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Power, control and empowerment in alcohol and other drug treatment

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POWER, CONTROL AND EMPOWERMENT IN ALCOHOL AND OTHER DRUG TREATMENT

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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

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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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