to make changes to provide a better life for his daughter. Both he and his previous partner were drug users and this added to his difficulty and uncertainty about custody. The last time he had custody of his daughter had been spent travelling from doctor to doctor seeking drugs:

I'm 33 ... I've been abusing drugs in one way or another for over 15 or 16 years ... I've separated from my partner, I've got a four year old daughter which [sic] I can see on school holidays and once a month if I can get down to where she is. I just want the time that I have with her to be quality time, instead of me worrying about where I'm getting my next drug from ... and having her tagging along ... I love my little girl, she's my life. I just want to have a clear head so I can have quality time with her and instead of worrying about doing things for myself, do things for her in the short time that I do have her.

Lindsay, consumer, Detox.

Although all consumers spoke of wanting to make changes, five of them (19 per cent) expressed ambivalence about why they wanted to make the changes, or were ambivalent about whether they could continue in AOD treatment. They were weighing up the advantages and disadvantages of continuing with their AOD use at this stage:

Just at the moment I'm just having a hard time analysing myself, just trying to make it through here, and I suppose I'm kind of half waiting for someone

to come along and say this is how you've got to do it, waiting for an instruction manual. It is important, and half the time I think I could probably do it myself but I've tried before and it doesn't work.

Lee, 12 step Rehab.

Strategies to maintain change

Consumers discussed the need to have strategies in place to enable them to continue with their decision to change their AOD use when they leave the treatment setting. They felt it was important to learn many different coping mechanisms and to be aware of the potential difficulties associated with specific situations:

Learning different ways to cope with it ... I'm starting to realise the areas, some call them trigger points and to become more aware of them ... Not to dwell on it if it's just getting hold of me and starting to screw me right up. It's to realise it for what it is and make it go away

Doug, consumer, Detox.

Consumers think it is important not to rush the process of making change, and not to make too many decisions at the one time. They described taking one step at a time, which is consistent with the 12-step philosophy, although they may currently be participating in the CBT program:

It's good not to have too many choices and too many decisions to make at this period of time because I'm really concentrating on how to better myself so that when I do leave here I have the tools to operate in a social manner. But at the moment I think it's important to work in with the information.

David, consumer, CBT Rehab.

Another strategy seen as useful is being able to ring the residential unit after completion of the treatment program. By doing this, consumers can seek advice or guidance.

Sometimes consumers feel confident and ready to leave residential treatment, but when they actually try on their own, it is too difficult because of other people pressuring them

to return to using. One consumer spoke of a specific incident when he had finished his treatment program and was discharged. He felt pressured to return to using drugs and had in fact used heroin twice, before putting a strategy in place. The strategy was to ring the treatment centre and ask to come back for a while until he felt able to cope with saying no:

Yeah it was difficult but I just, I had to get away from where I was. Everywhere ... I went I ran into practising addicts and it was really difficult to say no. It was shoved in my face and it was a real battle to say no, especially where my head was.

Peter, consumer, 12 step Rehab.

One useful strategy for consumers was to think of the good things about being sober or not using drugs. Some consumers remembered these times from previous attempts at not using, while one recounted an experience he had had recently when he had gone out for the day with his family:

You just get better responses from people. At service stations all the staff's *talking* to you ... I just couldn't believe it. I thought wow you're *talking to me*, whereas two or three months [previously] I'd be that wasted, they'd just think, look at this no hoper. It makes you feel good.

Lindsay, consumer, Detox.

Being Empowered

Consumers discussed what empowerment meant to them. They were not familiar with the term, but when asked, associated it with being able to control their AOD use. They were able to identify several components included in the notion of empowerment, such as having self-control and being able to make choices.

Consumers feel that empowerment is not easy to achieve and that often they need to be shown that they *can be* empowered and concentrate on their own identified goals for empowerment. They also want to feel empowered in their interactions with clinicians and want to work with clinicians in the planning of their treatment.

Meaning of empowerment

When consumers were asked to reflect on the meaning of empowerment, they all offered a meaning. It is significant to note that those consumers who were not familiar with the word focussed on the word *power*:

Maybe me to have power over somebody else? Or somebody to have power over me?

Jan, consumer, 12-step Rehab.

Empower seems like to be able to give power and to have power is to be able to have control over other people.

Dave, consumer, Detox.

Empowerment is explained from a personal or subjective perspective that has meaning in relation to their desire to control their AOD use. It is related to feelings of self-confidence and increased self-esteem. Empowerment is interconnected with self-responsibility:

For me there are two different sorts of empowerment. One is having power and control over other people and the other is self-empowerment where you have self-esteem and feel confident in your life.

Peter, consumer, 12-step Rehab.

Feeling empowered

When consumers feel empowered they speak of feeling positive about themselves and feeling in control of their behaviour. This feeling of confidence is reinforced by how others respond to them:

It's amazing, when ya clear your head out, how differently people respond to you. For example ... We were up at a club, and two friends, that used to be friends until I ... They just didn't really want to know me. ... They could see that I had changed and [it] must just have been in something I was letting out. They come up and they were just stoked, and just the reaction I got from them I thought, well, I want this, you know.

Lindsay, consumer, Detox.

Thirteen consumers (50 per cent) spoke of the importance of being empowered as an AOD consumer in treatment. They want a partnership with the clinician during the treatment process, and suggest it should be a collaborative relationship as they are the ones who know about themselves, not the clinician. Both parties would benefit from partnership:

Because nobody knows me as well as I know me, so I have to have a lot of say in what goes on. I don't know how to explain it. Like for you to tell me something without fully knowing me, you may be totally wrong, so I need to give my input so you know where I'm coming from, that sort of thing.

Cameron, consumer, CBT Rehab.

I don't want to be babysitted [sic]. I want to have my input; not just to be told this is what you do, and this is how you do it. I want to have some of my own input, so at least the counsellors and nurses don't just generalise everyone into one category and [say] this is how you do it.

Mick, consumer, Detox.

Empowerment was not seen as something that is an easy or straightforward process. It was seen as taking a long time to achieve and is an ongoing battle to maintain, but the end goal is viewed as important:

Like with an addiction ... each time I challenge the temptation, I gain power, so it's kind of this lesser self, or this *darker* bit of myself which creeps forward and tempts me. And that is the irresponsible self and if I can go against the temptation, and the more often I do it, the stronger I become.

Helga, consumer, Detox.

Being Disempowered

Being disempowered was most often described as a process that recurs throughout consumers' lives and leaves them feeling failures. Consumers feel disempowered because of their AOD use and also disempowered by AOD clinicians. Thirteen consumers (15 per cent) discussed being disempowered by AOD clinicians; by their attitude, by a lack of qualified staff, and by the rules imposed. Nine consumers (70 per cent of consumers who spoke of being disempowered) commented that this occurs more often in the detoxification unit than any other unit, although it does also happen in other treatment programs, though to a lesser degree. Women consumers feel disempowered in AOD treatment. They feel disempowered by AOD clinicians. They feel disempowered by the AOD treatment programs.

Disempowerment is a recurring theme running through consumers lives. Not being able to trust others was a problem that three consumers (12 per cent) spoke about, and they described how it impacted on their lives and created difficulties when they attempted to commit to relationships:

You know I think if someone's nice to me, they want something from me, you know, because I've always been like that and you know every time I've got something when I was a young kid it was for a price. I still think that way you know.

Mike, consumer, Detox.

If the relationship falters, consumers blame themselves for the failure. They also feel powerless to change the situation. Hence the process is repeated time after time. This blame and related feeling of disempowerment is often connected to a decision to begin AOD use again. Once again, the cycle is repeated and they feel even more of a failure. They feel that they cannot succeed at anything:

My previous experience has been that partners in the past, they've never taken my power away from me, I handed it over, and they've changed me. I've allowed them to change me, to what they want. There's nothing wrong with the relationship in the early stages but once that's changed, the relationships changed, I became weak and I was allowing somebody else to take over my life, or take away my stance and confidence. They probably didn't even realise what they were doing.

Hamish, consumer, CBT Rehab.

There [have] been times I've just wanted to die. I didn't want to control it to live, I didn't want to live, I just wanted to get off this earth, you know, and I can't even succeed in that.

Mike, consumer, Detox.

Consumers feel disempowered for many reasons. Some feel they are disempowered by AOD clinicians. Both men and women experience this, but it is men who speak about the way they are disempowered while residing at the detox unit. Three men (50 per cent) who were in CBT rehabilitation services, spoke of the disempowerment that they experienced while at detox. Consumers feel disempowered by all being treated the same

whether alcoholics or addicts, rather than as individuals with specific AOD problems. They feel that AOD clinicians relate to them as a homogenised group and that their individual differences are not taken into consideration:

... And you were given no empowerment whatsoever, no trust. I don't think they look at people on an individual basis, maybe it's not feasible for them to look at every person individually and rate them, and say oh we can trust this person and this person here needs a little bit more work, or a little bit more direction. But personally I found it quite demeaning actually.

Tim, consumer CBT Rehab.

Consumers are aware that many health workers hold negative views about them and that these attitudes may affect the treatment that they receive, both in AOD as well as other services:

A lot of people have a very bad view, particularly [of] people who are addicted to drugs. I suppose you come into the emergency room looking like death warmed up, or not even warmed up, you must look a terrible sight, and they know or they feel you're going to do it again, so why bother wasting the facilities on somebody who we're gonna see back here next week. It's rush him in, patch him up and throw him back out there anyway.

David, consumer, Detox.

The rules that are imposed in the detox unit are seen as being restrictive and disempowering to the consumer. Consumers feel they are in a no win situation as the rules make no sense to them. If they obey the rules they gain approval, if they question the rules, they gain disapproval. Some consumers struggle with the notion that clinicians know best and attempt to resist or question decisions. They may view the rules with contempt, while at the same time feel forced to follow them:

... You walk into the office; you can see the sign up above the TV and video. No one's allowed to touch the TV and video, only the staff [are] allowed to touch it. But if they're not there, what are we supposed to do?

Walk up here and get them to come down and change the channel for us? And they get the shits if we do. If we touch the TV they'll get the shits about it... It's only one button you have to press. Just stuff like that's ridiculous, I reckon.

Andrew, consumer, Detox.

I haven't been made to go and have a sleep at one o'clock in the day since I was one and a half year old, and here I am at 27 years old and I get made to go to bed at one o'clock and sleep till two o'clock. How ridiculous is that? That's just one thing I can't seem to fathom.

Andrew, consumer, Detox.

Some consumers questioned the rigidity of the rules and they feel that the rules create a dependence on the clinician. This is not beneficial to their self-esteem:

Well to be honest being here, I don't feel empowered at all. I sort of feel reliant on everyone here.

Mike, consumer, Detox.

I just think that the main reason that a lot of us drink is because of low self-esteem and that sort of stuff, and the way I see it, to get your self-esteem back you've gotta be able to do things for yourself. And if they're making you run to them every time you want something, how are you supposed to get your self-esteem back?

Andrew, consumer, Detox.

Although consumers might not like or understand the rules imposed on them, many accepted that they had no choice but to put up with the rules if they wanted their treatment to be successful. They internalise the message that the 'clinicians knows best' because clinicians have information that the consumer is not privy to. Even though some consumers may question or resist, the imposition of these sorts of rules which seem not to have any real safety or therapeutic purpose (where to drink coffee, when to

rest), indeed the very power to be able to impose rules, indicates to consumers where power resides. The structure of care within the institution is giving consumers the message that they are not capable of autonomy and self-regulation.

Consumers within AOD treatment also categorise other consumers. When the dominant group (those who do not have problems with using alcohol and other drugs) marginalises people, those marginalised (those in treatment) begin to take on the practices of the dominant group in a futile attempt to regain some feelings of belonging:

I understand personally that there's a big difference between an alcoholic and a drug addict, we don't really see eye to eye, I know there's a big age group [difference] as well, but I find it very hard to mix with them, they're undisciplined, and have no respect for the staff.

Hamish, consumer, Detox.

As this excerpt reveals, people who identify as alcoholics set themselves apart from people who identify as junkies. This research did not confirm this process occurring in the opposite direction, perhaps because drug-use is linked with illegality, while alcohol plays a prominent role in 'normal' social interaction and so its use, even excessive use, is less stigmatised than drug-use. It is interesting that those who are marginalised, in any way, are able to make fine judgements about the degree of their marginalisation.

Women's experience of disempowerment

Three women consumers (60 per cent) feel disempowered in AOD treatment. This may be related to loneliness and not having anyone available to talk to:

Last night I was very upset, being away from my children over Christmas and New Year and there was nobody to talk to, nobody qualified. I was very vulnerable last night.

Sian, consumer, CBT Rehab.

Sometimes women consumers feel that clinicians are not interested in them putting them down or treating them with contempt. This makes women feel more disempowered and creates anxiety and uncertainty about whether to continue with their treatment regime:

I just think that some of them have got the attitude ... they haven't hit rock bottom and they put themselves up on pedestals. 'You're all low, you're scum of the earth', and they talk to you as if they're preaching to you.

Bronwyn, consumer, CBT Rehab.

Every morning she is right off, [referring to counsellor] I don't know why, and she always **raaagh** and then apologises, and it scares me cause she's my case manager now. And I feel intimidated by her and I really want recovery, but I never can relax.

Jan, consumer, 12-step Rehab.

Empowering Others

Consumers overwhelmingly think that AOD counsellors who are recovering people are best suited to be able to empower others, although some think that certain nurses are also capable. Specific characteristics or skills that they identify in staff as being essential are trustworthiness, a caring attitude, and the ability to build rapport.

Most consumers were unaware that nurses are employed in AOD treatment. Their experiences of nurses are in a general hospital or when detoxifying in a specialised unit. Most, but not all, consumers distinguish between recovering people and those they term 'text book counsellors' (AOD clinicians who were not 'recovering'). Sixteen consumers

(61 per cent) felt comfortable with a counsellor who is a recovering person. They felt that the person 'who had been there' can better understand the issues:

They're both here to help me so I don't differentiate between either nurses or drug and alcohol counsellors. One thing I do think is the drug and alcohol counsellor, most of them are recovering alcoholics or addicts themselves, and I can talk to them probably more easily than I can to a nurse who's more or less a textbook counsellor.

Mick, consumer, Detox.

Conversely though, not all consumers feel it is necessary to have a recovering person as a counsellor. This is reflected by phrases such as, 'he is just one needle away from being a junkie' and 'you don't have to put your hand in the fire and get burnt to know it's hot'. In detox there was only one consumer who did not express a preference for a recovering person as a counsellor. In CBT rehabilitation and the 12-step rehabilitation units nurses are not employed.

The perspective of consumers at Detox, where all but one consumer expressed a preference for recovering people as counsellors, is in contrast to the preference of four consumers who were resident in the CBT program⁵ (50 per cent of all CBT participants). These consumers thought that any counsellor could assist consumers to become empowered and although they did not appear to have a preference for either a recovering person or a nurse as a counsellor, they were marginally in favour of a non-recovering person.

⁵ Clinicians in this unit have studied psychology and to my knowledge, no recovering counsellors are employed there.

Sixteen consumers (66 per cent) thought that AOD counsellors need to have some additional education and training to be able to work effectively in this area:

I find counsellors who've had a drug problem much easier to relate to, rather than someone who's just come out of university. ...they can't really relate to where you're coming from. It's just textbook stuff and I quite often find they don't really understand where you're coming from. ... Probably also having some sort of educational, education or whatever is important as well

Cameron, consumer, CBT.

While nurses and AOD counsellors were viewed as being able to assist or encourage them to become empowered (change their AOD use), the final responsibility for empowerment lies with individuals themselves:

I think the only person who can empower is yourself, they just try and find the problem and stuff that they can't understand.

Paul, consumer, 12 step Rehab.

A consumers needs to be able to trust the clinician and feel valued as an individual. In addition, consumers want to feel that they have some control over the process:

They've gotta be knowledgeable, they've gotta know what they're talking about. I don't know how many times I've asked one counsellor and 'I don't know' and you sit there and wait for 'but I can find out', but it never comes.

Bronwyn, consumer, CBT.

I think trust is the main thing. You can talk to anyone if you feel safe.
Trust!

Johnny, consumer, CBT.

What stops empowerment?

Consumers generally thought that empowerment is positive in spite of them not knowing its meaning. They also discussed some negative aspects such as thinking that alcohol and other drugs are empowering rather than disempowering.

Women consumers described tensions in their relationships with others when they became more self-confident and assertive as they gained control over their AOD use. When they stopped their AOD use, they were faced with how their AOD use had affected their children and this caused them pain and anguish.

Male consumers, like male clinicians, speak about the link between power and empowerment. Finding a balance between the two components is difficult and can result in them becoming too confident and thinking they are able to deal with situations where AOD are being used without having adequate strategies in place. They may also want to control others. If either of these situations occurs, they can feel guilty about letting others down and abusing the trust that others have in them.

Empowered by the drug

Feeling empowered by alcohol or drugs was discussed by almost half (45 per cent) of consumers. Empowerment in this sense is related to the confidence that they feel when they are intoxicated, and consequently, they use more AOD in an attempt to recapture this feeling. These consumers feel empowered initially by their AOD use, but this changes over time, and the empowerment they feel changes to a need for the substance(s):

No matter how hard I've tried I just can't get off it [heroin]. I steal; I do everything I can just totally. I just can't stop doing it. I don't want to do bad things, but I've got to go to court so I'm not sick, so my girlfriend's not sick, so my girlfriend's not using. I'm not going to let her be a prostitute

Paul, consumer, 12- step Rehab.

Six consumers (23 per cent) agreed with clinicians and felt that they were not empowered by the drug although they recognise that this is a common perception.

These consumers explained empowerment by its absence:

...Alcohol doesn't empower you to do things, it disempowers you... but most people think it empowers them. There's nothing empowering about alcohol.

Ralph, Consumer, Detox.

Women and dissonance

Women consumers described a dissonance as they became more confident and gained control over their AOD use. This is viewed as both exciting and positive as well as having the potential to alienate them from some of their family and friends:

Might be a few people who are going to be a bit shocked that I'm finally sticking up for myself instead of letting them walk all over me. That's not negative for me.

Bronwyn, consumer, CBT Rehab.

They also describe experiencing dissonance when they return home after being in a residential unit. Now that they have some control over their AOD use and have made changes in their lives, they find that when they return home they are faced with their children's misbehaviour which they attribute to their previous AOD use:

When I get back home then I feel different, I feel better, and I see my children and I can see little things, or they mention little things, and they haven't changed you see... But I think I become more healthy and I see

how it affects them. I mean I can see those things, and that's how I can see that I have changed, but [also] how my previous behaviour has affected them. So maybe that's a little bit negative. Through my empowerment I'm clearer and I actually can see what I've caused them.

Helga, consumer, Detox.

Tension between power and empowerment

Twelve consumers (46 per cent) felt that empowerment can be misused. They represent 57 per cent of all the male consumers interviewed for this study. No women consumers discussed this idea. The tension between power and empowerment that men refer to can be seen in the following extract where a person may be in a position of authority but misuses this position to manipulate others into performing tasks or activities. This shifts the notion of empowerment into power or control over others:

I don't know if it's actually empowerment. If you're in a position, say, in employment, and you've got power over other people, where you can manipulate people to do things that you don't want to do yourself, sort of thing. It's a two-sided thing for me. I feel there's empowerment over other people and self-empowerment.

Peter, consumer, 12 step Rehab.

Consumers also thought that it was possible to be too controlling of themselves. This might mean that the individual does not take any risks and may end up becoming too rigid and inflexible. This idea again looks at the tension or balance between empowerment and power:

I suppose you could probably get too controlling of yourself. I suppose you've got to be able to relax and enjoy things and let things flow at times, as long as you don't get too carried away with things.

Lee, consumer, 12 step Rehab.

Misusing the trust that others have in a person is another way of describing a tension associated with empowerment. The misuse of trust is related to consumers gaining confidence and feeling that they have some control over their AOD use, and then returning to using and thereby breaking the trust (belief) that others had in them:

Only that if I knew I was going to have people who were going to be empowered a certain extent and they're going to misuse that trust and that empowerment that's been given to them. There again that's not the A and D worker's fault. It's entirely up to that particular person and A and D support is to try to help them to understand.

Tom, consumer, CBT Rehab.

One other way that the tension between power and empowerment is explained is related to becoming too confident. This takes the form of consumers thinking they are ready for discharge and that a return to their previous lifestyle without using AOD to achieve their goals will be easy:

Maybe it could go to your head and you could have a great life, with a really great looking girlfriend, you could have a really hot car and big houses, and maybe it all could go to your head, and you'd be looking down on people. I suppose that's a negative outcome.

Lee, consumer, 12 step Rehab.

Conclusion

Both male and female consumers of AOD treatment feel out of control with their substance use. All of the consumers interviewed want to gain some semblance of control over their own lives. They all desire to be the same (normal) as others and to possess what they see as the normal things in life, such as material possessions, a job, their own transport, relationships that are not dependent on drug use, good health, control over their emotions and not having to commit crimes to support their AOD use.

Women consumers feel particularly disadvantaged by being out of control. They feel that they spend a lot of their lives doing things for other people and putting their own needs second, which adds to their feelings of being out of control. It is harder for them to access treatment because of the arrangements that they need to make for their children, and when in treatment they worry about their children's welfare and feel isolated from them. In addition, they may find it difficult to seek help because of the guilt and shame they feel as victims of abuse.

Women spoke about wanting to be good mothers and they discussed the impact that their AOD use had on their children for whom they craved stability. Even when they were using AOD they tried their best.

All consumers want to make changes in their lives for a variety of reasons, though all link to control. For most, the need to change is a gradual realisation that occurs over time, but for some there is a dramatic incident that prompts the change. All consumers had considered making changes long before they eventually attempted to. Even those consumers who have been ordered by the court to undergo treatment wanted to change their AOD use and are relieved to be directed to AOD treatment.

Empowerment is an unfamiliar term to consumers and although they do not know its meaning, it is something that they think is desirable. They relate it to their own circumstances and equate it with gaining control over their AOD use. It is acknowledged that it could take a long time for this to occur and that the process would not necessarily be an easy one.

Although consumers do not know that there is a stated philosophy of consumer empowerment in AOD treatment, they want to feel included in their own treatment goals and to work in partnership with the clinician. They do not want a passive role in their treatment regime.

Consumers feel disempowered. They feel disempowered by their need to obtain AOD, which often leads to them seeking treatment. In addition, when they are in treatment they sometimes feel disempowered by the clinician's attitudes, by the rules imposed on them and by feelings of mutual mistrust. This impacts on how they feel about themselves and whether they will continue with their treatment. Most consumers who discuss disempowerment in AOD treatment refer specifically to the detox unit. Only a few had experienced disempowerment in other treatment centres. It is women consumers who speak of being disempowered in other residential treatment centres.

Consumers generally think that recovering people are better placed to be able to empower other people because they understand what the consumer is going through. However, the downside with recovering counsellors is that there is a risk which is reflected by the saying 'He/she is only one needle away from being a junkie'.

It is also felt that other counsellors and nurses can empower consumers but they are viewed as somewhat inferior as they 'learn through textbooks' rather than through life experience. Empowerment is the responsibility of the individual and while another person can aid or assist in another's empowerment, it is ultimately up to the individual.

Consumers think that having specific characteristics and skills is more important than having a 'professional background' These skills are identified as having a desire to empower others, maintaining trust, being caring and trustworthy, having insight into others problems and being able to build rapport.

Although empowerment is viewed by consumers as something positive and desirable, (even though initially they did not know the meaning of the term) it is also acknowledged that there are tensions associated with it. These tensions are evident in the notion that consumers feel empowered and at the same time, disempowered, by AOD.

Women consumers discuss feeling confident and in control, and then returning home and being faced with some behaviours displayed by their children which was related specifically to their previous AOD use. Compounding this, they also feel that others may not like the changes that they had made in becoming more assertive, and this has the potential for some negative impact in their relationships.

Male consumers are more likely to discuss tensions between power and empowerment. They feel that it is not an easy balance to find, and that there is always a tension between being empowered personally and using that empowerment to gain control over others. They also feel that it would be easy to become too self-confident, many believing they could deal with specific situations before being fully ready. This can have a negative impact and misplaces the trust that others have in them.

CHAPTER EIGHT

DISCUSSION

Introduction

This research is concerned with issues of power, control and empowerment in alcohol and other drug (AOD) treatment. Institutional influences and the perspectives of clinicians and consumers have been presented in the previous data chapters. In this chapter I present the main findings of this study and discuss them using a Foucauldian analysis. These findings are summarised below.

1. Rhetoric is about the art of oratory, and broadly speaking is a style designed to appeal to the emotions rather than reason. The style or diction can be elaborate but often insincere (The Australian Concise Oxford Dictionary 1992). Although clinicians use the term empowerment in their explanation of how they implement their treatment regime, when analysed it become clear that in fact it is compliance that they describe, not empowerment. In other words, it is a contradictory discourse and as such is described as 'the rhetoric of empowerment'.
2. Institutional arrangements work against empowerment ever happening. Clinicians are afraid of losing power and employ discursive practices which serve to maintain their position and reinforce their notion of 'truth'.

3. The major value underpinning practice is not empowerment, but control. Clinical practice is concerned with who has control, who wants control and how control is maintained.
4. The real purpose of treatment is to make people normal. Both clinicians and consumers appear to accept this, and this belief is reinforced by the overlapping roles of the health and the criminal justice system.
5. Women in AOD treatment are particularly disadvantaged. They face more difficulties in accessing treatment than men do. The still dominant 12-step abstinence philosophy was designed *for men by men* and the organisational structure of many treatment facilities is geared more towards the needs *of men*.
6. AOD clinicians feel disempowered by the attitudes of other health professionals, by members of their own multi-disciplinary team and by clinicians from disciplines other than their own. Added to this is the volatile and political nature of AOD policy and treatment, which compounds their feelings of disempowerment.

These findings are discussed separately using the frames of power identified by Michel Foucault which were presented and discussed in detail in Chapter Three. These frames of power are used to illuminate, explain and make sense of each finding. Foucault explores power from the macro level such as societal, political and structural influences, down to the micro-level, which includes individual characteristics and attitudes of consumers and clinicians, and in which I have included treatment philosophy. Each major finding is linked to the others, and while I have attempted to deal with each one

separately, given the circular nature of power and the intertwining of knowledge, it is not entirely possible. Finally, conclusions based on the analysis of the findings are presented, including a critique of the usefulness of Foucault's work to this area of practice.

The rhetoric of empowerment is used to convey the 'truth'

When consumers were asked what empowerment meant to them, most were not familiar with the concept, although they did attempt to extrapolate meaning from the word and guessed that it had something to do with having power, using power or power over others. Clinicians, on the other hand, were familiar with the word and the concept, and readily gave definitions and examples of how they used the concept in practice. The data chapters show that empowerment has different and personal meanings for each individual and this is supported in the literature on empowerment. The following authors, who were presented in the literature chapter, have discussed this perspective (Rappaport 1987; Gibson 1991; Hawks 1992; O'Neill 1992; Matzat 1993; Jewell 1994; Sines 1994; Gilbert 1995; Sheilds 1995; Ritchie 2001). However, when the use of the concept was analysed in this study, it became clear that clinicians were in fact describing compliance, rather than empowerment. They believe that if consumers obey the rules, follow the clinicians' directions and do not question or challenge them, (in other words, comply), then they will be able to control their AOD use and thereby become empowered.

Although clinicians are inconsistent in their definition of empowerment, they are consistent in describing compliance. AOD treatment is geared towards ensuring that this happens and discursive practices are enacted to support compliance. Consumers are

not familiar with the term empowerment, but through clinicians' discursive practices which are supported by institutional and organizational strategies, consumers will defer to the 'authority of the scientific/medical discourse from which their [clinicians] expertise is both derived and in turn legitimated' (Cheek 2000, p.24).

One way to begin to make sense of, and to understand what is happening in AOD treatment is through analysing discourse. The notion of discourse is important as it provides a useful starting point to analyse the 'taken-for-granted' nature of reality. The dominant discourse tries never to speak its own name; its authority is based on absence. The absence is not just that of the various groups classified as 'other', although these groups are routinely denied power. It is also the lack of any overt acknowledgment of the specificity of the dominant culture in any given society, which is simply assumed to be the all-encompassing norm (Ferguson 1990; Chater 1999).

Empowerment is a concept that is in part politically motivated and plays a strategic role in the provision of health. It has entered the discourse of AOD clinicians, but not consumers, and for empowerment to be implemented (if indeed it is possible), it means that there must be a shift in the way that power is conceived. For AOD clinicians this means they must let go of (redistribute) some of the power that they hold, because while the words have changed, the discourse within AOD treatment remains the same.

A fundamental feature of discourse is that the words used and their meanings depend on who uses them and with whom. Therefore words differ depending on the social and institutional settings (Jupp and Norris 1993). Foucault (Foucault 1980) does not consider that discourses in themselves are true or false, but that each society (in this

case AOD treatment agencies) has its own mechanism for deciding what counts as truth. Truth is not outside power. The 'truth' which AOD clinicians hold is that consumers must comply with the strategies and practices of clinicians because clinicians 'know what is best' for the consumer. For them, empowerment is the rhetoric used to convey this 'truth'. There is an unquestioning acceptance of discourses and practices by both the clinicians and the consumers, and dominant discourse is 'a particular form of power that its wielders are often sadly unconscious of' (Davies 2000, p.20).

There is a multiplicity of discourses operating at any one time and they may be competing with each other as they offer different ways of explaining the world and legitimising truth (Cheek, Shoebridge et al. 1996). People mobilise a variety of discourses within different contexts and for different purposes, and can move between the different subject positions available within these discourses. These various discourses which often overlap may complement each other, or they may oppose each other. For example, in contemporary health care practice, there is an emphasis on 'self-responsibility'. Individuals are encouraged to accept responsibility for their own health by maintaining a healthy body; that is, having regular exercise and eating and drinking in moderation. Health promotion activities and media advertising reinforce the emphasis on self-responsibility. However, in AOD treatment, consumers are told (by the 12-step philosophy and reinforced by clinicians) that they are *unable* to be responsible and must give their 'power' over to a higher being, thus creating a contradictory discourse.

The discourse of empowerment is also a contradictory discourse. In the wider, more general use of the word, empowerment is concerned with sharing power, or giving back power, yet in AOD treatment, the discourse of empowerment is concerned with compliance.

The way that discourse is reinforced by action and practices is known as ‘discursive practices’ (Danaher, Schirato et al. 2000). It is through discourse and by discursive practices that new discourses are ‘spoken’ into existence and people actively produce social and psychological realities. In this context, a discourse can be understood as an institutionalised use of language ‘which can occur at the disciplinary, the political, the cultural, and the small group level’ (Davies 2000, p. 88). Discourses and discursive practices can also develop around a specific topic such as gender or AOD treatment. It is through discourse and discursive practices that AOD clinicians are shaped, and their associated norms and values are carried into forming part of their everyday roles. AOD clinicians are attached to what Foucault calls ‘an apparatus of truth’ (hospital). Truth is linked in a circular fashion with systems of power, which produce and sustain it (Strawbridge 1993). Foucault uses the term ‘scientific classification’, as outlined in Chapter Three, to refer to the way that the institutionalisation of knowledge is generated to provide evidence of the supremacy of the dominant group (clinicians).

AOD treatment is concerned with ‘normalising’ consumers, and clinicians have a variety of strategies that they use to ensure that this occurs. Procedures are developed that try to ‘normalise’ the consumer within the clinical context (Anderson, Elfert et al. 1989). This has the effect of sanctioning, reinforcing and legitimising the discursive knowledge represented in both AOD clinical practice and the notes written by clinicians

about the consumers. The consumer can then be seen as a passive recipient, a 'docile body' that can be transformed into something that is manageable (Berg 1996). The consumer is represented as a set of issues or problems that requires intervention and monitoring.

Becoming normal can only be achieved if consumers are compliant, and one way that clinicians encourage compliance is through the rhetoric of empowerment. Discursive practices ensure that clinicians do in fact hold the same understanding of empowerment and they use measures to ensure it (compliance) is implemented; hence, the discursive position is maintained. AOD discourse and discursive practices are supported by institutional practices and organisational strategies. The daily program implemented in AOD treatment is an organisational strategy structured around the clinicians' understanding of the 'disease' and its treatment. This approach enables clinicians to organise their interactions with consumers and to define what can or can not be said and what consumers are allowed or not allowed to do. The daily activities are shaped by the discursive frames of the clinicians, and these institutional practices make it possible to construct 'difficult consumers' (those who question or challenge the rules, do not comply and are labelled as 'damaged') who do not fit the 'normal' mode of behaviour expected from them. In addition, these discursive frames enable clinicians to describe compliance (which is the unwritten rule of AOD treatment) when they think they are describing empowerment.

Empowerment has not entered the discourse of consumers, although they might see the word written in agency material such as in mission statements and philosophies. AOD consumers will defer to clinicians, as they (AOD clinicians) are seen to have the

authority to speak about AOD issues (scientific classification). The powerful discourse of compliance which, is couched in the rhetoric of empowerment, can have the effect of limiting other ways of thinking and talking about the same phenomenon becoming yet another example of the way in which ‘discursive practice’ (Davies 2000, p.88) actively produces social and psychological realities.

Empowerment does not happen

Because the discourse of empowerment is reduced to rhetoric and consistently integrated into AOD practice as compliance, it comes as no surprise that empowerment is not happening. The discursive practices in AOD treatment reinforce the priority given to compliance.

Michel Foucault’s work is focused on his problematisation of knowledge and, as discussed in detail in Chapter Three, he argues that knowledge and power cannot be separated. A Foucauldian analysis can be used to question and explore the relationship between power and knowledge, and how such a relationship is embedded in contemporary AOD treatment.

In Foucault’s analysis of discursive frameworks, which he suggests both constitute and manufacture meaning, the interplay of power, knowledge and discourse is understood (Foucault 1984). He conceptualises the interplay between them as dynamic, and power actually works to produce reality. Foucault asserts that the production of discourses according to certain procedures simultaneously controls, selects, organises and then reorganises them. All individuals in society (in this case AOD treatment society) are ensnared in a network of power, often so subtle that they are unaware of it. Foucault

locates power outside consciousness or intentional decision, and clinicians, like consumers, remain unaware of this whole process because of the very subtle and pervasive nature of power and its relationship. Clinicians and consumers are thus caught in the web of power.

The circular nature of truth, which is defined by the dominant discursive structures, results in power, which in turn is used to produce more truth. Power gives individuals the right to ask questions, give answers and be the purveyors of truth. However, individuals working within dominant discourses are more likely to limit the possibilities of what questions can be asked and, to some extent, control the answers. In AOD treatment, the clinicians are the group with knowledge and, consequently, power, and through discourse and discursive practices they are able to produce more truth ensuring that the truth as they understand it is constructed and maintained. By continuing with the rhetoric of empowerment to describe compliance, clinicians serve to reinforce their own dominance and maintain their power; in fact they (unwittingly) ensure that empowerment for consumers does not eventuate.

Institutional practices are in place to serve AOD clinicians and the continuity of 'truth'. The dominant treatment modality (12-step approach) has remained constant, and one major function that it plays is to add weight to the belief that the consumer is out of control and needs to gain control (become normal). In addition, the consumer is viewed as not able to be trusted because of AOD use, and must hand over 'power' to a higher being. AOD clinicians, like priests, take on this role because they have authority vested in them through their position as clinicians. Once again, 'truth' results in power and power produces more 'truth'. Consequently, empowerment does not happen because

AOD clinicians' main concern is to 'normalise' consumers and to maintain their own position as the ones with power. AOD clinicians construct and maintain the discourse ensuring that they have the power to define the very notion of truth itself (Fox 1993c).

Major value actually underpinning practice is not empowerment, but control

Foucault puts forward the notion that modern societies control their populations by sanctioning the knowledge, claims and practices of 'human sciences' (Foucault 1972; Foucault 1977). AOD treatment operates as a micro-society with clinicians in control. Foucault suggests that the relationship between power and knowledge can be seen in modern forms of governance. Government in this way refers to all of the tactics, strategies and means that shape the beliefs and the conduct of populations.

Governmentality is the term Foucault uses to describe the changes in technology and attitudes towards governing, which developed in Europe in the 18th century. It entails the surveillance and disciplining of both individuals and entire populations. Citizens are both regulated by the state and its institutions and discourses, and educated in order to monitor their own behaviour (Foucault 1991). Surveillance and discipline operate at the macro-level and at the micro-level.

Being able to classify, measure and regulate populations that are a social threat to the prevailing order is seen as important. Burman suggests that contemporary psychology, which is concerned with categorisation, fulfils the middle class's desire to classify that which it does not understand and to bring it under surveillance in an attempt to control it (Burman 1994). By perceiving individuals in this way, it fails to take into account the

context of their lives and can lead to individualistic interpretations of socially constructed behaviour. This inexplicably leads to 'victim blaming', and the behaviour itself becomes responsible for many of the social problems in the world. Legislation may be developed to 'address the problem', such as that which prohibits individuals consuming alcohol in public places. The consumption of alcohol by people in a public place, such as the street or in a park, means that such people are positioned as dangerous to society and as such require 'treatment' or locking up. They are perceived to undermine the power and control that government believes is needed for the smooth running of the country.

Foucault uses the terms 'pastoral power' and the 'shepherd-flock game' as a metaphor to imply that the aim of government is to promote the well-being of its subjects by means of detailed and comprehensive regulation of their behaviour (Hindess 1996). It is possible to translate this metaphor to AOD treatment. The notion implies a relationship between the ruler (AOD clinicians) and the ruled (AOD consumers) which is more intimate and continuous, with consumers revealing their innermost thoughts and being reliant on clinicians, in some cases, for twenty years or more. Inherent within this metaphor are three central points. First, the shepherd (clinicians) governs a flock and each of its members, rather than as a group of individuals (consumers) in a territory (individual treatment agencies). Secondly, the flock exists in, and through, the activity of the shepherd; if the shepherd is removed, the flock collapses into a mass of individuals. Thirdly, the shepherd cares for the flock both individually and collectively; thus, the shepherd is responsible for the welfare of the flock, while at the same time creating a dependency for survival (AOD treatment) on the shepherd (AOD clinician).

Furthermore, Foucault suggests that Christianity modified the earlier Hebrew shepherd-flock metaphor to appropriate self-examination through the use of the confessional and other means to expose the individual to more effective guidance and observation.

Individuals are trained in the exercise of self-government (through the confessional of AOD treatment and AA/NA), and AOD clinicians maintain law, order and control by policing and encouraging confession. Control is maintained by AOD clinicians at the micro-level by surveillance, discipline, confession and by scientific classification.

Scientific classification, described in detail in Chapter Three, refers to the generation and institutionalisation of knowledge that exaggerates or mythologises the difference between groups, and thus provides evidence of the supremacy of the dominant group which allows this group to be more powerful than another and to maintain that supremacy. Those who are seen to have power stick together, and others reinforce this superiority. This can be seen in comments made by psychologists about nurses or comments made by nurses about AOD clinicians and exemplified by Wendy on p.165 where she describes how the staff joined ranks and swept the consumer's concerns 'under the carpet'.

The purpose of treatment is to make people normal

Consumers state that they want to be 'normal'; that is, they want to have what others have. Not only do AOD treatment consumers aspire to be normal, AOD treatment itself is also geared towards 'encouraging' consumers to conform and become normal. There are 'normal' ways of practising health care and treating disease and illness. Clinicians use a variety of strategies to ensure that consumers become compliant with the

unwritten treatment goal (to become normal) and these strategies are reinforced and monitored not only by health institutions, but also by the criminal justice system.

Foucault (Foucault 1977) uses the term ‘normative judgements’ to assess and monitor the actions and attitudes of people according to a norm or average. AOD consumers fall outside the ‘norm’ as their behaviour (actions) creates difficulties for the ‘social body’ (wider population) which then becomes perplexed about how to deal with them. They have been identified as having violated some social norms. These social judgements (normative judgements) work throughout various institutions such as schools, prisons and hospitals, as well as throughout the ‘social body’ to divide the normal from the abnormal (Danaher, Schirato et al. 2000). People are categorised into distinct groups (those with AOD problems are abnormal, and those who do not have a problem are normal) through a process which Foucault terms ‘dividing practices’.

Dividing practices are described in detail in Chapter Three. They serve to further reinforce that those who are considered ‘abnormal’ need to be brought back into line with the dominant group. Dividing practices are those that differentiate one group of people from another (Foucault 1975). The most effective dividing practice is the confinement or exclusion of a group based on their differences. This is most often seen in the labelling of people using binary opposites such as sane or mad, healthy or sick, good or bad, clinician or consumer. There is a tendency for one of the pair to be thought of as normal and the other to be a dependent term that takes its meaning in the difference. The first term can be thought of as ‘privileged’, and is often equated (although unstated) with ‘humanness, normality, and the way anyone would be and could be if they were not ‘different’, that difference being understood as a deviance

from the ascendant term' (Davies 2000, p. 108). It is a deviance that AOD consumers are not necessarily able to correct because their category membership may specifically preclude the behaviour which is defined as normal for those positioned in the ascendant category. Dividing practices work to qualify or disqualify people as fit and proper members of the social order. This is illustrated by Ron (p. 142), where he describes how AOD consumers are perceived 'as nothing' by clinicians working in a general hospital.

It is not only the health system that operates 'normative judgements'. In AOD treatment, the legal system overlaps with the health system, and governs AOD consumers as well. In addition, religious organisations such as the Salvation Army and the Catholic Church are involved because they offer shelter and treatment to individuals affected by their AOD use. Public authorities or institutions, such as hospitals, are tied up with notions of 'truth'. Individuals within these agencies draw their authority from their capacity to speak the truth about some situation, such as the positive and harmful effects of alcohol on the individual, or the 'best' way to treat someone with AOD problems. Because of this 'recognised authority', and ability to 'speak the truth', the notion of the clinician being in control and knowing what is best for the consumer is perpetuated. If consumers comply with the rules and regulations instigated by the clinician, they will be able to regain control and become part of the 'norm' rather than being outside of it and viewed as social deviants. Because most people do not want to be viewed as 'deviants', they accept the normative values that are supposed to make them 'good' citizens.

Foucault (Foucault 1975) was particularly interested in the emergence of the clinic as central to health care, which became possible because of the disease-based model of

health care. He perceived the clinic as institutionalising the medical gaze (Foucault 1975). By this he is referring to the way in which the total package of disease, illness and the provision of health care is conceived and implemented. By focusing on the body, Foucault is concerned with power at the micro-level, and he specifically distinguishes his approach from other studies of power which focus on the dominating role of important individuals and institutions, but fail to address power in the everyday interactions and aspects of daily life and routines.

The institutional gaze, which Foucault perceived as an extension of his ⁶metaphor of the panopticon, may take the form of evaluating consumers in terms of their bodies, their behaviours and/or their attitudes. It can involve routine questioning regarding how they are feeling, what they think about their AOD use, what they regard as the good things and not so good things about their AOD use (Prochaska and Di Clemente 1986), and so on. It can also take a more intrusive form such as blood tests, liver function tests, and neurological tests amongst others to determine the degree of damage that can be attributed to an individual's AOD use. Biomedicine acts as the most privileged knowledge of the body as the results are always measurable, quantifiable and able to be compared to the norm. The AOD user is examined, scrutinised and becomes the object of the health professionals' gaze. The consumer's use of AOD is questioned, analysed and compared to the 'national norm' (quantified as standard drinks and, therefore, able to be measured). The results of the various pathology tests provide evidence that their AOD use is abnormal and reinforces clinicians in their belief that they are justified in their efforts to normalise consumers.

⁶ Explained in detail in the literature chapter and defined in the glossary of terms

The health professional's goal is to encourage the consumer to alter or cease AOD use and to conform to 'normal patterns of behaviour'. AOD health workers stand in for the doctor in performing this monitoring role and therefore become 'embodiers of the gaze' (Foucault 1975). Foucault asserts that this has become possible and desirable because of the discursive frames that operate. These discursive frames include the rules and regulations as well as the discursive language of health and illness, including that which supports the moral perspective of AOD use. For Foucault, 'our thoughts and actions are influenced, regulated and to some extent controlled by these different discourses' (Danaher, Schirato et al. 2000, p.31).

Residential AOD treatment areas become a micro-society within the larger society, with its own experts (doctors, nurses, psychologists, AOD counsellors), hierarchies (alcoholics versus drug addicts; men versus women), codes of conduct (no drinking or drugging), protocols (no visitors for a prescribed period of time) and procedures (all consumers will attend AA meetings). In addition, they have their own internal 'legal' system, where consumers will be punished if they break the rules (refused further treatment until a set period of time has elapsed, or being negatively labelled by being categorised as difficult, non-compliant or brain damaged), and good behaviour will be reinforced (being given extra privileges by clinicians 'bending the rules').

AOD clinicians are also expected to identify with their professional organisation and workplace; to support and espouse the values, discourse and ways of doing things peculiar to specific treatment agencies. This may be seen in the unquestioning support of a particular treatment philosophy or by enforcing rules and regulations which do not

appear to make much sense to them and even less sense to consumers; all of which are used to enforce compliance and to normalise consumers.

Women are particularly disadvantaged

Women consumers are particularly disadvantaged in AOD treatment. They feel guilty because of the impact that their AOD use has had on their family, in particular the impact on their children, and they feel that they have little control over their own lives. Furthermore, they are faced with the unspecified or covert expectations of the general population as to how they should act, and be able to control their AOD use to fit the ‘norm’ of how women and mothers should be. Women consumers, like their male counterparts, want to be ‘normal’.

It is difficult for women to make the decision to seek treatment and to access treatment because of the arrangements that they need to make for their children’s care. There are not many treatment centres that cater for mothers with children. Added to this, residential treatment facilities are often situated a great distance from where they reside and when women do access treatment they worry about their children’s welfare, feel isolated from them and, as discussed in the literature (Copeland and Hall 1992; Copeland 1994; Broom 1994a; Broom 1994b; Thomas 1995; Swift, Copeland et al. 1996; Ezard 1998), are consequently more likely to leave treatment without completing the program. Compounding this, the treatment program is geared towards the needs of men, rather than being individually tailored or tailored to meet the needs of women. This is in part the result of history, when treatment centres only catered for males and the AA model was designed by men for men.

Whilst tensions exist between feminism and the theories of Michel Foucault, specifically related to his own lack of interest in gender, his work goes part way in answering why women are disadvantaged in AOD treatment. His work proposes new ways of understanding the control of women, especially the control of bodies. It is Foucault's notion of 'the body' as the centre of where power relations are manifest. He insists that the body must be viewed as an historical and culturally specific entity (Bartowski 1988). One of the most important contributions that Foucault made for feminism is the way he conceived the body without a fixed biological essence. A biological essence results in the oppression of women because it is the edifice on which gender inequality is built and legitimised. 'The idea that women are inferior to men is naturalized and, thus, legitimized by reference to biology' (McNay 1992, p.17). Not surprisingly, he has been criticised by some feminists for failing to treat women differently to men (Bartky 1988; Hartsock 1990).

Foucault's theory of discourse and power does allow a different analysis of patriarchal power relations. He did not define the body in terms of biology; the body itself is objectified. In addition, his notion of power /knowledge and disciplinary processes, all of which are historically located, enables and constrains individuals to behave in a certain manner (Manias and Street 2000). By following this frame, it is suggested that sex and bodies can be seen as social productions, thereby allowing the possibility of multiple social identities, rather than being confined to one truth about who we are.

Feminists take the patriarchal structure of society as their starting point. ('The term *patriarchal* refers to power relations in which women's interests are subordinated to the interests of men' [Weedon, 1987, p.2]) Patriarchal power rests on the social meanings

given to biological sexual difference. In patriarchal power, women are defined in relation to a norm, which is male. Feminists and Foucault begin to disagree at this point.

Although many women may have problems with their use of AOD, it is still, in many instances, not spoken about. This may in part be due to a discursive frame that shapes the seeking of assistance, namely, that of individual responsibility for health. This discourse draws on 'common assumptions about the role and nature of the individual within contemporary capitalist society in the west' (Workman 1996, p. 71).

Such discourse is concerned with taking responsibility for one's own AOD consumption. The number of standard drinks contained in each alcohol container is labelled, there are health warnings on cigarette packs, health promotion messages detailing links between breast cancer and alcohol consumption are disseminated, television and radio advertisements detail the risks of drinking and driving and every household in Australia has recently (2001) received a booklet from the Federal Government, detailing the dangers of illicit substance use on young people.

With all of this, women (and men) learn how to monitor or 'police' themselves and each other, which culminates in the development of a 'compliant docile body' that is characterised by the desire to attain the 'norm' in AOD use. The docile body is an outcome of the 'increasing rationalisation, organisation and homogenisation of society in modern times' (Hoy 1986, p.131), where everything is seen as a commodity that can be quantified, rationalised and purchased. As Jane Kenway says, 'the New Right is

conducting very moral surveillance over an increasing number of aspects of civil, economic and political society in Australia...' (Kenway 1990, p.168).

The focus is on individual responsibility for health, and when a woman falls outside the norm, she is blamed and the context of her AOD use is not considered. Women want to be 'normal', and when they fall outside that norm, it becomes difficult for them to seek treatment. It becomes increasingly difficult to hand over one's self for treatment, or to 'grass' on a friend and admit to having a problem with AOD use that they or their friend have.

Another discursive frame that operates simultaneously with that of 'self responsibility' is one which is instigated and supported by the liquor industry itself. Advertisements depict women as popular, glamorous and stress-free with a drink in their hand. These circulating discourses add to the dissonance that women may feel about their AOD use, and, in turn, make it more difficult for them to seek treatment:

There is not, on the one side, a discourse of power, and opposite it another discourse that runs counter to it. Discourses are tactical elements or blocks operating in the field of force relations; there can run different and even contradictory discourses within the same strategy; they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy (Foucault 1979, p.102).

Surveillance techniques have become a fundamental part of life. Part of our socialisation influences us to become the subject of our own gaze and we are constantly monitoring our own action, bodies and feelings (Danaher, Schirato et al. 2000). There is a gender dimension to this authority of the 'gaze'. Women have been positioned as desirable objects of a male gaze (the dominant gaze), and this has led to a fundamental

assessment of how women are valued (and how they value themselves), particularly in relation to how they look. The gaze of surveillance as the gaze of power has been internalised. 'Women have internalised the hearing and visual gaze of an objectified other' (Johns 1999, p.243). Women in AOD treatment are no different to women anywhere, and they constantly compare themselves and measure themselves against the norm, which is determined by discursive practices.

Subjectivity, a term used to describe and explain identity, is the product of discourses, ideologies and institutional practices. The discursive constitution of subjectivity begins at birth and is constantly repeated throughout life:

Subjectivity works most efficiently for the established hierarchy of power relations in a society when the subject position, which the individual assumes within a particular discourse, is fully identified by the individual with her interests (Weedon, 1987, p.109).

Women 'learn' how they should behave and act. When they fall outside the socially constructed 'norm', they are labelled as deviant, and sanctions (displeasure, isolation, being directed to undergo AOD treatment) are imposed to restore order. The ideal (subjugated) image of self has not met the expected standards. When this occurs, women in AOD treatment feel guilty. Guilt also serves to be self-regulating (Gastaldo and Holmes 1999) and the process of self-surveillance is perpetuated. Consequently, women, through the process of self-surveillance, become their own gaolers.

Foucault uses the term 'games of truth' to describe a set of procedures that leads to a certain result which, based on these procedures, may be considered valid. These games of truth are important as they help produce our subjectivity. The rules governing these games are not written down, but they involve *mores* and expectations of behaviour, and

consequently, how we view ourselves. For women, the rules governing their behaviour are in relation to males, and the submissive and nurturing role that they are expected to perform. In addition, there are games of truth around women and AOD use. Many women are unable to question these rules, but struggle to accept them, and in doing so believe that they alone are responsible for their predicament and that they are failures if they do not 'measure up' to the male standard or norm.

Although Foucault's work is useful in explaining most of what appears to be happening in AOD treatment, there are still some situations which are not fully explained by his work. His notion of power, subjectification and the body is useful in explaining how power works to subjectify, but it fails to fully take into account and explain the dominance of women by men. Nancy Hartsock (Hartsock 1990) amongst others, raises the concern that by concentrating the focus on the micro-politics of power, Foucault shifts the focus away from the important larger patterns of power or domination. She goes further and suggests that his notion of power undermines any possibility for social change. For Hartsock (1990), change cannot occur if Foucault's concept of power is accepted, because his ideas obscure the importance of gender oppression. If 'blocks' of people cannot possess power, then how will women ever be able to have their perspectives validated against the patriarchal dominance of men?

Sandra Bartky (Bartky 1988) argues that Foucault's treatment of the body as an undifferentiated or neutral gender is inadequate, because it fails to explain how men and women relate differently to the institutions of modern life. She argues, as do others such as Giddens (Giddens 1984), that the concept of disciplinary power that is generalised from an analysis of the prison, a total institution, fails to take account of social

institutions which do not operate in this way. Bartky also criticises Foucault for positing that the female body seems to possess no specificity apart from the male norm and that by accepting this and remaining silent, the very act of remaining silent reproduces a conspiracy undermining women in a supposedly gender-neutral social theory. Certainly, it seems that Foucault's work cannot fully explain why women's experience is different to men's, and why men continue to be more dominant. Sandra Bartky goes on to say that:

Foucault is blind to those disciplines that produce a modality of embodiment that is peculiarly feminine. To overlook the forms of subjection that endanger the feminine body is to perpetuate the silence and powerlessness of those upon whom these disciplines have been imposed (Bartky 1988, p. 64).

Dean MacCannell and Juliet Flower MacCannell (MacCannell and MacCannell 1993), from their study of women who have been victims of male violence and assault, question the neutrality of Foucault's analysis of power, and the utility of his distinction between power and force. They argue that while Foucault suggests that power, through its capillary action, allows the possibility of resistance, he fails to explore that through resistance, capillary power may be backed up with capillary violence, and that violence is backed by force, which in turn may be backed by wider systems of authority. For example, of the five female consumers interviewed for this study, only one spoke of being the victim of sexual violence (rape), although studies consistently show women in AOD treatment have a higher than average incidence of being victims of sexual abuse (Woodhouse 1992; Long and Mullen 1994). In a recent study of Australian women in AOD treatment, nearly three quarters of them reported a history of physical or sexual assault (Swift, Copeland et al. 1996). Although rape is a criminal offence, the victim in my study felt unable to report it or even discuss it with friends and family because of

the wider sanctions; that is, she felt that she would be ostracised and blamed because she had a problem with alcohol use. This is an example of capillary power (male) backed up with capillary violence (rape) and backed by wider systems of authority (widely held attitudes about women who have problems with their AOD use).

Ramazanoglu and Holland (Ramazanoglu and Holland 1993), in their work about young women and sexuality, argue that whilst Foucault did acknowledge men's exercise of power over women, he denied that men, as a block, held power. Foucault did not see this as a problem, since he thought that women (or other 'subordinate' groups) could destabilise power by seeking and shifting specific points of resistance. Ramazanoglu and Holland argue that he did not speak from women's experiences of having power exercised over them, and that he did not see it as his role to specify political actions for those who might resist. They suggest that there has been insufficient analysis of what they term the 'middle ground' of power relations, between the micro-politics of struggles around bodies, and the deeply entrenched male privilege throughout social life.

While there may be limitations to the application of Foucauldian analysis in AOD treatment, the legacy of Foucault's work lies in the challenge it poses to accepted practices such as within health care. Although Foucault's gender neutrality and his conception of power raises many more questions for feminists, it does allow the possibility to explore power from a different perspective. Diamond and Quinby (1988) identify four areas on which feminism and Foucault agree: both identify the body as a site of power, both view power as local, both emphasise discourse and both criticise humanism's privileging of the masculine and its proclamations of the universal

(Diamond and Quinby 1988). The areas where difference becomes obvious is related to feminists' necessarily political nature of working towards ending the oppression of women and their commitment to the conception of a subject capable of moral and political agency, not of a subject 'seemingly incapable of moral and political agency' (McLaren 1997, p.109).

McNay (McNay 1992) suggests that while it is correct that Foucault should be criticised for failing to pursue the implications of his theory of the body in relation to the issue of sexual difference, there is a danger that by placing too much emphasis on the different strategies by which women's bodies are disciplined, one ends up by positing a separate history of repression for women. She suggests that this could create an artificial polarisation between the experience of men and women. Of course, this position is itself open to debate. Women and men do have different experiences, and women's historical accounts of events are different to men's, and history itself is written from a gender biased (male) perspective. However, Foucault does offer another perspective based on a gender-neutral frame. By doing so, Foucault challenges how traditional ways of thinking produce their own dominating tendencies that are more oppressive than liberating (Manias and Street 2000).

Although Foucault's work fails to fully answer questions of inequality and differences between women and men, neither do the other theories of power referred to in the literature chapters, although they, too, go part way. Gender oppression cannot be understood in isolation from class oppression or racial oppression (Bartky 1990), nor can it be understood completely from a sociological perspective, such as that offered by Giddens (1997) because gender oppression is so complex that no one perspective can

fully explain it. While Foucault's theories on power as a capillary action and the objectification of the body do not completely satisfy feminists' questions, it certainly allows for different possibilities by allowing exploration at the peripheries (micro-level exploration) rather than as all inclusive blocks of power (macro-level exploration).

It is not easy being an AOD clinician

AOD clinicians feel disempowered for a variety of reasons, including interpersonal reasons and structural restraints; consequently, the disempowerment that clinicians feel can lead to the disempowerment of consumers. The domination of one knowledge over another disempowers those with the subordinated knowledge (Ritchie 2001). This is supported by literature presented in Chapter Three, which investigates the disempowerment of nurses (Gott and O'Brien 1991; Carlson-Catalano 1992; Barnes, Eribes et al. 1995) and the consequent oppression of consumers, including the role that institutional practices play in ensuring that empowerment does not happen.

AOD treatment and AOD clinicians are shaped by the context in which both operate. Such understandings frame the way clinicians view themselves and are viewed by others. Just how AOD clinicians and AOD treatment are portrayed is, to a large extent, the result of power and practices that operate to position AOD issues in one way rather than another. Notions of subjectivity, dominant discourse and discursive practices, as described earlier in this chapter, are all useful frameworks to begin to make sense of why AOD clinicians feel disempowered. Another means to explore this is through Foucault's three modes of objectification which is useful in explaining not only why clinicians feel disempowered, but how this, in turn, impacts on consumers and they, too, feel disempowered (Curtis & Harrison 2001).

Foucault maintains that power is always exercised at a cost. Members of the non-dominant group often distance themselves from their own group and become marginalised (Falk Rafael 1996). He states that the way this happens is by a process of subjectification, comprised of three stages which, he names dividing practices, scientific classification and the final stage, subjectification, which has been described in detail in Chapter three, but brief explanations are used in this section to aid description and application. This process of subjectification, along with the processes already discussed, may assist us to understand the difficulties and feelings of disempowerment experienced by AOD clinicians.

Dividing practices are used to differentiate one group of people from another. Health professionals also categorise other members of the health services into distinct groups. This may take the form of professional differences such as doctors versus nurses, psychologists versus nurses or nurses versus AOD counsellors. Dividing practices can also occur within a discipline such as emergency nurses versus AOD nurses, registered nurses versus enrolled nurses or mental health nurses versus AOD nurses. In addition, they can occur within a specific AOD treatment agency, such as AOD professionals versus AOD counsellors or even AOD counsellors versus recovering AOD counsellors.

The process of categorising (dividing practices) occurs most often as unconscious mechanisms, but they have a devastating and long-lasting effect on individuals and groups of people. Dividing practices may be seen as entrenched values and beliefs, which are evident in attitudes towards others. When attitudes are reinforced by the group, they are substantiated and, as a result, may become more entrenched. Data

showed that AOD clinicians felt that their peers in other health services or professions treated them with disdain.

Foucault suggests that scientific evidence is generated to support and legitimise dividing practice. He sees a person as occupying a position of truth by virtue of being attached to an 'apparatus of truth' such as a university or a hospital, as described earlier in this chapter. Knowledge from one discipline can be used to exclude knowledge from another, or used to maintain its own dominance. Discipline, in this sense, is different to discipline when used to describe disciplinary techniques such as surveillance, but at the same time they are interconnected. Discipline in this sense (health disciplines such as nursing, medicine, psychologists) relates to a body of skills and knowledge that need to be mastered in order to be recognised and valued within a particular field of health. The chosen discipline monitors individuals' progress, passes judgements and moulds individual's attitudes and behaviours in various ways.

Another concern of disciplines is in the production of healthy, docile bodies that can be utilised in work and regulated in terms of space and time. A program of daily activities in AOD treatment regulates both clinicians' and consumers' activity patterns as they move from one activity to another (individual counselling, meal breaks, group work, AA meetings, report writing and resting). Clinicians can be moved from one place to another depending on the needs of the unit or institution and the abilities of the clinicians themselves, 'and with each move their position in the literal and metaphorical space in the institution changes' (Danaher, Schirato et al. 2000, p.51). Disciplinary power accords AOD clinicians with a space within an institution and a rank within a system. Thus ranking enables institutions to both regulate the movement of clinicians

and the progress that they make. Individual clinicians are modified through a system of punishment and gratification. They may be sanctioned (or impose self-sanctions) for various indiscretions, but at the same time, through disciplinary work, they are able to gain rewards and move further up the scale into a more senior position. Although AOD clinicians may be the ones who have power in AOD treatment at the micro-level, at the mid-level and macro-levels, they are relatively powerless.

Disciplines themselves are accorded a place in a hierarchical ranking system. In health, the most powerful group is that of medicine. Doctors base their dominance within health care on the 'superior' knowledge of disease aetiology and as the biomedical model of health care is so widely accepted, the dominance of the medical profession is acknowledged and accepted (Brown and Seddon 1996). AOD treatment is no different. The truth status of 'taken for granted' medical/scientific discursive frames has shaped dominant, 'taken for granted' understanding of what is appropriate and authoritative practice (Lupton 1997). Psychology, which has built another body of knowledge, is lower down on the scale, but it, too, is perceived to have specialised knowledge of the mind. Psychology and psychiatry as disciplines have flourished, as conceptions of insanity and mental illness (including AOD perspectives) have shifted, and have found a seemingly infinite proliferation of psycho-medical conditions and categories (McCallum 1997). It has been discussed in this research that nursing on the other hand is perceived to be subordinate to medicine, and nurses are viewed as being less knowledgeable than psychologists are:

Nursing subordination is set within a framework of the biomedical model of health care within which doctors are presumed to have the knowledge to cure whereas nurses take the supporting position of caring. This

subordination revolves around the right of doctors to diagnose and thus to define who is a patient (Brown and Seddon 1996, p.31).

AOD counsellors rank lower than nurses as they have few if any qualifications, and those who are viewed as 'recovering' are ranked lowest of all.

Clinicians working in areas other than AOD are perceived as being more knowledgeable than AOD clinicians. Although clinicians working in other treatment areas were not interviewed, AOD clinicians freely discussed that this was their impression. This perception is supported by literature (Happell, 1999; Cusack, 1995). The power of a profession, or segments within a profession, depends in part, on the ability to exclude or marginalise other ways of thinking about health care practice. Until fairly recently AOD 'addiction' was viewed as an individual problem (based on the moral perspective) and its treatment was based on individual resources and self-help groups. Although AOD treatment has since been medicalised, it is one of the 'newer' areas of the medico/scientific frame and is not held in the same regard as other areas of medicine, psychology and nursing. Clinicians working in other arenas strive to maintain their dominance and knowledge, and thereby marginalise the skills and abilities of the AOD clinicians.

The third phase in the process of disempowerment is that of subjectification.

Subjectification refers to the concept that individual thought and actions are shaped by, and reflect social power relations (Doering 1992). Another way to describe subjectification is as a process of self-formation in which individuals internalise social power relations. It builds an individual's sense of self and understanding of the world, and involves the active participation of an individual in his or her own process of self-

formation (Falk Rafael 1995). This process has been identified as a characteristic of oppressed groups who assimilate the characteristics, practices and values of the groups that dominate them, including the perceived normalcy and inherent superiority of the dominant group. These ingrained prejudices and the way people are viewed and categorised (dividing practices) and reinforced by the professional and institution (scientific classification) may have an impact on the feeling of self-worth felt by AOD clinicians, and these feelings may become internalised (subjectification).

Clinicians working in AOD services feel disempowered and this affects their ability to work in an empowering way should they want to. The disempowerment they experience occurs on many different levels; when their expertise appears to be routinely disregarded by clinicians in other areas of the health service, when their commitment to their colleagues is called into question, and, for some, by the strain of working within a treatment philosophy with which they are uncomfortable.

Subjectification may occur between different branches of the health service, in particular, mental health services. When their skills, knowledge and expertise are not recognised by other professionals working in different areas, the staff in AOD treatment are left feeling devalued and angry (disempowered). The disempowerment may occur between clinicians where one member may uphold the complaints/rights of consumers and others may interpret this as being disloyal to the other members of the team. This overt disciplining of individual team members by the leader using an explicit appeal to group loyalty, coupled with a criticism of the member's competence, as occurred in this study, illustrates how easily AOD workers may be forced to practise in a particular way that prevents them identifying with consumers and their needs, and limits the

possibilities of collaborative practice because the AOD workers feel that they themselves are not trusted or valued.

The disempowerment that AOD workers experience may be a result of working with a treatment philosophy at odds with their own belief. This may happen if clinicians are working in a program that is abstinence focussed and they personally subscribe to a harm reduction philosophy. As a result, dissonance may occur and the individual feels 'at odds' with the dominant philosophy and consequently disempowered.

Usefulness of a Foucauldian analysis

Foucault's work provides a useful way of exploring what poststructural approaches can tell us about AOD treatment and practices. His notion of discourse and discursive frames demonstrates the link between power and knowledge and assists in explaining why taken for granted practices in AOD treatment occur and are constantly perpetuated. The process by which consumers and clinicians are subjugated strips away another layer to further expose dominance by the medico-scientific disciplines and exposes dominant discourses. His metaphor of the panopticon is important in understanding issues of discipline, surveillance and the subsequent use of the gaze. Self-surveillance, the birth of the clinic, and the production of docile bodies allow yet another way of viewing and understanding AOD treatment. The power of compliance, which is the unspoken goal of AOD treatment, can be clearly identified using a Foucauldian perspective.

There are always limitations and criticisms of theory. While Foucault does not advocate one particular theory, he does offer perspectives that are useful to support or develop

theory. Other theories of power which were presented in the data chapters, offer some understanding of how power operates and affects consumers and clinicians in AOD treatment. Foucault's work encourages the investigation of power at its peripheries in a way that other perspectives do not. Other viewpoints tend to concentrate on power as the central force and are more interested in power at a macro-level, and as such, may be useful in exploring how one group (clinicians or men) hold power and control over others (consumers or women).

Toffler's assumptions of power go some way toward explaining the notion of power as discussed by consumers and clinicians in AOD treatment, and in particular, his perspective on the moral and philosophical beliefs about equality. He argues that inequality itself is not immoral, rather that certain groups of people are disadvantaged or discriminated against because of characteristics such as gender or race. In this study it has been shown that women who have problems with AOD use are disadvantaged and discriminated against (Hughes 1989; Hamilton 1991; Ezard 1998), but Toffler does not offer any answers on how to overcome gender inequality. Although his views on the distribution of knowledge are useful in gaining another insight into the notion of power in AOD treatment where clinicians have power (and knowledge) and where they use strategies to maintain that power, often to the detriment of the consumer, he does not provide any solutions on how to alter the distribution of power. It must be noted, however, that neither does Foucault.

Traditionally, power has been considered in terms of a 'juridical-discursive' model (Rorty 1992; Wartenberg 1992; Wolfe 1990). This model is based on the theory of power as a force which dominates or subordinates (Fraser and Nicholson 1988). This

theory is based on three central assumptions. First, power is possessed; secondly, it flows from top to bottom; and, thirdly, it is primarily oppressive in its exercise.

Foucault criticises this perspective as representing only one form of power. Instead he focuses on the power relations; how individuals are affected by the power relations which thereby allows power to be viewed as non-egalitarian and mobile. He also views power as multi-directional, and in doing so, allows for the possibility that power can also operate from the bottom up. By so doing, he avoids using universal terms such as 'oppression, patriarchy and horizontal violence...' (Manias and Street 2000, p.53), terms which are viewed by some writers as helpful, but by others as a hindrance.

Foucault's notion of discourse allows us to challenge and understand why some views and practice in AOD treatment persist, and how the dominant discourses in health practice are maintained and reinforced. Once such discourses and discursive practices are exposed, it may be possible to investigate them further. AOD treatment is shaped by the discursive practices that are in operation. These practices frame the ways AOD clinicians view themselves and others, and how they are positioned in relation to the scientific/medical discourse. By exploring these discursive frames, it reveals much about the ways of thinking and practices that are embedded in AOD treatment. Foucault offers a way of understanding power and its effects, rather than a grand vision of how power may be overcome.

AOD clinicians appropriate and use regimes of power in different ways. By far the majority of these fall into the dominant abstinence discourse of the 12-step program, but some fall into more marginal forms of discourse. By using a Foucauldian analysis it is possible for AOD clinicians to explore their own realities that produce truths, and

through the search for truth expose the way that regimes of truth develop and gain strength. This, in turn, offers the possibility for alternative discourses to be created and dominant discursive practices to be decentred.

The perspective of power put forward by Foucault allows AOD treatment to be viewed with a 'different' vision and provides another layer through which to analyse what is happening.

The fundamental question: Is empowerment possible?

The assumption underpinning this research is that empowerment is both achievable and desirable. This taken-for-granted assumption has been challenged through the analysis and discussion of data and we are left to question whether empowerment is possible.

Using a Foucauldian framework to answer this question, the answer is most likely in the negative because of the forces operating within AOD treatment. His work, unlike that of critical social theorists, is not concerned with providing an environment in which individuals, through a struggle for self-emancipation, can become empowered (Fay 1987). Instead, Foucault refers to the circular nature of power through a capillary-like action and in doing so, challenges the traditional model of power as something that can be possessed. He posits that it is something that is exercised, and by taking this viewpoint and concentrating on how individuals are affected by power relations, power itself becomes non-egalitarian and mobile (Manias and Street 2000). Power is not primarily repressive, it may be productive. He suggests that by understanding this notion of power, the possibility of resistance is offered, as individuals armed with this knowledge are able to disrupt and challenge power relations. In this way, power can be conceived of as productive, and although Foucault does not advocate any clear direction

to take, his ideas do allow the possibility for change, although change may be difficult because it depends on individuals being reflective and exploring the taken-for-granted assumptions.

The idea that empowerment may not be entirely positive and occasionally may be used to justify paternalistic practices is beginning to receive attention (Patterson 2001). It has been suggested that simply changing the language that is used is not sufficient for empowerment to be effected. There must be changes in the very complex power relationships between clinicians and consumers (Opie 1998; Arksey and Sloper 1999).

Similarly, professional dominance has been highlighted in studies that investigate the experiences of people who have lived with a chronic physical illness, and it is highly probable that the generalised situations would be similar within AOD treatment. AOD consumers are likely to have had a long relationship with their AOD problems and with AOD services, so it is possible to argue that these consumers may also have authoritative knowledge about what works or doesn't work for them. The authoritative knowledge that these consumers bring about their illnesses is considered by them to be legitimate in making self-care decisions about how to manage their illness, even if it contradicts the advice given by health professionals (Nyhlin 1990; Mathieu 1993; Kingfisher and Millard 1998; Patterson 2001). Some health professionals devalue the authoritative knowledge of people with chronic illness in favour of the more 'objective' tests (Kingfisher and Millard 1998), and clinicians are often reluctant to acknowledge the sophisticated patterns of awareness that some consumers with chronic disorders have about their situation.

Clinicians may, in fact, talk of empowerment in their interactions with AOD consumers, but then act according to a traditional biomedical model in which the clinician is the ultimate decision-maker or does not offer the resources necessary for the consumer to be an active participant in decision-making. If clinicians remain uncritical of the rhetoric of empowerment and are not prepared to identify practices that belie participatory decision-making, AOD consumers may continue to experience frustration in their interactions with clinicians. Furthermore, an uncritical adoption of the discourse of empowerment may encourage clinicians into a false sense of security, and may lead them to believe that all they need to do is to simply extend an invitation to AOD consumers to be able to enter into collaborative partnerships with them.

A humanist discourse operates within AOD treatment as elsewhere in the social and health sciences, and included within that discourse is the concept of agency. Agency, in the humanist perspective (discourse), is synonymous with being a person and is 'used interchangeably with such concepts as freedom, autonomy, rationality and moral authority' (Davies 2000, p.55). There are, however, fundamental differences between the way that the concept of being a person is theorised between humanists and poststructuralists.

In poststructuralist theory, the subject itself, as explained in Chapter Three, is, in effect, produced and caught in the web of discourses, social practices and subjectivity. Using this model, individuals have no fundamental essence, they can only ever be spoken into existence within the terms of the multiple discourses that operate, and thus are multiple, rather than unitary beings. Therefore, from a poststructuralist perspective, agency cannot be any of the things that it is assumed to be in humanist thought.

In the humanist model agency is, by definition, a feature of each sane adult human being. Those who are not considered as agentic (women, children, the insane and addicts) are by definition within that model, not fully human (Davies 2000). For them, agency is the exception rather than the rule. In addition, agency assumes an agnostic relationship between the self and society. Individuals are conceived in relation to something external to themselves (society) and are judged against it (normative judgements).

Embedded within the humanist discourses is an understanding that individuals accept responsibility for their actions. Such responsibility is understood as resting on a moral base and entails personal commitment to the moral position implied in choices. It is by the discursive placing of responsibility that we are made agents by default. If AOD clinicians continue to work within this dominant discourse and accept the concept of the person from a humanist perspective, it remains highly unlikely that empowerment can be effected without some reframing of the way they view the world. However, this is not impossible. By utilising a poststructural perspective, individuals and groups are offered an opportunity to decentre the dominant discourse and allow for alternative discourses.

Although empowerment may not be possible because of the nature of power and of the dominant humanistic discourse, Foucault's work provides a useful framework for analysing the complexities and contradictions in AOD treatment. Although AOD clinicians may not be able to control their overall direction, they are able, as Weedon (1987) suggests, to choose among the practices available to them. By reflecting on and

considering the various practices available to them, and attempting to unravel the hierarchical network of power relations inherent in their practices, AOD clinicians have the opportunity to adopt new positions and practices. This enables the possibility of producing new discourses and AOD practices. In so doing, the possibility is offered of minimising the way in which AOD clinicians disempower AOD consumers through questioning the *mores*, rules, and assumptions that guide AOD practice.

Conclusion

This chapter has discussed the main findings that have emerged from this study on power, control and empowerment in AOD practice. Six main findings have been extrapolated from the data and these have been explored in detail using a Foucauldian framework to illuminate how power operates in generating and perpetuating discursive practices. These findings offer theoretical insight into power, control and empowerment in AOD treatment. The usefulness of a Foucauldian analysis has been explored and, finally, the question of whether empowerment is possible in AOD treatment has been addressed and the emergent issues identified. The theoretical insights are reiterated below.

Although clinicians use the rhetoric of empowerment in their explanation of how they implement their treatment regime, it is in fact a contradictory discourse. It is compliance that they describe, not empowerment. The major value underpinning practice is not empowerment, but control. Clinical practice is concerned with who has control, who wants control and how control is maintained. Clinicians are afraid of losing power and employ discursive practices which serve to maintain their position and reinforce their notion of ‘truth’. Institutional arrangements assist in ensuring that

empowerment does not happen. The real purpose of treatment is to make people normal. Both clinicians and consumers appear to accept this, and this belief is reinforced by the overlapping roles of the health and criminal justice systems.

Women in AOD treatment are particularly disadvantaged and feel disempowered. They face more difficulties in accessing treatment than men do. The still dominant 12-step abstinence philosophy was designed for men by men and the organisational structure of many treatment facilities is geared more towards the needs of men.

AOD clinicians also feel disempowered by the attitudes of other health professionals, by members of their own multi-disciplinary team, by clinicians from disciplines other than their own, and by the volatile and political nature of AOD policy and treatment. These factors implode on clinicians and, in turn, used to disempower consumers.

In the final chapter I explore the implications of these findings for clinical practice and service provision. I discuss the limitations of this research and offer suggestions for further research.

CHAPTER NINE

CONCLUSION

Introduction

The concept of empowerment has readily entered the discourse of health professionals and service providers in all areas of health, including AOD treatment. It is found written into mission statements, expected outcomes and statements of intent. Clinicians are encouraged to work with consumers in a way that can be seen to be collaborative, and in doing so, 'empower' the consumer. However, there has been a dearth of research into just what is meant by empowerment, how the concept is operationalised and how it impacts on consumers and clinicians in AOD treatment. Therefore, the purpose of this study has been to explore the concepts of power, control and empowerment and its effects and influences on AOD treatment, and to develop theoretical insights.

The perspective of consumers and clinicians in a variety of treatment centres has been sought. These facilities included a methadone clinic, detoxification unit, AOD outpatients centre and two residential rehabilitation units, one of which subscribes to a 12-step philosophy, and one which uses CBT. A grounded theory approach to the study has been used because it offered a rigorous and systematic method of collecting and analysing data. This approach yielded a depth of information that otherwise could not have been obtained by other methods. The experiences of consumers and clinicians were examined through the process of in-depth interviewing, and data were coded thematically using a grounded theory process. This process involved three stages of coding; substantive, selective and theoretical. One core category, control, emerged from

the data and other categories were developed, refined and related to the core category. Analytic ordering was also undertaken to make explicit the linkages between interaction and the conditions that affect it. The findings were then analysed using a Foucauldian perspective.

This chapter summarises the major findings of the research and the theoretical insights that have emerged from them based on this perspective. The implications for practice and for service provision are discussed. The final section presents the limitations of this research and offers suggestions for future study.

Theoretical insights

The themes of this research have been described in detail in the three data chapters, and the six major findings that have emerged from the data form the basis of the discussion chapter. The theoretical insights are summarised below. By applying a Foucauldian analysis, it can be seen that although the stated aim of AOD treatment is to improve the health of individuals, it is not that simple.

The rhetoric of empowerment is used to convey the ‘truth’. This truth is not empowerment, but compliance, and clinicians use a variety of discursive practices to ensure that consumers become and remain compliant. The real purpose of treatment is to make people normal, and underpinning AOD treatment is the notion of control.

Clinicians have control which they maintain through discourse and discursive practices. Institutional strategies are designed to assist in the maintenance of control. In addition, AOD clinicians themselves feel disempowered by their peers, other health professionals and by the wider political and social sphere. Consequently, empowerment cannot happen

and at times, AOD clinicians disempower AOD consumers. Women in AOD treatment feel doubly disempowered, both by the treatment provided, which is designed for and by men, and also by their gender.

Implications for practice

One major implication from this research is the stability of explanation, in particular the emphasis on the moral perspective of AOD use. Although the disease explanation deflects some of the blame from the individual, the moral perspective prevails. Even today, when the rhetoric of harm reduction is espoused, the influence of the moral perspective is still evident. Consumers are encouraged to change their AOD behaviour and become part of ‘normal’ society. If they do not do so, clinicians blame consumers rather than investigate whether the treatment regime really meets the needs of consumers, or whether their own attitudes and behaviour impact on the consumer. Once again, the moral perspective is reinforced.

Clinicians and consumers need to question and challenge structural issues that are punitive or nonsensical; for example, some of the rules that are currently operating in treatment facilities. Consumers are treated as a unified group, rather than as a group of individuals.

Clinicians (and consumers) need to question why empowerment is seen as an expected outcome of treatment, even though this is not and cannot happen without a change in discursive practices. Poststructuralist research may be useful in achieving change. This is not meant to imply that change will occur overnight or dramatically, but one way is

to introduce alternative discourse into consciousness, and thereby create a gradual shift of the discursive centre, as explored below.

The history of AOD treatment is defined more by breaks and ruptures, rather than by a clear evolutionary, progressive movement from one stage to the next. These breaks and ruptures move in cycles and what might be *passé* today may be in vogue a decade from now and vice versa. AOD treatment perspectives and approaches seem to be moving away from grand narratives and overarching ontological and methodological paradigms. The centre lies more in the humanistic quality of the clinician to address the perspectives of those individuals and groups who have been disempowered and oppressed by the larger ideological, economic, and political forces of a society or a historical moment. This commitment defines an ever present, but shifting centre in the discourses of AOD treatment. The centre shifts as new, previously disregarded or silenced voices enter the discourse. One way that this centre can shift is through reflection on practice (Schon 1983; Schon 1987; Schon 1993). For example, if clinicians and consumers are to work together in partnership and collaboration, the obstacles that impede this need to be investigated. By reflecting on practice and analysing what is and what is not happening and asking why, as well as by truly involving consumers in the decision-making process, AOD clinicians may find a way to work in partnership with consumers. Some ways that 'reflection on practice' could be operationalised could be through holding regular debriefing meetings, supervision meetings, organising and formalising mentorship strategies for both new and existing staff, encouraging clinicians to undertake further related study, and by setting aside dedicated time within the overall programme structure to reflect and discuss positive and negative events within a safe and supportive environment.

A poststructuralist perspective provides clinicians with the opportunity to question, analyse and reflect. Questions can be asked, such as: Who defines AOD treatment? Through which discourse(s) is it constituted? Who is granted an authoritative position within that discourse? If this is a discourse that is fundamental to the addict/ non-addict dualism, how then can it be resisted? Can we draw attention to elements that are susceptible to change? Can we counterpose alternative discourses? Can we develop alternative metaphors, images and storylines to counteract the impact of the dominant discourse? In poststructuralist analysis, agency is no longer seen as central to the analysis of the AOD treatment game. Choices are understood to be more akin to forced choices, since the subject's positioning within particular discourses makes the 'chosen' line of action not the only action, but rather the one which the subject has been constituted to want.

Women consumers need to be better catered for. Their family commitments are very important, and if women consumers feel that their children are not being cared for adequately, they will not complete their treatment programs. Clinicians also need to be more aware of the special needs of women and to take these into consideration when working with them. This is covered in more detail in the next section which addresses implications for service provision.

Finally, AOD clinicians need to be aware that their feelings of disempowerment directly affect consumers and, in fact, may disempower the very group of people whom they are trying to empower. If clinicians do not address their own disempowerment,

then consumers will continue to feel disempowered, and clinicians will continue to reinforce and maintain the status quo.

Implications for service provision

Service provision also needs modification. One major issue that emerges from the research is the impact that AOD treatment has on women. Not only are women badly served by the paucity of treatment programs that address women-specific issues and priorities, they are also badly served by a lack of treatment agencies which offer services and accommodation for women with children. The provision of such services is imperative for the welfare of mothers seeking AOD treatment and for the welfare of their children. In 1993, the National Drug Strategy recommended that services need to accommodate gender differences in AOD treatment:

Both women and men should have the choice of having a therapist of their own sex. Women who are admitted to residential or inpatient facilities should have single residential facilities. This would ensure privacy and freedom from sexual harassment. ... There is a need for agencies to examine whether structural impediments are leading to the exclusion of women from treatment (Mattick 1993, p.222).

Yet, according to the research presented here, the recommendations of that report have not been met.

Service providers need to look closely at the philosophy that they articulate and the philosophy that they implement. With the 12-step philosophy still operating in services that subscribe to a harm reduction approach, there is a responsibility on the part of both service providers and clinicians to investigate how this philosophy is perpetuated in their particular place of work, and to implement strategies that discourage its continuance.

This is not to say that the 12-step approach does not have a place in contemporary AOD treatment. There is no one treatment that has been found to suit all consumer groups, and for some consumers, both community members and those in residential treatment, the 12-step approach is their preferred choice. It is needed as one of a range of treatments offered. It may be by having choice in selecting one's preferred individualised treatment that consumers can benefit most. Empowerment can be viewed as a reflection or outcome of having personal choice and it is choice of treatment that is currently recognised as the greatest predictor of positive outcomes, and thus being offered choices of types of treatment, and types of services and clinicians, that may be the final arbiter of whether or not consumers are empowered.

As with all initiatives, it is essential to have adequate financial provision to plan, implement and evaluate. Both national and state governments need to make AOD treatment a priority for both policy and financial provision. There has been an increase in the number of services provided as a result of the NSW drug summit in May 1999, where a comprehensive four-year plan of action was outlined. This plan of action included projects ranging from diversionary trials, traditional treatment modalities, prevention, community education and collaboration, but it has already been pointed out that there has not been a comparative increase in the number of suitably qualified personnel to meet the increase (McKey, 2000). It appears once again, that AOD services and AOD clinicians will feel that their needs and the needs of consumers are not being adequately catered for.

It is acknowledged that these recommendations represent an ideal scenario, and that it is not possible to implement them all because of competing interests and expectations. However, they are offered as ‘food for thought’ and if they challenge only one other clinician to question his/her practice, then this research will have been worthwhile. By reinforcing alternative discourses, such as harm reduction, the discursive centre is shifting, and as more knowledge is gained in this area, more alternative discourses will operate.

Limitations of research

This was a qualitative study with a non-probability sample and as such the findings can not be generalised to the population. The consumers who responded to the request to be part of the research were consumers who had already made a decision to attempt to change their AOD use. Although they had not all entered treatment voluntarily, it became evident that many who were there on a seemingly voluntary basis had in fact been coerced by family and friends into entering treatment, but during the process had decided to change their AOD use. It may be that if those consumers who did not want to change their AOD use had volunteered to participate, the results of this research would have been different.

AOD staff employed by each treatment facility had to make the initial approach to consumers regarding their participation in the study. (This was a condition of research approval from the Research Ethics Committee. See appendix 1). This could have resulted in only those consumers who were motivated to attempt to change volunteering to be part of the research. Another potential or probable impact of staff making the

initial approach may have been that some consumers did/did not volunteer because they thought that they might invoke approval/disapproval from particular staff members.

Another limitation was that consumers were drawn predominantly from residential units, although many have used and still use methadone maintenance facilities and outpatient services. Consumers who access non-residential treatment facilities may have relayed a different perspective of their experiences to those in residential services.

No participants in this study identified as Aboriginal or Torres Straight Islanders, although the research was undertaken in a multi-cultural region with a relatively high indigenous population. Indigenous Australians are identified in AOD statistics for this region and an Aboriginal counsellor is employed by the regional AOD service. Again, if consumers and clinicians from this background had participated, the findings may have been different.

Finally, the participants in this study were drawn from specific populations who were in treatment for their AOD use, and during this treatment they were exposed to the 12-step model whatever treatment facility they attended. The question needs to be asked, how might they have differed from others with an AOD problem who *were not* in treatment and were attending AA/NA in the community? Perhaps this group who had opted for voluntary non-institutionalised attendance at AA/NA is a signal of being empowered through free choice and membership of a community of people who together [re]gain their own power over their own disrupted and disruptive lives/behaviours, while at the same time being helped by peers (and not powerful clinicians) to stop using AOD.

Suggestions for future research

As this was an exploratory study, using these findings as a springboard for further research is warranted. Theoretical insights have emerged through this research which justifies further investigation. To widen the scope and generalisability of this research, more consumers from outpatients and methadone maintenance could be interviewed. In other regions, other drugs are being used instead of methadone. It would be interesting to ascertain if the introduction of these drugs has any impact on the way services are provided.

While this study investigated issues of power, control and empowerment related to AOD treatment, participants emphasised their loss of power in relation to their 'addiction' or to the substance. It did not explore in any great detail and possible losses of power that occurred prior to 'addiction', which then led to the addiction and which could then be viewed (ie. addiction) as a coping mechanism or way of having power over pre-existing troubles and losses; in other words, the history behind the losses of power that impacted on the current experiences of consumer participants. This could be the basis for further research.

Another area for further research could be to investigate the experiences of people who attend AA/NA in the community without first having attended a treatment centre. It would be interesting to compare their experiences of power, control and empowerment and the impact of self-help and peer support as opposed to assistance by clinicians to stop drinking or using drugs.

Research data on the needs of women AOD consumers are sparse. More research that looks at barriers to treatment for women is recommended, and more information is needed about programs and services for women.

Australia's population is aging and statistics show that there is an increasing number of older people presenting with AOD problems. We know little about their specific needs.

Finally, whatever directions are taken in this research area, focussing on the experiences of consumers and clinicians can only further the advancement of consumer-centred care, rather than clinician-focussed care. Advancing the practice of consumer-focused care will improve the standard of treatment provided to consumers in AOD treatment. For AOD treatment practices to be improved, alternative discourses need to enter conscious thought and be embraced in a manner that allows people to have power within them.

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APPENDIX 1

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APPENDIX 11

INTERVIEW SCHEDULE

What is your reason for using AOD services?

What is your understanding of the term empowerment?

Importance?

Ways in which empowerment is used?

Not being used?

Do consumers want to be empowered?

Do clinicians empower consumers?

How?

What impedes empowerment?

What is positive about empowerment?

Any negative aspects of empowerment?

How does empowerment impact on clinicians and consumers.

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SOURCE: CORBIN & STRAUSS 1996

NOTE: The top half of the matrix explains ‘the greater range of potentially significant conditions, consequences and interactions that might be noticed’ (Corbin & Straus 1996, p.145).

The bottom half of the matrix gives an example of how it was used in this study to ‘sensitise’ the researcher to the “range of conditions conceivably affecting the phenomena of interest and to the range of hypothetical consequences” (Charmaz 2000, p.516).

APPENDIX 1V

GLOSSARY OF TERMS

Abbreviations

AA (Alcoholic Anonymous)

NA (Narcotics Anonymous)

CBT (Cognitive Behavioural Therapy)

Twelve Step Program (Based on the twelve steps identified by Alcoholics Anonymous)

NGO (Non Government Organisation)

Take Aways (Take away dose of methadone)

Detox (Detoxification Unit)

DOC's (Department of Corrective Services)

AOD (Alcohol and other drugs)

Alcoholics Anonymous

‘AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others recover from alcoholism’ (A.A., 2000). It is an informal society of more than 2, 000,000 ‘recovered alcoholics’ throughout the world. Women make up 35 per cent of the total membership

Cocaine

A stimulant of the central nervous system. It produces euphoria or wakefulness and, historically has been used to stem local bleeding. It can be produced in a variety of

ways to produce different potencies. **Freebasing** produces the purest and most potent form of cocaine (**crack**). It can be injected and ingested, but is most often inhaled (snorted).

Cognitive behavioural skills training

A broad array of therapeutic interventions (including CBT) that aim to provide individuals with a range of skills designed to enhance their functioning. This approach assumes that the AOD user has poor coping and living skills and that an improvement in these will reduce the need for substances.

Consumers, clients, patients

There are subtle, important political differences denoted by the meaning of each of these terms (McLean 1995), but for the purpose of this research, the terms are interchangeable and used as identified by the various participants or authors referred to in the literature.

Controlled use

Use of AOD that is sufficiently temperate to avoid intoxication or dangerous use. As an intervention, controlled use is generally pursued when there is reason to believe that the client may return to dangerous or harmful use (Hamilton, Kellehear et al. 1998), p282.

Crack

A beige-coloured substance obtained by heating cocaine salt combined with baking soda, a process (known as freebasing) that creates a crackling sound. It is the purest and most potent form of cocaine.

Delirium tremens (DT's)

An acute psychotic state occurring 48 hours or more after the commencement of alcohol withdrawal. It is characterised by confusion, disorientation, paranoid delusions, fearfulness, agitation and restlessness. Physical symptoms include an increased rate of metabolism, tachycardia, hypertension, sweating, increased gastric motility and coarse tremor.

Discipline

Refers first to the notion of punishment or coercion, and second to the notion of skills and knowledge's which must be mastered in order to achieve success in particular fields. Foucault connects these two meanings through his concept of 'power-knowledge' (Danaher, Schirato et al. 2000, p.x).

Games of truth

Refers to the sets of rules within particular institutions by which truth is produced (Danaher, Schirato et al. 2000, p. xi).

Gaze

Foucault is referring to the act of seeing, in this case the way in which disease, illness and health care are thought about and viewed. The act of examining the body is a central tenet of the construction of health care around the locus of the clinic. In the examination, the body is made the object of the health professionals gaze (Cheek 2000, p. 26).

Governmentality

Is the term Foucault uses to describe the changes in technologies of, and attitudes towards, governing which developed in Europe in the eighteenth century. This involved a greater emphasis on the state's ability to manage its resources (including its population) economically and efficiently, and a concomitant increase in state intervention in the lives of its citizens. There have been two major consequences of this change. The first is that citizens are both 'regulated' by the state and its institutions and discourses, and educated to regulate and monitor their own behaviour. The second which derives from what Foucault terms the 'liberal attitude', is the emergence of an understanding, on the part of citizens, of the need to 'negotiate' those forces of 'subject regulation' through a process of 'self-governing' (Danaher, 2000, p. xii)

Harm minimisation (harm reduction)

Harm minimisation attempts to reduce, to as low as possible, the harmful consequences that arise from the use of drugs. It includes:

- Demand reduction (prevention through information-provision and education)
- Supply reduction (regulation and law enforcement)
- Environmental responses that aim to assist people using drugs to do so in the safest possible manner (Rumbold and Hamilton 1998).

Heroin

A derivative of opium produced by a chemical modification of morphine, a process that increases potency. Three milligrams of heroin produce the same pain-relieving effects as 10 milligrams of morphine. Heroin is also called scagg, hammer, slow, smack, dope,

shit, junk, rocks, powder, snow, beige, sweetjane, speedball (a mixture of heroin and cocaine) and crank (a mixture of amphetamines, cocaine and heroin).

High risk level

For males, consuming nine or more standard alcoholic drinks per day. For females, consuming five or more standard alcoholic drinks per day (Mattick 1993).

Intermediate risk level

Consumption of between five and eight standard alcohol drinks per day or occasional excess for males. For females, consuming four standard alcoholic drinks per day (Mattick 1993).

Knowledge

For Foucault, knowledge is made up of perspectives, ideas, narratives, commentaries, rules, categories, laws, terms, explanations and definitions produced and valorized by disciplines, fields and institutions through the application of scientific principles.

Different and new knowledge emerges from the struggle between the different areas within a culture (Danaher, Schirato et al. 2000) p. xiii.

Methadone

A synthetic opioid used in maintenance therapy for those dependent on opioids. It acts to block heroin-induced euphoria and is less prominently sedative than heroin.

Methadone has a long half-life (approximately 24 hours), with onset of withdrawal occurring 36-72 hours after last use. When used in maintenance therapy, methadone is given orally, typically once daily with medical supervision.

Motivational interviewing

A set of techniques applied, in particular, in alcohol and other drug treatment, but also applicable to any other volitional disorder. The goal of motivational interviewing is to enhance the consumer's motivation for changing their behaviour. The primary strategies are examination of the positive and negative consequences of AOD use, and evaluation of the short term and long-term impact on the consumer's substance related behaviour. It is a rational discursive process rather than an advice giving process and is based on the understanding that motivation comes from within. Ideally, it results in consumers developing their own conclusions regarding the desirability of their substance-related behaviour (Hamilton, Kellehear et al. 1998, p. 278).

Normative judgements

Are used to assess and monitor the actions and attitudes of people according to the notion of a norm or average. Such judgements work throughout various institutions such as prisons, schools and hospitals, as well as throughout the social body as a whole, to divide the 'normal' from the 'abnormal' (Danaher, Schirato et al. 2000, p. xiii).

Opioid

The generic term applied to substances derived from the opium poppy, their synthetic counterparts, and compounds synthesised in the body (endogens), all of which interact with the same specific receptors in the brain. Opioids have the capacity to relieve pain and produce a sense of well being (euphoria). This is produced by the interaction between the opioids and opiate-specific receptors in the brain. Taken in high doses, the opioids can also cause stupor, coma and respiratory depression.

Relapse prevention

Relapse prevention programs aim to teach consumers a set of cognitive and behavioural strategies that will enhance their capacity to cope with high-risk situations that precipitate relapse (Hamilton, Kellehear et al. 1998, p. 281).

Subjectivity

Is the term derived from psychoanalytic theory to describe and explain identity, or the self. It replaces the commonsense notion that our identity is the product of our conscious, self-governing self, and instead presents individual identity as the product of discourses, ideologies and institutional practices (Danaher, Schirato et al. 2000, p.xiv).

Subjugated knowledge

Is a form of knowledge that has been subjugated or ‘buried’ under the official or dominant forms of knowledge that emerge within a social order (Danaher, Schirato et al. 2000, p. xv).

Technologies

Foucault, refers to two main functions or mechanisms: first, the ways in which societies pacify, dominate and regulate subjects; and second, ‘technologies of the self’, which allow individuals to shape their own bodies and thoughts (Danaher, Schirato et al. 2000, p. xv).

APPENDIX V

ISSUES AND INNOVATIONS IN NURSING PRACTICE

Beneath the surface: collaboration in alcohol and other drug treatment. An analysis using Foucault's three modes of objectification

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