A QUALITATIVE FEMINIST ANALYSIS OF HEALTH AND SOCIAL CARE SERVICES TO ILLEGAL DRUG USERS

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A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy

September 1997

stack no
1167

ABSTRACT

My research examines the work of two agencies delivering heath and social care services to illegal drug users and in so doing, aims to reveal how far these services operate in women's interest. The analysis draws on feminist principles of health and social care practice in order to construct an analytic framework for the collection and processing of data. It adopts a research methodology which is congruent with a feminist approach to social enquiry and which is committed to exposing the knowledge creation process to critical scrutiny. Data is collected using the techniques of participant observation and in-depth interview and the study integrates both sets of data in developing its discussion of findings.

An early decision was taken to focus on the way in which the services are delivered to both men and women in order to examine the operation of gendered power relations and their impact on the ways in which clients are seen and responded to. The use of gender as a key variable has resulted in an analysis which points up a lack of attention to men's abuse of women in the social work encounter. Men's abusing rather than abusive behaviours are the main focus of attention. In contrast, a marked concern with women's potential abuse and neglect of their children was evident on one of the research sites. A propensity to respond to women primarily as mothers has been revealed and critically scrutinised. These, together with other key findings, suggest that services are not gender neutral, that they are designed to respond to a predominantly male drug user and that treatment strategies have been tailored accordingly.

In drawing the analysis to a conclusion I have revisited the feminist principles of health and social care which provide the study's conceptual framework and have considered how far they can assist in developing services which meet women's needs and in furthering a feminist political agenda. I reflect critically on the methodological approach I have adopted and consider its impact on the validity of the research.

INTRODUCTION

Background

My research into services for illegal drug users draws upon and was prompted by my own experience in a social care agency dealing with problem drug misuse. In undertaking the research I have been concerned both with developing theoretical insights into the operation of the services under scrutiny and with reworking my own past experience as a practitioner and social care provider. The research arose out an awareness that women were under-represented as clients of services to drug users and from an interest in the development of a feminist health and social care practice. I was concerned to understand the extent to which services for illegal drug users 'speak' to men rather than to women.

I took an early decision to focus on the service providers rather than the service users since I felt that much attention had already been paid to drug users (Becker, 1963: Rosenbaum, 1981: Sargent, 1992; Auld, 1986: Bourgois, 1996; Adler, 1985; Pearson 1987) and that a more original contribution to knowledge might be made by turning the research spotlight on services. I was also mindful of the power of research to intrude into the lives of the powerless (McRobbie 1982) and was concerned that my research should avoid exploiting the vulnerability of the drug user. By focusing research attention on a more powerful group, i.e. welfare professionals, I felt I could avoid the risk of exploitation and be able to conform more closely to feminist research principles.

Aims

My research aims to develop new insights into the delivery of health and social care services to drug users by adopting a feminist perspective and a feminist research methodology. I engage with feminist analyses of health and social care practice in order to assist my understanding of specialist services to illegal drug users. A central question I bring to the research is how gendered power relations can be challenged in the social work/social care encounter and to what extent this challenge is being met by services to illegal drug users.

Feminist perspectives

Recognising that there are competing perspectives within feminism, it is important to try to locate myself more precisely. The starting point for all feminists is a concern to challenge and change gendered power relations which are oppressive to women. How this is to be achieved depends on how women's oppression is perceived and explained. Simply pursuing gender equality through an appeal to reason and through changing women's legal status and employment opportunities has been criticised as a fundamentally flawed endeavour (Eisenstein, 1986). While I would not wish to dismiss entirely the value of such strategies, I consider that they can only play a relatively minor part in a much broader strategy for social change. Like many

feminists (Walby, 1986, 1990; Hartmann, 1986; Ramazanoglu 1989) I draw on the concept of patriarchy to explain women's subordination and consider that patriarchal power needs to be challenged and transformed if women's emancipation is to be achieved. Feminists have however, increasingly recognised the existence of other power structures in society, notably class and race within which patriarchal structures are embedded and which change the nature and impact of patriarchal oppression (Brittan and Maynard, 1984). The essentialist notions of some early feminists (Rich, 1977; Rossi, 1977) have been critically scutinised (Sayers, 1982) and it is no longer possible or desirable for feminists to seek to develop universal explanations of women's common oppression. I am impressed by these concerns and my own feminist stance is one which strives to take account of diversity and difference between women. It recognises that while feminists rely on the privileging of gender as the main explanatory variable, the mediating power of other variables - race, class, ethnicity and sexual orientation - must be made apparent.

My perspective is one which advocates a movement away from the notion of an iron cage of patriarchal oppression in which all women are imprisoned, to one which encourages an altogether more flexible and fluid analysis of the impact of gender relations. It is a perspective which pays attention to the ways in which women resist as well as to the ways in which they are oppressed.

Like many contemporary feminists I find my thinking being increasingly influenced by post-structuralist analyses of discourse but I am concerned that the feminists project does not drown in the post-modernist stream. I am currently getting to know the work of Luce Irigaray (Grosz, 1989) and am increasingly espousing a position which emphasises the politics of difference rather than the politics of equality. My interest in gender difference leads me to a concern with the ways in which the delivery of services to illegal drug users is not gender neutral and it suggests that a strategy of simply encouraging equal access to male-defined services is misconceived.

The feminist perspective I adopt in my analysis of health and social care services is used not to reveal 'the truth' but rather to ask new questions and by so doing, challenge existing practice. The stance I take stops short of claiming that it is just one amongst many competing claims to know, but it recognises the dangers in merely setting up a new orthodoxy and thus perpetuating the very problems, i.e. the suppression of alternative voices, which feminism sets out challenge. Developing alternative ways of explaining social phenomena is a strategic as well as a theoretical exercise. In presenting alternatives the aim is not simply to replace existing orthodoxy but to destabilise it and thus render it more open to change.

I have long recognised the danger of losing the 'subject' in the deterministic thrust of theorising which emphasises patriarchal, capitalist and white supremacist structures of power. There is, I believe, a need to restore the 'subject' into sociological discourse more generally and to feminist theorising in particular. In this respect I find the notion of 'discursive subjectivity' helpful and illuminating. It is a notion which emphasises an individual's rationality and freedom of choice but which draws attention to the fact that they "speak as 'fettered' subjects bound within a variety of discourses or different fields of power/knowledge" and it recognises that "this speaking is a social endeavour involving others." (Ettorre and Riska, 1995 p.92)

I have tried to reflect a concern with the subject throughout the research process. My analysis of the services relies heavily on conversations with service providers, designed to illicit their views and to their perspective. But I also offer a critical reading of the data, drawing attention to ways in which an understanding of the health and social care task can be located within a professional discourse which is heavily gendered and takes little account of the impact of social, cultural and racial diversity on an individual's experience of drug use.

Research Sites

The research is based on two sites where services to illegal drug users are delivered. One of the services is a Community Drug Team, the other a Therapeutic Community. My original research design included other services, i.e. a street agency, a specialist service within the NHS, and the Probation Service. This would have made the study too large for its present purposes and the research was narrowed down to two sites which were decided upon because they were representative of the range of services available to illegal drug users.

The Community Drug Team is a joint venture between Health, Probation and Social Services, staffed by professionals qualified in Social Work, Probation, Nursing and Community Mental Health. It adopts a policy of harm-reduction and offers services which range from a needle-exchange scheme operating on a drop-in basis, to supervised detoxification and long-term counselling /case-work.

The Therapeutic Community offers a highly structured programme of long-term residential rehabilitation. It adopts a policy of abstinence and its self-help ethos ensures that it is staffed by a balance of professionally qualified workers and ex-drug-users. A fuller description of the two sites is given in the introduction to **Part 2.**

The study's structure

The study is in three parts. Part 1 explores the relevant literature, Part 2 is concerned with the research process and Part 3 with a critical analysis of findings.

PART 1 . Chapters 1 and 2 examine the literature which has been concerned with the delivery of services to women who use illegal drugs. I focus my attention on this particular body of literature because the study arose from a concern about service delivery, triggered by my own experience as a service provider. The chapters draw out the themes that are explored in the literature, some of which are picked up later by my analysis of services in Chapters 8, 9 and 10.

In the introduction to Chapter 1, I identify a less than perfect fit between a literature review which is concerned with women's use of services and my broader concern to examine the operation of gendered power relations and their impact on services. The review does not include a concern with some general themes which emerge in my findings, like the operation of power in the social work encounter, or the

dominance of the medical model in defining and constructing the response to illegal drug-users. It is the study's starting point, service provision to illegal drug users, rather than a concern to anticipate later themes, which dictates its literature base. While this enables the study to link some of its findings to earlier research into the gender bias of services to drug users, it leaves the exploration of some of the wider themes of power and control which emerge, relatively underdeveloped.

Chapter 3 is concerned to explore the methodological issues pertinent to feminist research endeavour. I consider that if the study is to succeed in its aim to develop a feminist analysis of services to illegal drug users, it needs to ensure that its methodology is congruent with these aims.

Having explored *how* the research might be conducted in Chapter 3, I turn my attention to *what* I might be looking for in Chapter 4. I explore the feminist principles of health and social care practice, identify some key themes and consider how I might discover whether they are operating on the two research sites. I devise an analytic framework from the principles by considering each of them in turn. I suggest where I might look and the questions I might ask in order to discover if, and how, feminist principles of practice are operating on each of the research sites. My aim in this chapter is to devise a framework against which each of the sites can be 'measured'.

PART 2 . Chapters 5, 6 and 7 are concerned to open up the research process to scrutiny. I consider the impact of my past experience as a practitioner on my current research endeavour. I consider the partial and fragmentary nature of my view of the services under consideration and my ability to do feminism while doing research. The identities of feminist and of practitioner are what I bring to the study and they provide the lens through which the research data is sifted and findings analysed. There are times when conflicts of interest between my three identities - researcher, practioner, feminist - arise. One of the aims of these chapters is to examine these conflicts.

I have explored the research process at this stage, i.e. before I offer my analysis of findings, since I am concerned to make my commitment to exposing the knowledge creation process to scrutiny a central, rather than a peripheral focus of my study. I am concerned to give the reader an insight into how data was produced before I embark on my analysis of practice on the two research site.

PART 3 . Research findings are analysed in Chapters 8 and 9. The sites are discussed separately since the aim of the research was to discover not how they compared to each other, but how far feminist principles of practice were operating on each. Before embarking on a discussion of findings I offer some reflections on how far the analytic framework, constructed from principles of feminist practice, assisted the collection and analysis of data. I conclude that the framework offers a structure around which data can be hung rather than a strict coding mechanism.

Chapter 10 draws out the main findings explored in chapters 8 and 9 and offers some further reflections on methodological and technical issues. The final part of the chapter explores the research's policy implications and outlines the main features of a feminist approach to services for illegal drug users.

Sources of data

My analysis of services draws on three main sources of data; existing literature concerned with women's drug use; in-depth interviews with the staff of the projects under scrutiny and insights gleaned through participant observation. Different type faces are used for quotations, to indicate their different sources.

Italicised Times New Roman indicates that I am using direct quotes from the literature:

Bold Ariel Narrow indicates that I am quoting from my field notes:

Bold Courier indicates that I am quoting from interviews with service providers

Terminology

By and large I have used the more neutral term, drug or substance use, in developing my discussion of services. Where substance use is clearly being constructed as a problem, however, either by the literature, by service providers, or the thrust of my analysis, I have used the term drug misuse or drug abuse to reflect and give emphasis to the fact that the use of illicit substances is not a neutral activity.

CONTENTS

PART 1 : THE LITERATURE

My research is underpinned by three distinct bodies of literature. The first is concerned with the treatment of women's drug use, the second with the methodological principles of feminist research and the third with the principles and practice of feminist social work/social care. This literature is scrutinised in **Chapters 1 - 4.**

Chapters 1 and 2 focus on the literature on women's drug use and its treatment. A central concern of the discussion here is to examine how far this literature is informed by a feminist perspective and how far the treatment described succeeds in challenging a structure of gender relations which is oppressive to women.

Chapter 3 is concerned with the literature on feminist research. It points up some major epistemological and methodological issues which feminists have addressed. The aim of the chapter is to identify some underlying principles which the researcher can adopt in order to ensure that the study is designed and carried out in a way which is congruent with a feminist political stance. Some consideration is given to the problems of rendering feminist research principles operable within the context of the study but a fuller discussion of these issues is developed in Part 2, Chapter 7.

The literature on social care practice is examined in **Chapter 4.** The aim is to identify the principles of a feminist social care/social work practice which then provide the basis for the construction of an analytic framework for data collection and analysis. The principles provide the basis for a model of feminist practice against which the services under scrutiny can be measured.

CHAPTER 1

REVIEWING THE LITERATURE : WOMEN'S DRUG USE, ITS TREATMENT AND CONTROL

In scrutinising the literature which provides a background to the substantive issues arising from my research I have adopted an approach which identifies significant and recurrent themes in the literature but which also gives sustained and exclusive attention to some substantial texts (Ettorre, 1992; Sargent, 1992; Rosenbaum, 1981). These are recent works which make a serious and explicit attempt to focus on women and, in the case of Ettorre and Sargent, bring a feminist perspective to bear on the issue of women's drug use and its treatment. These three books provide the focus for discussion in Chapter 1. Chapter 2 takes up some of the themes identified in the books and explores them further, using journal articles and collections of papers concerned with the treatment of women's drug use. A major concern in both the chapters in to assess how far the literature is informed by feminist theories of women's oppression and draw attention to some of the debates and competing perspectives within feminism.

All the literature currently identified is exclusively concerned with women. I have discovered no work to date which is centrally concerned with an exploration of men and masculinity in relation to the drug-treatment process. Auld's (1986) work makes some attempt to problematise masculinity and to recognise the role that drug use plays in maintaining restrictive masculine identities but he is concerned with drug use rather than its treatment. My own research is concerned to point up the gendered nature of services and their impact on both men and women, but my concern with men and masculinity cannot be reflected in a review of the literature since it is largely absent.

The three writers under consideration here, Rosenbaum, Ettorre and Sargent, are concerned with many aspects of women's drug use and therefore go well beyond the boundaries of my concern with services, interventions and treatment. Nevertheless, each of the three books has a good deal to say on the subject of treatment and it is here that I have centred my interest and analysis. Over and above these direct concerns with treatment, however, explorations and explanations of women's drug use have a bearing on its treatment and control. This will be seen most clearly in Ettorre's attempts to restructure the entire debate and in so doing, raise new questions with regard to the way in which women's illegal drug use is viewed, treated and responded to.

The discussion which follows offers some introductory comments designed to identify the main features of the books, followed by a more detailed analysis of each.

Introduction

Rosenbaum's and Sargent's books arose out of their research into women's illegal drug use. Of the two, Rosenbaum's is the more rigorous. She puts forward a clearly argued thesis which sets out the ways in which options for women are increasingly narrowed as they continue with a drug-using life-style. Rosenbaum's work is not explicitly feminist in its approach or analysis, although her research is carried out by women on women. Her work is aligned with an interactionist perspective and the ethnographic traditions of the Chicago school of sociology.

Rosenbaum's use of the concept of deviant careers and narrowing options make sociologists like Becker, Lemert and Goffman her natural allies. The work of these sociologists is, however, largely gender blind and uncritically incorporates masculine bias. Heindenshohn (1985) , discussing the interactionist approach to crime and deviance, suggests that they did not fulfil their promise in terms of explaining women's crime and deviancy. She says

> *Becker himself tossed a provocative thought into the air in Outsiders - 'it is true in many respects that men make the rules for women in our society (though in America this is changing rapidly)'..but he did not catch the thought himself and nor did any other interactionist. (Becker, cited in Heindensohn, 1985 p.138)*

In aligning itself with this tradition, Rosenbaum's work, while offering some important insights into women's illegal drug use, ultimately remains within a tradition which seeks to add women into an existing framework of analysis rather than to explain women's drug use from a strong feminist perspective. A stronger, more explicit feminist analysis might be achieved by combining a micro sociological exploration of the drug user's world with an analysis of the ways in which women, through their drug use, resist, subvert and transgress the constraints which gendered power structures in society impose on them. An analysis along these lines would overcome the problem of an interactionist analysis which works with an a too diffuse and underdeveloped concept of the operation and location of power.

Sargent's work is disappointing but her comparative analysis of drug policies in Sydney, Amsterdam and Britain enables her to identify, if not develop, some useful feminist insights.

Ettorre's work contrasts quite markedly with both Rosenbaum's and Sergent's, in that it is concerned with women's substance use, rather than their illegal drug use per se. Her chapter on heroin use sits alongside chapters on alcohol use, cigarette smoking, tranquilliser use and food dependency. Each of the chapters are incorporated into a well developed theoretical analysis of women's use of substances. Her methodology fractures the traditional boundaries of conventional approaches to women's illegal drug use and makes a serious and sustained attempt to re-define the ways in which women's drug use is perceived and responded to.

Both Ettorre and Sargent make explicit attempts to bring a feminist analysis to bear on the issue of women's drug use. Ettorre's analysis is far more rigorous and sophisticated than Sargent's although neither pay sufficient attention to the more recent developments in feminist thinking which identify diversity and difference between women as key issues for feminists.

Marsha Rosenbaum (1981) Women on Heroin

Women on Heroin is grounded within a theoretical framework which is committed to the definitions and meanings used by the actors, in this case women heroin addicts, to organise and make sense of their world. It suffers like similar works, from a lack of analysis of the power structures which maintain women and men in their subordinate/dominant positions. The book and the research on which it is based is nevertheless a sustained attempt to render women addicts visible and reveal 'the view

from below'. It uses in-depth interviews with women heroin users in the United States to explore their experience of drug use and its impact on their lives. Although the interviewees were split equally between white women and women of colour, there is no attempt to explore the racial dimensions of the women's lives or the impact of racism on their drug use and treatment. The research identifies how women get involved in drug use, the impact of drug use on their legitimate and illegitimate work activities and on women's experience of mothering. It also explores and assesses the role of treatment in assisting women heroin users to get and stay clean. It is this aspect of the work which is of particular interest and which will provide the main focus for discussion.

Rosenbaum's thesis is that women's heroin use results in the development of an addict career and the gradual reduction in life options. She sees these reduced options operating both objectively and subjectively in respect to women addict's interpersonal relationships and in respect to work. In her rather brief exploration of the policy implications of her theory of reduced options, Rosenbaum emphasises the importance of interventions which enable women to escape from a heroin career as early as possible when fewer alternative options will have been reduced.

Rosenbaum identifies occupation options as being crucial to women's success in the 'straight' world but sees a lack of attractive work options available to women ex-addicts. She also sees parenthood as a vital *"bond to the conventional world"* so that removing children from women addicts may become a *"destructive gesture"* as it reduces their hold on the conventional, i.e. non-drug-using world.

The concept of career reduction is illuminating and well developed in Rosenbaum's study. It enables her to identify some key factors in breaking into the downward spiral of women's drug use. Her exploration of the policy implications of her thesis is far less well developed, rather general and relegated to the appendix. She recommends affirmative action be taken in jobs and in preparation for work to enable women to have access to at least the same occupational training opportunities as their male counterparts. In respect to women addict's role as mothers she recommends the shortening of sentences for women with children, as a damage limitation strategy. She also recommends the incorporation of children into treatment facilities.

Rosenbaum devotes a substantial section of the book to an exploration of women's experience of treatment. In it she demonstrates the effects on women of the type of therapy common in treatment facilities for drug users and relying on confronting the individual, often very aggressively, with their inadequacies. The assumption of this 'Synanon' model of therapy is that until individuals confront themselves 'in the hearts and minds of others' they are running away from their problems. The aim of the therapy is to strip away the individuals image and identity as a drug user so that they can begin to rebuild their lives. Rosenbaum, through her interviews with women who have undergone such treatment, suggests that the impact on women is to undermine their already low self -esteem and erode their confidence in their ability to remain drug-free. She cites secondary source material which suggests that at the Delaney Street Foundation in New York women were humiliated by their failure at motherhood. One of the women she interviews says of the therapy:

> *It made me feel really bad about myself...I felt like I really couldn't make it in the straight world even though I'd gotten clean... It made me feel dependent too because I felt she (counsellor) was saying that*

I was weak....being a women, I feel some of that anyway, that I'm not as strong and independent as I would like to be. (p.115)

This critique of therapeutic strategies in treatment programmes is a strong theme in the literature and one which I shall return to later in this discussion.

Rosenbaum also discovered that many of the women she interviewed saw treatment as a game, since counsellors themselves used drugs. Rosenbaum sees this failure to take programmes seriously as working in women's favour since it mitigates the excesses of the destructive influences of confrontational group techniques on women's self -esteem.

The suggestion of some resistance on the part of women addicts to the abuses built into systems of treatment is reflected in other aspects of Rosenbaum's analysis. She explores women addict's ability to get tranquillisers, sleeping pills, and opiate-based pain killers from doctors by utilising sex-role stereotyping to their advantage.

As in many other areas of the heroin world, women addicts utilise sex-role stereotyping and their stigmatised position to their advantage. (p.120)

Rosenbaum also develops an interesting discussion of the ways in which addicts subvert the treatment system for their own benefits by using the drugs dispensed legitimately in illegitimate ways and by using detoxification to lower their tolerance and thus increase the impact of the heroin when using is resumed.

Rosenbaum is critical of methadone maintenance programmes which she sees as over-controlling and rendering addicts dependent on welfare, since it is difficult to combine the use of methadone and the demands of the treatment programme with paid work. Far from helping women and men out of drug use, methadone is seen as prolonging it. Much of the analysis here is gender blind although the interview material is drawn exclusively from women. Rosenbaum's interests would seem to strain in favour of exploring the heroin user's world rather than in using gender as an explanatory variable in exploring women's experience of heroin use.

The most effective treatment, in Rosenbaum's view, is live-in treatment as it gives respite from the drug-using scene and therefore from temptation. She points out that such facilities are only useful for women if they do not have children. Since many of her sample were mothers, a large proportion of the women she interviewed were effectively shut out of residential treatment.

Her overall conclusions suggest that both detoxification programmes and methadone maintenance programmes lock women into the heroin life since repeated failures confirm their inability to kick the habit and stay clean. In this way treatment contributes to an addict's narrowing options since her failure at abstinence, brought about by treatment itself, confirms her in her addict role.

While Rosenbaum's analysis of treatment and its role in the lives of the heroin users interviewed offers some important insights, her analysis is essentially gender-blind What she is describing much of the time, is the heroin user's experience rather than the

specific experiences of women, although this is by no means overlooked. Her final assessment is puzzling and contradictory, although perhaps not surprising given the starting point of her analysis. She suggests that treatment is one aspect of heroin life that is similar for men and for women, except in respect to the obstacle posed to women in getting into treatment due to their child-care responsibilities and in the sexism they experience in group therapy. To relegate two very substantial obstacles to women's involvement in treatment to 'exceptions' not only seriously diminishes their significance but contradicts the evidence of the interviews.

Before leaving this discussion of, *'Women on Heroin'* some exploration of the research methodology used in the study adds support to my contention that Rosenbaum's work is limited in its feminist intentions and concerns. An exploration of the research design and methodology, included in the book's appendix, addresses some important issues. These include, the ethics of accessing and interviewing women engaged in illicit drug use and problems of validity in interviews which rely on women reflecting retrospectively on events in their lives. Rosenbaum also considers the researcher's moral and ethical obligations to the women interviewed, particularly in respect to their need for money. While Rosenbaum's analysis of methodological issues is a genuine and successful attempt to share some of the researcher's dilemmas and experience, there is little attempt to espouse the feminist research principles I discuss in Chapter 3. There are fleeting attempts to make links between the researcher' lives and those of the women being researched and some common ground is acknowledged,

> *...all the interviewers...are mothers and wives, which made us especially sensitive to those areas of women's lives that often caused them the most pain - their children and spouses. (p.145)*

But while Rosenbaum acknowledges this common ground, she does not explore it. Neither does she explore in any depth the nature of the relationship that she, and her team, tried to establish in the research encounter. There is no explicit recognition of a feminist agenda for change and no attempt to consider how the research might facilitate change, either for the women heroin users concerned, or for women drug users more widely.

Margaret Sargent (1992) Women, Drugs and Policy in Sydney, London and Amsterdam.

This book offers some useful insights into women's drug use and treatment but few, if any, are rigorously pursued. The book as a whole is rather disappointing as it tries to cover too much ground and is poorly organised. It gives the impression it has been put together in some haste. This is a pity as Sargent clearly has an interest in and commitment to her subject matter, which she approaches as a feminist and as a sociologist. The book is the fruits of a research project carried out by Sargent (single-handedly) in the late 1980's. It is clear that the project was undertaken on a shoestring. The book lacks clarity with regard to its aims and its main themes are not coherently developed. This presents difficulties for the reader and detracts from its value as a serious contribution to the development of a feminist perspective on drug use, its treatment and control.

The author makes a clear and early statement indicating that she approaches her subject from a feminist perspective but it is a feminism which depends on the notion of

the universal oppression of all women and which takes no account of the developing body of work (Albrecht and Brewer, 1990; Davies,1982; Hooks, 1981, 1984) which questions the universalising tendency of this kind of analysis. Sargent's claim that *'as a woman I have everything in common with my eighty-eight interviewees'* (p.2) overstates the common bonds between women while at the same time leaving them unexplored.

In bringing a feminist analysis to bear on the issue of women's drug use, Sargent sees the need to place women's drug problems *"into the same theoretical perspective as domestic violence, incest, rape and sexual harassment" (p.4).* This is a useful critical point since it emphasises the importance of retrieving drug use from the margins of deviancy theory and seeing it as an important and central facet of women's lives. However, Sargent then goes on to suggest that a single explanation can embrace all the problems experienced by women *"namely, that they occur as an extension and enforcement of the superior power of men"* (p.4). This all-embracing view of the origins and perpetuation of the oppressive structures in women's lives does not assist our understanding of the specific issue raised by women's drug use. Some attempt to recognise the different elements or structures of patriarchy (Walby, 1990) together with a consideration of its 'private' and 'public' face is needed if the notion of male domination is to be useful and meaningful.

One of the more promising, and original aspects of the book is its intention to compare drugs policy in three countries, the U.K., Holland and Australia. Although identified as a central aim, this discussion is relegated to an appendix. There is some attempt at comparing women's drug use, their lives and experiences in the three countries but this is done in an ad-hoc manner rather than rigorously pursued and the links between women's experience and drug-policies in the three countries are never really drawn out. Sargent's discussion of her research design and methodology is limited to a brief review of the work of Whyte, Becker and Goffman followed by a short list of studies into the lives of heroin users. This is followed by brief summary of the way in which research has traditionally focused on men and assumed a correspondence between the needs of male and female users. In a later chapter some discussion is developed which indicates the principles which guide the research and this reconfirms Sargent's commitment to feminist principles and a style of research which is about 'mutual understanding' and which is not exploitative.

The interviews that Sargent conducts with drug-using women in Amsterdam, London and Sydney form the basis of her analysis of a wide range of issues pertaining to illegal drug use. However, her analysis seems to extend to well beyond the material collected in the interviews and results in the book sitting uneasily between an ethnographic account of the lives of women drug users and an exploration of the wider social, economic and policy issues of drugs and drug misuse. Rather than the one leading the other, the two sit rather uncomfortably side by side as interview material is used to illustrate the discussion rather than to determine its shape and its parameters.

From my point of view it is the chapters on the treatment of women's drug use which are of particular interest. Sargent elicits the views of agency workers in an attempt to view the provision of services to drug users. Much of the discussion is descriptive rather than analytical and is concerned with general agency policy rather than that pertaining specifically to women. There is no attempt to tease out the gender implications of the policies described although some specific attention is paid to the issue of women's involvement in services.

Some recognisable themes emerge. Lack of child care facilities was notable in the various agencies visited by Sargent, this despite a recognition of the need for these facilities. Where child care was provided it was recognised that this needed to be flexible and should not undermine women's own care of their children.

The under-representation of women as users of the services is explored, this also being a recurrent theme in the literature. In attempting to determine the proportion of male to female users of the services it is interesting to note that Sargent finds that "*over half the agencies were unable...to provide statistics on the sex of their clients*" (p.158). This is perhaps some indication of the lack of significance which providers attach to the question of equality of access to services.

In Sydney and London services had a higher proportion of male clients but in Amsterdam the reverse was the case. In accounting for this Sargent suggests that it is the differences in policy towards prostitution which account for the variation. It is not made clear, however, precisely how the policies operate to generate these differences. A more detailed exploration of this important finding might have yielded further insight into what it is about Dutch policy which results in agencies attracting more women to their services than do agencies in the U.K. and Australia.

In examining staffing policies, Sargent's research suggests that a large proportion of agencies in each city had no women workers, the implication being that this in itself might to some extent account for the under-representation of women as clients of the services, although this connection is not explicitly addressed. In relation to the provision of specialist or 'women only' services, Sargent found these to be limited. Most services she visited made no distinction in the treatment offered to men and to women, this despite a high proportion of staff answering affirmatively to the question "*Do women have special needs when trying to get off drugs*?" (p.161). Agencies in Sydney did report holding regular groups for women and in Amsterdam 100% of agencies said they held meetings for mothers. But meetings, rather than job training, education or assertion training for example, seemed to be the limits of the specific treatment offered to women.

In evaluating the services offered to women, Sargent sought the views of agency staff on the problems women experience in getting off drugs. Some of the problems identified, however, are so ill-defined as to be virtually meaningless. For example, she cites "male domination" and "social stigma" as obstacles to women's recovery in her questionnaire to agency staff but makes little attempt to operationalise these concepts more precisely. In her discussion of the problem of "male domination" it is clear that the concept is being used to refer both to relationships individual women have with their male partners and to the situation in rehabilitation centres where only one in five residents are women.

Sargent's analysis here, as elsewhere, is full of tantalising insights which she does not pursue. For example, in researching services available to women she cites the comment of a charge-nurse (in one of the DDUs she visited, presumably, although this is not made clear) who says that they "*have nothing specially for women, unless they are pregnant of course and then we look after the children*". Sargent follows this by a single comment "*women are only vessels, it seems*". (p.116) before moving on to examine sexism in a London rehabilitation centre. Here her critical analysis is contained in a single paragraph and ranges from a comment on a woman staff-member's concern at not

being given maternity leave to a concern with women residents being perceived as "*manipulative and disruptive*".

The book's analysis of the work projects set up by agencies in Amsterdam is similarly cursory. Further insight into attempts made to equip recovering drug users with the skills for employment and/or further education, would have been interesting and valuable since little has been written about attempts to insert education and job training into rehabilitation programmes for addicts.

The most interesting and insightful section in the chapter is Sargent's identification of "needs for the future". Here she lists needs identified by workers as necessary for the future development of drug services. While lists themselves are of limited use, Sargent does draw out the fact that in all cities a need for a woman's house where children could accompany their mothers, was identified. And in contrasting the 'demands' in the different cities, Sargent draws attention to the fact that the suggestions of London workers "*give a feel for the rigid controlling nature of the drug policy*" (p.169). In contrast to agencies in London which emphasised the need for change, e.g. men's groups, non-punitive care for pregnant women, agencies in Amsterdam were asking for more of what was already on offer.

In a further chapter, Sargent continues her examination of treatment, broadening her discussion to a critique of the psychiatric discourse which underpins the medical approach. She is critical of conventional interventions which individualise the problem of drug misuse and which for women "*may lead to renewed acceptance of individual powerlessness, lack of self worth and dependence of a social, emotional and economic nature*"(p.203). Sargent's critique offers no new insights here but gives a useful summary of the arguments.

The chapter also makes an attempt to examine the 'view from below' and this offers an opportunity for an exploration of more original insights. It is difficult to know, however, how far Sargent is reporting her findings and how far she is using extracts from interviews selectively to illustrate her opinions. When she reports that "*Programs for women run by women, were thought desirable by some women users*" (p.211) it is not clear how many or what proportion of the sample thought this. Other than an apparent preference for women-only rehabilitation services, the only other point that Sargent derives from this 'view from below' is that "*there is a special need for accommodation for women who are homeless and continuing to use drugs*" (p.212) and that a 'junkies union' along the lines of the union in Amsterdam could provide much needed self-help support for users.

Sargent's discussion of women's specific health needs when using and getting off drugs offers some new insights and reaffirms others. She points up the fact that women are often acutely conscious of putting on weight when they stop using drugs and suggests that women users need to develop a critical awareness of the pressures that society places on women, to be slim, attractive etc. Women also, she points out, need specific help and support on diet, exercise and nutrition.

The use of interview material is a problem which the book never appears to resolve since it is never quite integrated into the analysis. This is illustrated particularly clearly in the final section of this chapter when Sargent offers a vignette of 'Sue'. The portrait is offered but its relationship to the themes that the chapter pursues are left

unexplicated. The result is to suggest a voyeuristic rather than analytic interest which undermines the book's intentions.

Elizabeth Ettorre (1992) Women and Substance Use

It is immediately apparent that Ettorre's approach to illegal drug use is a decided break with convention. Chapter titles indicate that the book is concerned with women's use of alcohol, tranquillisers, cigarettes and food, as well as with women's use of heroin. This suggests that women's illegal drug use is being seen as just one aspect of women's use - and misuse - of substances. There is an explicit intention to replace drug use with the notion of substance use and in so doing include "*within our frame of reference new discourses on bodily management and regulation*" (p.7). I see this as a clear move forward and a desire to break with the traditional boundaries which insist on illegal drug use having a special status and being defined as a particular social problem. In refusing to treat illegal drug use as a separate and special problem in women's lives, Ettorre is fracturing the boundaries constructed by what she terms "addiction professionals". At the same time, she is broadening the focus to include a concern with women substance users who have not been the subject of clinical attention. This is a further break with a traditional approach which focuses on those seeking treatment or help. In this way women's drug use is being set in the wider context of women's lives rather than being treated as a sub-discipline of the medical establishment and/or the criminal justice system. Her analysis has profound implications for the way we respond to and 'treat' women's illegal drug use.

The quotation which Ettorre uses to begin her book (Mary Daley in cahoots with) Jane Capati (1988) suggests an alignment with radical feminist thinking and a commitment to a woman centred analysis. She confirms this commitment in her opening paragraph when she states her intention to offer an account of women and substance use written "*by women for women*" in order to counter the resistance to *"a woman-orientated perspective in the area*" (p.l). Ettorre makes a clear statement of her aim which is to provide a feminist analysis of substance use and in so doing challenge the dominant perspective developed by a largely male, middle-class medical profession. She clearly sees herself as breaking new ground in attempting a feminist critique of the field since substance use has not been scrutinised by feminists.

Her exploration of the reason why the field has been impervious to an approach which highlights gender as a central issue, focuses on the dominance of the 'disease model' of addiction. Ettorre draws attention to the way in which a focus on the epidemiology of the disease successfully de-politicises the issues. Moreover, little significance is attached to the apparent gender imbalance in the drug-using population. When this issue *is* addressed, explanations rely on and re-affirm stereotypical images to explain the preponderance of male users. Just as the criminological literature has relied on stereotypical images of women to explain their propensity for crime (Heidensohn, 1985; Smart, 1976) and portrayed them as 'doubly deviant' because they transgress both the rules of what constitute an appropriate femininity and the rules/laws of society, so the female drug user has been constructed as more deviant and psychologically sicker than her male counterpart.

Ettorre's brief critique of the way in which women have been dealt with in the research literature also draws attention to the way in which they have been seen as "aggravating factors" in relation to their male partner's alcohol abuse and to the way in

which violence towards women has been treated benignly as a manifestation of alcohol abuse rather than an issue in its own right. This latter insight is particularly illuminating as it is an issue which has some considerable relevance to my own research. Her anecdote which tells of the Alcohol Treatment Unit which excludes violent alcoholics but which does not regard wife beating as violence, illustrates the lack of awareness with regard to gender issues which much of my own field work confirms.

Ettorre sets out her intentions to break into this traditional framework and to develop an analysis which politicises the issues. In drawing attention to the global economics involved in the production and distribution of drugs together with a reference to the relationship between drug use and unemployment, I wonder if Ettorre runs the risk of extending the parameters of the debate beyond that which can be adequately confined in the one book. In this discussion she makes an intriguing reference to the Foucaudian idea that drug use runs "*counter to the ethos of a disciplinary society*" (Smart, cited in Ettorre, 1992) but she does not pursue it. Nor is it clear how these ideas are picked up and developed in the various chapters. Nevertheless, the book's introduction not only gives a clear indication of its intentions and perspective, it also offers an insightful, if rather too wide-ranging critique of the 'disease model', a model which is altogether too narrow to encompass the complexities of the issues involved in women's and men's substance use.

My main concern about Ettorre's approach is that in adopting a woman-centred perspective the analysis encourages a somewhat undifferentiated view of the category of 'women'. In attempting, and succeeding, to dig the debate out of the pre-feminist mire in which it appeared to be stuck and in injecting a much overdue consideration of gender, Ettorre's treatment takes too little account of the developments in feminist thinking which emphasise difference and diversity between women. Since there are clear class and race dimensions to women's illegal drug use, drinking and smoking, a greater concern with the ways in which women's experience of substance misuse is shaped by race, class, culture, ethnicity and sexuality might have been achieved.

While it is the book's feminist approach to women's substance use which is of most interest, the chapter on Women and Heroin warrants some specific attention from my point of view. Here Ettorre takes her commitment to feminist methodology seriously by promising to "*look beyond the drug treatment system to the women themselves in order to have a clear idea of the problems they face*" (p.72). This commitment does not translate into an attempt to glean first-hand experience of women's use of heroin, as in Marsha Rosenbaum's work. (One might argue that we have reached near saturation point with this type of approach). Ettorre draws on Rosenbaum's work and other secondary sources to give an insight into the impact on women of using heroin which tends to be regarded as a "masculine drug". She draws attention to the fact that, while drug users have been demonised and set apart from 'normal' society, relationships and access to power within drug-using communities reflect the institutionalised oppression of the wider society.

Ettorre's woman-centred analysis leads her to emphasise the similarities between women: "*women heroin users are clearly subjected to the same social expectations and forms of subordination as many women in society*"(p.75). She points out that they have similar caring and domestic responsibilities to other women (p.80). It is this insistence on the links between drug-using and non drug-using women and her refusal to confirm

heroin-using women's separate status as a pariah group which characterises Ettorre's feminist approach.

As with many writers on the subject of women's illegal drug use (Perry, 1979; Sargent, 1992; Oppenheimer, 1989) Ettorre is concerned with the way in which women's illegal drug use is perceived and constructed in the wider society. She offers a very sophisticated analysis here which draws on the metaphor of pollution to explore the ways in which heroin use by women is perceived. It is an effective device which neatly captures the contempt in which drug-using women are held. Ettorre demonstrates that there is much to be gained from an understanding of how deviant women are defined and constructed. By exposing the limits and constraints on women's behaviour, the mechanisms which structure and maintain women's subordination are exposed for closer scrutiny.

In examining women's use of heroin Ettorre also looks at treatment services. Here her analysis is derived largely from secondary sources and as a consequence adds little that is new. She makes little attempt to differentiate between type of services and given the wide range and different orientation of treatment facilities in the drugs field, this hampers the analysis. She draws attention to the special needs of pregnant drug-using women but attempts little more than a brief summary of some of the main points made by others. She concludes her brief analysis of treatment services with the suggestion that women-only treatment settings might be a viable option given the complexities of the issues. In support of this suggestion she cites some experiments but fails to point up the problems with many women-only treatment options which collapse women and children's needs together and treat women as mothers rather than as individuals in their own right.

Ettorre's treatment with regard to the needs of Black women is cursory and 'added in'. She sees Black women as a 'special' group but her analysis is confined to stating the obvious, i.e. the need to address the racism and homophobia of treatment agencies and services. She gives no indication of how this might be achieved.

The final part of the chapter on women and heroin is devoted to a discussion of the issue of AIDS and HIV. Ettorre challenges both the idea that prostitution and drug use are inextricably linked and that women, as prostitutes are the main vectors of the HIV virus into the heterosexual community. She argues that AIDS is a feminist issue and takes up the question of women's lack of power in relation to prostitution, AIDS and HIV. She suggests that prostitutes and drug-using prostitutes in particular, have become a new target for intervention and intrusion from welfare professionals and researchers. She suggests that the advent of AIDS and HIV - and the monies available to research the problem - have resulted in the opening up of new, increasingly fashionable, channels for research and social intervention. She detects a certain irony in the fact that prostitutes have become increasingly organised in resisting the virus but have not always been able to resist the intrusions of the scientific community from gaining access "*to information about intimate details of both their private and public lives*" (p.89). Ettorre's exploration of the way in which professionals have penetrated prostitute's social and working networks is a good example of her sharp critical handle on the issues. She pursues her analysis further when she questions how far these "male-defined professionals" are helping prostitutes protect themselves and how far they are engaged in protecting heterosexual men.

The chapter on women and heroin demonstrates how, by adopting a thoroughgoing feminist analysis, new insights into women's drug use, its treatment and control, emerge. The chapter ranges rather too widely to provide an extended discussion of all the issues it highlights but succeeds in reviewing and re-working ideas into a stimulating discussion which addresses the complexities of the issues around women's illegal drug use.

Having explored women's use of cigarettes, heroin, tranquillisers, alcohol and food, Ettorre turns her attention in the penultimate chapter of her book to drawing together the issues and considering their implications for feminist praxis. This is perhaps the most successful chapter in the book since it brings all the preceding discussions together while at the same time moving the analysis on and into a concern with social action. Methodologically this is important since it is further indication of her commitment to bringing a feminist perspective to bear on the subject of women's' substance use and reflects a concern *"to understand the world and then change it"* (Stanley, 1990). Ettorre's commitment to producing useful knowledge which will "make a difference" is well sustained throughout the chapter.

The discussion is pitched at a theoretical level rather than a 'practice' level which is appropriate given the aims of the book. The strategies she identifies for the adoption of a feminist approach to women's substance use are modelled on the self-help women's health movement. These include "*developing social agency*" which urges a re-definition of women's use of substances - away from explorations which bolster the idea of individual weakness and lack of control to a more positive view of women's substance use as a "*viable course of action*" in "*oppressive social situations*". A second strategy returns us to the notion of pollution and advocates "*politicising pollution*". Here it is suggested that the very dynamics which exclude drug-using women as polluted out-casts could "*backfire*" and provide a focus for solidarity among the "*out-cast*" women. Other strategies include emphasising the importance of identifying women's shared experience of "*a gendered system of domination*" and of making connections between women's "*acceptable*" and "*unacceptable*" dependencies.

Self-help is the guiding principle from which the strategies emanate and Ettorre concludes with a useful discussion of different models of self-help. She makes a distinction between the "clinical model" of self-help and the "structural model", the former being a model which is dominant in the drugs field and which underpins the treatment approaches of organisations like Narcotics Anonymous and is still a powerful influence on the work of therapeutic communities such as Phoenix House where part of my research is based. The "clinical model", unlike the alternative "structural model" does not encourage political action since it relies on individual enlightenment more akin to the confessional than to political activism. Ettorre, not surprisingly, rejects a clinical model of self-help in favour of a model which has its roots in the Women's Liberation Movement, civil rights and gay liberation politics. The discussion here has clear parallels both with the work of Dobash and Dobash (1992) in respect of wife abuse and with Iris Young's paper discussed in Chapter 2.

In the final chapter of the book Ettorre continues to push at the traditional boundaries which define women's drug use. In attempting to re-define the meaning of women's drug use and thus our response to it, Ettorre returns to the notion of pleasure, explored earlier in the book. That this notion is being introduced to a discussion of women's drug use is a radical move since there is little acknowledgement in any of the

literature of the fact that women's drug use may indeed be pleasurable. The assumption in most of the literature, and in all treatment services, is that women's drug use is a problem and not a pleasure. In insisting that a *"women's substance use may be viewed as an assertive choice and a move towards pleasure" (p.147).* Ettorre subverts the traditional view of women's drug use as destructive, deviant and decidedly problematic. To suggest that women actively choose to consume illegal drugs, together with a range of other substances, is to seriously challenge not only the way in which women's drug use is constructed but the way femininity itself is defined and perceived. For women to take pleasure for themselves is not entirely legitimate as it runs counter to the idea of women giving pleasure to others.

Pursuing the theme of the empowering and liberatory potential of substance use in women's lives, Ettorre argues for the disengagement of physical intimacy from what she refers to as *"physical ultimacy"*. Ettorre's notion of *"physical ultimacy"* seems to refer to women's ability for self-direction and control. Ettorre is right to stress the importance for women of exploring and appropriating what is rightly theirs - pleasure and pleasure-seeking activities - although she is also right to stress that substance use may be a rather perilous way to achieve it. I am concerned, however, that Ettorre's argument here would seem to rely on a rather essentialist view of women and how they might achieve liberation. She implies that if women's *"psychic excavations"* are thorough enough they will succeed in retrieving women's passion and women's energy and they will cease to rely on drugs as a short-cut to pleasure. At this point drugs become a form of 'false consciousness', a substitute pleasure. But we have to ask how far there *is* in fact a shared energy particular to women, which can be unleashed and how far there is a 'real' woman to be found. Is there not a refusal here to engage with the current of post-modernist thinking which sees the quest for an essential woman's pleasure as highly problematic? Perhaps women's drug use needs to be seen not as a substitute for 'real' pleasure but simply one of a number of legitimate, albeit risky, ways in which women can derive pleasure.

Summary

The three books on which this discussion has centred offer some important insights into the treatment of women's drug use. Ettorre develops the most rigorous and explicitly feminist analysis of the issues, but Rosenbaum and Sargent also focus centrally on women's drug use and its treatment. Some serious shortcomings in service delivery are identified and can be summarised as follows:

- There is a need to pay more attention to jobs, training and educational opportunities for those women recovering from drug misuse.

- The confrontational techniques used by many treatment facilities for recovering addicts have the effect of undermining women's already low self-esteem.

- The high failure rate of maintenance and detoxification programmes serves to confirm a woman's inability to get off and stay of drugs.

- Residential facilities which take children are needed in order to meet women's needs.

- 'Women-only' time slots and 'women-only' programmes are seen as necessary to increase women's access to services.

- Women recovering from drug misuse have specific health problems which are not always recognised or addressed.

- The 'medical model' of drug use and the boundaries which make drug misuse a separate and specific problem in women's lives are challenged.

- A lack of challenge to male violence towards women, illustrative of the sexist assumptions which underpin service provision, is revealed. Sexism seems to be particularly entrenched in residential facilities.

- The possibility of establishing self-help strategies among women substance misusers, based on a 'structural' rather than a 'clinical' model is explored.

The literature discussed above reveals a number of important and recurrent themes in relation to women's drug use, its treatment and control. These themes are picked up and developed in Chapter 2 where journal articles are scrutinised.

CHAPTER 2

REVIEWING THE LITERATURE (ii)

Introduction

Current literature which focuses on women's drug use, its treatment and control, emanates either from a strong feminist perspective concerned to radically re-appraise and re-orientate the analysis of women's drug use and its treatment (Ettorre, 1992; Young, 1994; Sargent, 1992; Henderson, 1990) or from a weaker perspective which seeks the inclusion and fair representation of women (Rosenbaum, 1981; Levy and Doyle, 1974). A further set of literature can be identified which is concerned not so much with the issue of gender but with the effects of women's drug use on their children, particularly new-born children (Cuskey et. al., 1981; Densen-Gerber etc. al., 1972; Williams, 1989). The following analysis of journal articles and papers concerned with the treatment of women's drug use considers both the orientation of their concerns and the themes which can be identified. The first theme relates to Ettorre's work discussed in Chapter 1 and is concerned with the lack of understanding about the nature, extent and roots of women's drug use.

Understanding women's drug use.

Ettorre (1992) identifies a lack of understanding in respect to women's drug use and sees the problem as emanating from research concerns which centre on men as the most visible participants in the drug-using culture. There is an assumption that substance misuse is primarily a 'male problem' and that women users have similar treatment needs to their male counterparts. Failure to recognise that women use drugs differently from men, as a means of "*taking something for themselves*" results in a partial and distorted understanding. From this we might logically surmise that the treatment strategies evolved from such a partial knowledge base might be inappropriate, even irrelevant to women drug users.

In an earlier paper, Ettorre (1989) argues the need for "*the production of feminist knowledge*" within the addiction field, a knowledge which can only be achieved if boundaries are re-defined and reconstructed to allow links to be made between women's dependency on illegal drugs and their dependency on other substances. Ettorre identifies a number of issues in this paper which are then refined and developed in her book (1992) reviewed in Chapter 1. A key idea which is explored in both, is that of dependency. Ettorre makes an intriguing and subtle connection between women's social/emotional dependency and their dependency on substances; between dependency as addiction and dependency as "*a subordinate thing*". She points up the way in which the one is a socially desirable attribute in women, the other a sign of depravity. Her discussion here is closely related to her contention that we can only fully understand the issue of drug misuse as it relates to women if we are able to establish clear links between women's substance misuse and the overall structural dynamics of power and dependency (p.597).

Ettorre's analysis of the problem of male bias in relation to our understanding of women's drug use goes much further than wanting to add women in. In her paper she explores the terrain which a feminist approach to drug use might occupy by making some

subtle connections between the acceptable and unacceptable faces of women's dependency and between a variety of women's health issues. In a cogent analysis of the way in which women's drug use is perceived and constructed, Ettorre not only draws together legal and illegal drug use she also transforms the substance-using woman from a victim of psychic frailty into a resister of social and political pressures. In so doing she constructs an image of women's drug use which challenges traditional notions of the weak victim or out-of-control deviant. In challenging received wisdom with regard to the origins of women's drug use, Ettorre's analysis alerts us to the possibility that our present treatment strategies may have little purchase on women's drug use since they derive from a faulty understanding of its origins.

The relationship between women's legal and illegal drug use which Ettorre explores is clearly a key issue in gaining a fuller understanding of women's drug use. It is an issue explored in a much earlier paper by Lyn Perry (1979). Perry's discussion is critical of the way in which legal and illegal drug use are dealt with *"as two distinct and separate spheres"*, although she herself tends to reflect rather than challenge this separation in the structure of her article. Her analysis focuses on academic and popular reaction to women's drug use and is an early attempt to inject a feminist perspective into an understanding of women's drug use.

That the origins of women's drug use may fruitfully be revealed through a feminist analysis of the wider social structure and processes of gender socialisation, is confirmed by Edna Oppenheimer (1989) when she suggests that:

> *..the normal socialisation process which is applied to girls, with its powerful reinforcement of traditional female values and behaviours and especially its fostering of dependence amongst girls, underlies much of women's drug misuse and addiction to both legal and illegal drugs.* (p.186).

Similarly, but giving greater weight to the dimension of power, Ettorre (1989) suggests that a full understanding of the issues as they relate to women can only be developed if we are able to establish

> *..clear links between the issue of women and substance abuse and the overall structural dynamics of power and dependency.....* (p.593).

It is women's resistance to and denial of their ascribed passivity, which may account for much of women's substance using behaviour.

An analysis of women's drug use which identifies wider social processes as its root cause suggests that appropriate intervention may need to be re-directed - away from an approach which seeks to treat an individual's pathological dependency to one which seeks change at the social structural level. It is possible to see how such an analysis results in a dissatisfaction with traditional treatment approaches and a concern to develop more appropriate strategies of intervention. An exploration of alternative approaches to women's drug use is developed in the final section of this review.

A second theme which is revealed in the literature is that of:

The under-representation of women as providers and users of services.

This issue has had a good deal of attention in the literature. It is taken up by each of the writers reviewed above and receives some sustained attention from Sargent in particular.

Concern about women's under-use of services dates back to the 1970s and is regularly reiterated. Early concern about the under-representation of women as clients of traditional services to drug users can be seen in Lyn Perry's paper (1979). Having developed a perceptive and elegant exploration of the popular myths with regard to the female addict, Perry goes on to suggest that *"relatively fewer women than men approach addiction treatment and rehabilitation agencies"*. Fewer women are dealt with through the Criminal Justice System and therefore are less likely to be compulsorily referred. She suggests that women may be reluctant to come forward for treatment for a number of reasons - ability to finance drug use by prostitution, dependence on a man for money or drugs, fear of condemnation and fear of having their children taken away.

In support of her contention that moral condemnation of women addicts acts as a strong disincentive for them to seek help she cites two sets of figures. The numbers of (notified) addicts suggests that men are three times more likely than women to be notified. A survey of drug-related incidents at London hospital departments, however, demonstrated that women - both notified and not notified - formed almost half the number of patients treated. Although official statistics are notoriously problematic, such a discrepancy would seem to confirm women's reluctance to come forward to seek help. Where they are 'exposed' in emergency situations, women addicts appear in similar numbers to men.

Concern about the under-representation of women as users of residential services can be seen in the American literature. Cusky et. al. (1981) express concern about the fact that therapeutic communities have little success in attracting or retaining women and set out to research the reasons why this is the case. Having argued that there are growing numbers of female addicts of child-bearing age, Cusky et. al. express surprise that little attention has been paid to pregnant addicts and/or *"addicts with children and neonatal addiction"*. Their concern about the low take-up of treatment facilities by women, however, would seem to emanate more from an anxiety for children *"...sentenced at birth - either stillborn, born addicted, or dead soon after birth due to withdrawal" (p.271)*

The paper's analysis of the treatment model offered in the therapeutic community highlights some important reasons why women are not attracted to the programmes and find it difficult to stay if they are admitted. One of the features identified as inimical to woman's involvement is the *"strict regime of punishment and treatment"*. Women may lack the levels of self esteem and assertiveness needed to survive the effects of *"seemingly harsh regimes"* and *"radical "tearing down""*.

A further feature which, it is argued, may account for women's reluctance to seek, or ability to gain entry, is the requirement that strong motivation for change is a pre-requisite for admission. Lower levels of self-esteem in women make it difficult to find this motivation and belief in their ability to change. Yet a further barrier is seen to lie in the requirement of many TC programmes that addicted partners enter the

programme together. This takes little account of women's lack of power to persuade a partner to enter a programme with them.

Much of the material which points up the under-representation of women as clients of services to drug users is drawn from surveys of one type or another. Smart's work (1985) surveys Drug Dependence Units and discovers that only 13% of DDUs offered women patients treatment which differed from that of men and that only 3% offered facilities such as waiting rooms or creches. Smart does not pursue the implications of these findings. Indeed, she rather determinedly refuses to be drawn on the issue and states that it was not possible to infer from the questionnaire *"whether this indicates a neglect of the special needs of women drug users.. .or whether it reflects a scarcity of resources"* (p.139).

Watson and Ettorre (1989) are more centrally concerned with the issues of women's access to and use of services in their report of service provision as seen by women practitioners, researchers and policy makers in the U.K. This was a piece of research designed as an information gather exercise to determine the level of provision for women. Watson and Ettorre conclude that there is a lack of facilities for women, such as creches, women-only spaces and time slots, information giving and health screening. Their survey confirms DAWN'S (1985) earlier findings. They highlight sexist behaviour and attitudes in agencies as an important barrier to establishing gender sensitive services and women's equality of access to treatment and information, although they give no indication of what precisely is meant by sexist attitudes towards clients and the women who try to help them.

The survey which forms the basis of the research is limited in both its design and sample. Respondents were drawn from female participants in two conferences organised to address the issue of women's problems with drugs and alcohol. The researchers describe the survey as an exploratory study but their conclusions are so broad and ill-defined as to be of only limited value. The report concludes the obvious *"there appears to be a need for major change if we are to improve services for women"*. Ettorre and Watson give only the vaguest hint of what the nature and direction of the change might be. *"Service providers may need to change their behaviour and be less resistant to new ideas and treatment approaches for women"* (p.124). The research does little more than reiterate and confirm DAWN'S earlier findings which are based on a much more extensive and rigorous survey. Lack of child care is seen by both surveys as an important barrier to women's access to services, as is lack of women-only facilities. What the report does demonstrate perhaps, is that despite the setting up of DAWN in the mid-1970s, aimed at challenging traditional assumptions and approaches to women's drug and alcohol use, *"a full woman-orientated response is still lacking"*.

The issue of the under representation of women as users of services has been taken up by formal policy-making channels in recent years. Sheila Henderson (1990) draws attention to the fact that the need for change in this area was recognised by the 1989 Report of the Advisory Council on the Misuse of Drugs:

> *Research suggests that although proportionately fewer female than male drug mis-users attend drug services, services which make a particular effort to gear what is offered to the needs of women can be successful in attracting a much higher proportion of women*

clients. Drug services should review their policies to ensure they are receptive to the needs of women. (p.41).

She also considers, however, in a later paper (1991) that drug using women were scarcely acknowledged before the advent of HIV/AIDs, and it may be that official recognition of the need for services to attract a higher proportion of women is connected to the concern about the spread of HIV infection.

A third theme, clearly linked to the under-representation of women as clients of treatment services is that of:

Sexist Practices in the Treatment Setting

Some attention has already been given to the way in which sexist attitudes operate in the treatment setting. The discussion of the 'Synanon' model of treatment in Rosenbaum's work is an example. Ettorre's highlighting of the way wife abuse is viewed, is another. Further consideration of the literature reveals some clear examples of how sexism operates in the treatment environment and also gives an insight into attempts made to address it. It is an issue which has been given some sustained attention in the American literature on treatment programmes in therapeutic communities.

In the examination of the work of Cuskey et. al. (see above) we have seen that, in identifying the barriers to women's involvement in TCs, the researchers sketch the main features of a model of treatment which is centred on aggressive confrontation, confidence, motivation, expectation of success and strict regime of discipline. The paper calls into question the value of this male-orientated treatment model for women and draws heavily on the work of Solar (1976) to develop further critical insight into the masculine bias which characterises the treatment setting in TCs. Mixed sex therapy groups are seen as settings *"for displays of power on the part of the males, who band together to form positions of dominance"*. Cuskey et. al.'s research suggests that such groups generally average three men to one woman, that the *"male bonding"* which is a feature of such groups means that women are effectively silenced and that where attention was directed towards the women *"it was in the form of recriminations and sexist attacks"* (p.280).

In exploring other aspects of the therapeutic regime, the research draws attention to the way in which house jobs are organised in the TC.

Men and women do not get the same job assignments - women are placed in traditional "female" jobs such as cooking and secretarial positions and are usually discouraged from learning male household skills such as painting or carpentry. (p.281).

Moreover, jobs are organised into a status hierarchy and it is more difficult for women to achieve high status jobs and they are more likely to be 'fired' from them. A similar pattern of low expectations of women is identifiable in relation to employment opportunities and vocational placements.

Further evidence of sexist bias is to be found in the attitudes of male staff members who are dominant both in numbers and positions of authority. Oppressive 'street' attitudes towards women, especially women who have been involved in

prostitution, are reflected and reinforced in the treatment setting. Continuing to cite the work of Solar, attention is drawn to the fact that half the women interviewed in Solar's study *"had been propositioned by male staff members and often were forced by circumstances to submit to their demands"* (p.281). This results in an appalling contradiction between women being expected to retreat from pasts characterised by prostitution and sexual abuse while having those very experiences reinforced in the 'therapeutic' setting.

In addition to what would seem to be a catalogue of damning insights into the sexism which is rife in TCs, Cuskey et. al. highlight the lack of attention to women's health needs which is seen to result, not surprisingly, in lack of uptake by women of this potentially valuable service. Potentially valuable, since, as Rosenbaum (1988) points out, residential services offer respite from drug use and its attendant risks.

Cuskey et. al.'s paper seems somewhat contradictory. On the one hand it demonstrates its woman-centredness by acutely exposing the sexism in the TCs, both at an interpersonal and organisational level, but on the other it adopts a condemnatory tone towards women who expose their unborn and new-born children to danger through their drug use . The research lacks a strong feminist analysis of women's drug use and its treatment, although it does attempt to move away from an explanation which relies on individual pathology to one which recognises the significance of wider social pressures on women and their drug use. The paper offers some important insights into the treatment received by women in the TC environment and also pays specific and sustained attention to the position of lesbian women. Its pro-woman stance, however, is not robust enough to withstand the pressure to collapse women into mothers when pregnancy occurs.

An earlier example of work which explores similar territory to that of Cuskey et. al. is Levy and Doyle's study (1974). The rationale for this early study of women's experience and treatment in therapeutic communities is the fact that *"the drug abuse literature has largely ignored the fate of female clients in treatment"* (p.428), a much repeated complaint and dominant theme in the literature, as we have already seen. The study focuses on one particular, very large, TC in New Jersey, chosen because it was representative of this type of facility for drug users and because the researchers were able to gain easy access. Levy and Doyle make the point that such ease of access to TCs is rare. To my mind this is an important observation since it begs the question as to how accountable and accessible to scrutiny such closed communities are. This question is not pursued in the paper.

The research adopts quantitative techniques, using a survey administered to staff and to residents and designed to identify the major problems experienced by addicts. It is difficult to tell how the respondents were asked to rate a list of possible problems ie. whether they were merely asked to indicate if, for example "lack of job training"' was a problem, or whether some scale of seriousness, say 1 to 5, was used to indicate the extent of the problems. The way in which the results are given (p.431) suggests a crude yes/no response to each proposed 'problem'. As with much of this type of research, the findings pose problems of validity in as much as there is a clear risk that staff and residents were responding to the questions rather than identifying their major problems. There is nothing in the paper to say how the questionnaire items were constructed. If they were done through discussion with staff and residents, and one imagines they were, the problem of validity has to some extent been addressed.

Despite the shortcomings of what appears to be a rather crude survey, its findings appear to suggest a wide discrepancy between what residents regard as their major problems and what staff identify these to be. This was particularly the case with respect to the way in which women felt about their bodies, about suicide and about "not being smart" (i.e. clever). In each of these areas staff dramatically under-estimated the extent to which these were viewed as problem areas by women drug users. In addition to staff /resident discrepancies, the survey also suggests some marked differences in the way male and female addicts and their problems were viewed, by staff.

> *Women are seen as having poor relationships with the opposite sex, difficulty in being a parent, bad feelings about their bodies, childishness and dependency. Men are seen as lacking job training, being passive and having no desire to motivate themselves.* (p.430).

In short, staff attitudes towards men and women residents mirrored traditional beliefs about male and female roles and natures. The research concluded that there is little attempt at raising either men's or women's consciousness with regard to women's rights and women's issues in the TC. Indeed, Levy and Doyle's evidence would suggest that traditional oppressive role differentiation was being confirmed, not challenged, this despite the 'counter-cultural' image of the TC.

While the survey techniques employed in the study are limiting, the research is an early and successful attempt to focus attention on the shortcomings of a much used form of treatment for drug misuse. It is a model which was imported into the U.K. in the 1960s and 70s and given a new lease of life in the mid 1980s. Reservations about the appropriate use of such treatment facilities, in particular for women, continue to be expressed. While Levy and Doyle's research belongs to a much earlier era, its findings may still be relevant.

Despite its obvious attempt to render women visible and to highlight the sexist nature of treatment, the paper disclaims any political intentions. In outlining the aims of the study, the author says that their "*...intent was to explore women in treatment as a management/clinical issue rather than as a political issue*" (p.429), this despite the fact that their paper makes a deliberate and explicit attempt to relate the treatment of women in TCs to their subordinate status in the wider society, expresses concern about the lack of consciousness-raising efforts and the sexist nature of job allocation in the TC.

The same TC (Integrity House in Newark, New Jersey) is the focus of further attention in a study (Doyle et. al.1977) which is an interesting development of Levy and Doyle's research. The impact of the earlier research which "*showed that women received less effective treatment than men*" resulted in a serious attempt to alter the programme in order to make it more relevant to the needs of women drug users. Weekly women's staff meetings were organised together with women-only therapy groups for residents and vocational counselling was to be non-stereotyped.

The initial experiment was a failure as male senior staff began to make demands which the women staff felt conflicted with their ability to implement the changes. This resulted in them leaving, feeling "*angry and frustrated*". A second attempt at addressing the needs of women drug users took the form of a women-only house staffed by women.

Again there was pressure from male senior staff to conduct "*a more traditional programme*" and the facility closed some eight months after its inception.

The aims of the research were to discover the problems faced by women's treatment programmes, using Integrity House, as in the earlier research, as a representative sample of attempts at trying to respond more effectively to the needs of women in treatment. This time the research used both structured interviewing of staff of the TC and participant observation of therapy sessions, staff meetings, counselling sessions and routine daily activities.

The research concluded that differing perceptions on the part of staff with regard to "*the purposes and parameters of the women's programme*" led to rancour and disaffection. A crucial dimension of the difficulties experienced by women staff was having to fit themselves into the authoritarian mould demanded by the TC model of treatment. Attempts to change the nature of the relationship between staff and residents to one based on feminist principles of partnership, led to hostility and resistance from male staff.

Rather than critiquing and analysing the origins and meanings of this resistance, however, the researchers suggest women staff confused the aims of a social service with those of a social movement. In the researchers' view the

> *goal of social movements is to change an existing system, that of social services, to modify circumstances or behaviour within the existing system.* (p.1398).

The statement reveals the essentially conservative nature of the research and illustrates a view of treatment which many feminists take issue with. To want to separate social services from social movements is to deny the therapeutic power of empowerment. In suggesting that the clients of a therapeutic programme are not able to participate in action for social change because:

> *their presence in rehabilitation programs and their status as recent addicts presenting a myriad of psychiatric problems including low self-esteem, depression and anomie, preclude an ability to view their identity clearly, either as individual or as group member.* (p.1398).

.. the researchers reveal that they assume a model of individual pathology which requires treatment. This model conflicts with feminist principles of empowerment, principles which needed to be incorporated into the treatment programme if it was to meet women's needs.

The research is deeply contradictory since on the one hand, concern is expressed about the lack of success of a project aimed at meeting the needs of women, while on the other it denies the very links which might enable the necessary transformation of services and 'treatment' to be generated. The researchers conclude that women have special treatment needs and the search for appropriate ways of meeting these needs should continue. They reiterate their assertion that "*the evidence is strong that services and causes do not mix*" but make little attempt to argue the case. Finally, the women staff of the ill-fated experiment are roundly castigated,

...training programs for female staff must be devised to enable these women to distinguish their own ideals from their clients needs and abilities and to keep the two separate. (p.1398).

This seems to suggest a search for a model of service delivery which meets the needs of women drug users but which is uncontaminated by a feminist agenda of political action, a search which is surely fruitless.

In contrast to Doyle et. al's work which seeks to separate feminist action from social work practice, Mandel, Schulman and Monteiro (1979) adopt an explicitly feminist stance in reporting the results of a feminist awareness group in a mixed sex TC. Their commitment to injecting a feminist perspective into the understanding and treatment of women's drug use is made clear at the outset :

Many of the problems of female addicts are closely related to the more general problems of being a woman in a discriminating society. (p.950).

As a result of this discrimination, women entering treatment have more complex problems and more guilt than their male counterparts. Referring to the paper reviewed below by Schultz (1974) they point up the way women's sexuality continues to be abused by men in the programme and how women are encouraged to use their sexuality to gain acceptance.

The group which is the focus for the research was set up and run by the writers of the report, in an attempt to counter some of the negative effects of the male dominated TC on the treatment programme of women addicts. The initiative arose out of the Southern California Women's Substance Abuse Task Force, set up in 1974, itself an interesting development. The paper gives an account of the group's explicitly feminist aims and of the resistances it met from both men and women in the community.

One of the major difficulties which the two outside professionals and convenors of the group faced, was lack of willingness on the part of the women in the group to take any kind of leadership role or responsibility for the group. By way of an explanation, the group leaders observe that *"the energies of each person in the TC were self-directed"*. This point is not explored further although it suggests to me that the ethos of the TC does not encourage collective action or consciousness and as such is out of kilter with the feminist aims on which the group is operating.

The report on the outcome of the group points to some success and is modestly presented. The research has a decidedly practical focus since it encourages others to adopt the methods of work outlined. As such it is a valuable contribution to efforts to align the work of TCs more closely to the needs of women. The report is explicit in its commitment to feminist therapy and sees involvement of outside professional therapists, working alongside TC staff, as the way forward. In contrast to Doyle et. al.'s findings, this report suggests that a successful therapeutic outcome can be achieved when resistances are overcome and a feminist consciousness raising group is established in a TC. The report is optimistic about the ability to inject a feminist agenda for change into the TC.

The papers discussed so far have been concerned with attempts to counter the male-dominated culture of TCs in order to more successfully meet women's needs. Ardelle Schultz's work (1974) covers some similar ground but the paper emanates from a personal rather than an academic involvement in the field. Schultz gives a riveting account of her own journey through therapy and offers a personal perspective on the issue of women's addiction and treatment from an explicitly feminist perspective. Schultz's feminism is not just a lens through which she views women's experience of drug use and its treatment, it is also an awareness which she has come to as she grappled with her own addiction to and recovery from, alcohol abuse.

She is a woman who came to maturity in the 1950s and experienced the pressures operating in a world where she was expected to fulfil all the demands of a rigid and traditional femininity. Her description of encounters with therapists as she struggled with an alcohol addiction provides perceptive and personal insights into the inherent sexism of the "*therapy business*". Similarly, in her account of working in a treatment community, having recovered herself and wanting to assist others, she gives some stunning insights into the stereotypical and sexist ways in which women addicts were viewed and treated. When, for example, a male group was planning an extended therapy session, women residents/clients would be drafted in to act out the "*mother, sister, lover role*". That this was one of the ways in which women in treatment were seen, as assisting the recovery of their male counterparts, is born out by the example she gives of a statement in a funding proposal at the time (circa 1967):

> *...Women have recently been added to our community both as staff and residents, we are aware that alcoholics and addicts have many problems in their lives with women, as mothers, wives, sisters, lovers etc.. (p.492)*

In a number of important ways the paper illuminates, through personal experience, many of the more sterile and academic accounts of the sexism that is rife, not only in the TC but in medicine and psychiatry. Schultz's grasp of feminist principles in working with women appears almost intuitive and she demonstrates a deep commitment to working alongside women in a mutually supportive therapeutic environment. She also demonstrates an awareness of the specific needs of women-of colour at a time before it had become de rigour to insert such issues into feminist politics. Her understanding of the conflicts between race and gender issues in the TC is impressive:

> *In a TC minority men, both staff and residents, put tremendous pressure on the minority women to identify with the minority struggle only to see the women's issue as relevant just to the upper and middle class white women. (p.493).*

In reflecting on her current experience at TODAY a typical TC treatment programme, she offers some further feminist insights into, for example, the problem faced by lesbian women in such communities. However, I find Schulz's analysis of her current experience lacks the critical edge which she brings to the discussion of her past experience. She describes the TODAY program in rather glowing terms, glossing over some of the more contentious aspects of what passes for therapy. Nevertheless, her analysis had the effect of forcing me to review some of my own concerns about aspects

of the TC programme. In particular, the encounter group model of treatment. Schultz gives a very positive appraisal of such groups. She says:

> *For women, slip (encounter) groups offer one of the most valuable learning experiences since they offer women the opportunity to be angry, to express anger but also learn that they can survive male anger. (p.496)*

She goes on to suggest that

> *Slip groups provide women with the awareness of the power that anger can generate. They see how it has been used to keep them frightened and in their place and they also see how they have used their own anger against themselves. (p.497)*

This is view of group therapy in the TC contrasts with that outlined earlier by Cuskey etc. al.

I find Schultz's analysis here immensely challenging as my view of such groups has been much less positive. But while I find some aspects of her analysis of women's experience of TODAY stimulating, on the whole it is too ready to gloss over some of its more bizarre and authoritarian practices. Her only comment on a female member of staff's account of how she was *"verbally crucified in front of the entire residential community on account of (her) irrational, self-gratifying homosexual instincts"* is to say that *"...within the community there were problems"* (*p.500*). Ultimately the paper fails to fulfil its critical promise but it does offer some valuable insights into the potential for a more woman-centred approach to treatment. It also offers it from a very particular and personal perspective.

A further theme in the literature is concerned with the treatment of women who use drugs and who have children. To some extent this derives from a recognition of the male bias in service provision but is also a response to a growing concern about the health and welfare of babies born to drug-addicted women.

Treating women who use drugs and who have children

The above discussion has already raised some of the issues in respect to women, drug use and mothering. We have seen how male oriented services result in a lack of attention to women's needs, particularly in relation to child-care. Lack of child-care facilities is an important barrier to women's use of treatment services, particularly residential services. Some allusion has also been made to the fact that women may be reluctant to come forward as drug users through fear of having their children taken into care. The discussion of Cuskey et. al's paper demonstrates that where women's role as mothers is paid attention to, there is a danger that it is children's needs which dominate and women are cast in the role of abuser by the very fact of their drug use.

Feminists have scrutinised traditional approaches to drug use and pointed up the problems that women encounter with services. They have been critical not only of the lack of response but of unhelpful and inappropriate attitudes where services *have* been provided. This has particularly been the case where health care services have had to

respond to mothers or expectant mothers. The issue of women, drug use and motherhood has taken a new turn in recent years with the spread of AIDS and HIV (Henderson, 1991) and it is clear that this has spawned a growth in concern about and treatment services for, women drug users and their children.

I have identified a number of journal articles which focus on the response to and treatment of, drug-using mothers from a range of perspectives. A good deal of attention in recent years has come from the medical profession but the issue has also received attention from sociologists, lawyers and from agencies and providers of services. The articles by Gerada and Farrell (1990), Williams (1989) Densen-Gerber and Rohrs (1972) reflect the attitudes and approaches which feminists have been critical of and contrast with those by Koran (1989), Rosenbaum (1979), Conners (1990) and Shapiro (1990) in which a pro-feminist stance is evident.

An article by Claire Gerada and Michael Farrell (1990) on the management of the pregnant opiate user, is a good example of a medical approach to what is perceived as a growing problem. The article reflects some important medical concerns and its bibliography gives an indication of the amount of attention that drug-using mothers have received in recent years. As the title suggests, and its tone and use of language, confirm, the article is concerned with 'managing' pregnancy in drug-using women in order to ensure a successful outcome. Tables are used to set out clearly what the aims of managing opiate dependant women are and a summary of both the *"maternal"* and *"fetal"* effects of opiate use are given. Reference is made to the complexities of problems which accompany the pregnant drug user but the article is overwhelmingly concerned, as one might expect, with the medical facts.

By moving the problem into the medical arena in this way it becomes containable and manageable. A focus on the clinical aspects of the pregnancy has the effect of reconstructing the experience of child-bearing as a clinical event to be managed rather than an emotional experience to be shaped. The article is a good illustration of the medical approach to childbirth which feminists have castigated (Oakley, 1980; Martin, 1987) on the grounds that it appropriates women's control over childbirth and places it firmly in the hands of the obstetricians.

Nevertheless, the article is concerned to put the dangers of drug use in pregnancy in perspective. It identifies the dangers but also reminds fellow clinicians that "*the vast majority of pregnant drug users are no different from other patients encountered in clinical practice*" (p.140). It re-iterates the ACDM'S concern that drug abuse should not be seen as inevitably leading to poor parenting, nor must it be assumed that social services will need to be involved in order to protect the child. There is a clear attempt being made here to normalise the pregnancy and to emphasise that the care needed is no different than for other 'high risk' pregnancies. This attempt to deflate some of the panic which has been created with regard to the impact of women's drug use on pregnancy is to be welcomed. One wonders how far this deflationary message is contradicted, however, by the setting out in tabular form the "'*Medical Complications*", *"Fetal Complications"* and *"Obstetric Complication"* which would seem to confirm rather than deny the particular problems raised for the medical profession by pregnant opiate users.

A somewhat different approach is adopted by Lori Karen (1989), a medical practitioner writing in an American context and injecting a strong sociological dimension

into her discussion of the problems faced by women and their children both in relation to AIDS and chemical dependence. Karen adopts a woman-centred analysis and presents a sympathetic view of the difficulties women face in preventing HIV infection. Karen's grasp of the issues is demonstrated by her recognition that for some women sexuality is one of the few ways they can experience intimacy, so protecting themselves by insisting on safe sex means that they risk rejection, conflict and fear abandonment. The reader is reminded of the status that motherhood has in our society and how it is crucial to women's self-esteem. Women therefore will risk unsafe sex in order to become mothers and will resist the pressure to opt for an abortion where they are HIV positive.

Karen is concerned to examine the barriers which effect the treatment of women who are drug-dependent and risk HIV infection. She is deeply critical of preventive strategies which serve only to increase the burden of women's guilt when posters are issued which read *"She has her father's eyes and her mother's AIDS"*. Karen is also critical of the fact that treatment programmes are not geared to women's specific needs. Often they do not assume responsibility for medical needs related to pregnancy and cannot therefore admit women who are expectant mothers. Few programmes provide child care and they discourage visits by children under 12.

Although the article suffers from a tendency to list rather than develop its insights, it makes a serious and successful attempt to render visible women's experience of HIV, drug use and child-bearing and to identify the complexities. The article brings a sociological analysis of gendered power relationships to bear on the issue of substance misuse and women's sexual and reproductive health. However, the end result of such a comprehensive identification of the problems faced by women in this area seems to leave little room for manoeuvre. It is difficult to see how women can take control of their health and their sexuality in the face of such universally hostile forces.

A much more developed sociological perspective on the issue of drug use and motherhood but one written too early to consider the impact of AIDS and HIV is to be found in the work of Marsha Rosenbaum (1979). Writing within an interactionist and micro-sociological framework, Rosenbaum uses the theme of *"narrowing options"*, developed more fully in her book (1988), to explore the role of motherhood in the lives of women who use heroin. Rosenbaum considers that an addict's option to become and remain, a mother, may be one of the few still open to her. The risk of having this option closed may well provide the impetus to get out of the heroin life.

One of the most interesting aspects of the women's own account of being pregnant is their condemnation of women who remain addicted while pregnant and who thus risk addiction in their new-born babies. By exploring women's views on this matter, Rosenbaum demonstrates that drug-using women share similar views to those of non-addicted women with regard to the health of their babies. She thus challenges the view that drug-using women are wilfully irresponsible in putting their baby's health at risk.

The paper also explores the treatment of drug-addicted pregnant women at the hands of the health-care professionals. The women interviewed reported being treated with intense disrespect and disdain and as a result were deterred from maintaining regular contact with services. Rosenbaum concludes that hospital staff's stigmatisation and treatment of drug-using women may well result in them feeling that they have failed at motherhood almost before it has begun.

In a number of significant respects Rosenbaum draws out the similarities between drug-using and non drug-using women with regard to their experience of motherhood. This is an important insight and one which is too often overlooked. The dominant view is one which sees all addicts, both male and female, as having similar problems. Any attempt to differentiate problems and issues is usually done with regard to drug of choice rather than along gender lines. So for example, amphetamine users are treated as a group who have different needs to say, heroin users or steroid users. Differentiation of treatment needs are organised around drugs not gender. Rosenbaum's analysis challenges this approach by severing the links between male and female heroin addicts and forging those between drug-using and non-drug-using mothers.

In exploring the impact of a woman's addiction on her mothering role and responsibilities, Rosenbaum points up the way in which drug use takes on a new meaning when a woman becomes pregnant.

> *The state of pregnancy transforms the definition of addiction from so-called "crime without victim" to that of a crime with a very real victim - the unborn fetus.* (p.434).

This perception of women's drug use is an important determinant of the way in which women are responded to by service providers.

An article by Conners (1990) develops an interesting discussion of this issue and of the way in which it is a woman drug user's responsibility for children which ensures her unequal treatment in the criminal justice system, not her gender per se. The paper offers a legal perspective on the issue of women, motherhood and drug use and suggests that while there is little evidence to indicate that the operation of the law and criminal justice system is anything other than gender blind in relation to the possession, supply, purchase and abuse of drugs, it is highly gender specific with regard to women user's child care responsibilities. In order to ensure the welfare of the child, English courts can intervene in women's lives in a *"Draconian"* fashion.

Conners suggests that for the pregnant woman who is using illegal drugs the ultimate legal sanction may well be loss of her child, whereas male users are subject only to criminal penalties. The article offers a useful, if rather legalistic, review of the 1986 case in which Berkshire County Council secured a care order on a child born to a registered drug addict on the grounds that the child's proper development was being impaired. The decision was challenged on the basis that the mother's conduct before the birth was insufficient grounds for concluding that the child was being improperly cared for after its birth. The decision was upheld, thus confirming that the treatment by a mother of her child before birth is of *"vital legal significance"*. It was made clear, however that care proceedings were only justified where there was evidence to suggest that the mother's pre-natal drug use would continue into the future. Nevertheless, Conners draws attention to how this raises the issue of how maternal conduct during pregnancy leads to the possibility of the removal of a child from its mother.

Having reviewed some of the literature which explores the response to treatment of illegal drug use in women who are also mothers from a medical, sociological and legal perspective, I shall now attend to the ways in which the theme has been treated from within the drugs field itself. Two papers and two short articles will be used to explore

some of the ways in which the fact of motherhood in drug-abusing women has been responded to.

An early, and rather disturbing paper (Densen-Gerber and Rohrs, 1972) concerned with the treatment of drug use among women who are mothers was written by the directors of Odyssey House, a therapeutic community in the USA. It is disturbing (a) in its use of highly emotive language while purporting to be a professional view of drug-addicted parents and (b) in its assertion of a clear link between drug abuse and child abuse. The paper's introduction castigates addict 'parents' (i.e. mothers) and hospitals and social services for their failure to prevent the ill-treatment of *"helpless infants born addicted to heroin and methadone"*. It makes it clear that its concerns are the rights of the child *"to be born drug-free"* The authors are critical of methadone maintenance programmes and suggest that the solution to drug-addiction in 'parents' lies in placing addicts *"under mandatory treatment until they either deliver drug-free children, or relinquish their claims to the children, or demonstrate an ability to responsibly care for them"* (p.694).

In assessing the 'Services to Women' programme at Odyssey House, the authors demonstrate a lack of confidence and trust in the women recruited to the programme when they conclude *"that even under supervision and with continuous professional counselling and assistance there is always the danger of potential (child) abuse"* (p.691). It is clear from the description of the programme that the primary focus is on women as mothers and *"the transmission of mothering attitudes and behaviours"*. Indeed, the article refers to treating the mother-child unit as a *"single entity"*.

The paper offers an important, if rather alarming insight into the development of a women's programme within the therapeutic community. It makes it clear that it is responding to the assumed link between drug abuse and child abuse and that its primary interest is in making women better and safer mothers. It makes no attempt to critically examine the links between drug misuse and child or fetal abuse. That the authors of the paper were directors of the programme is of some concern since their attitude to the women in their care is highly critical and characterised by derogatory comments and anecdotes. In speaking of the women in treatment, and presumably trying to indicate how necessary such a programme is, they say:

> *Another (mother) was constantly endangering her child's life. Unaware of an observer, she was noted to leave her 7 month-old child unattended in a tub of water or to leave him unattended on a high table. When this was discussed with her she would break into tears and sob that she "tried so hard" only she "couldn't remember everything". When this girl against advice, attempted to leave with her baby, a staff physician took custody of her child. (p.692).*

Not only does this extract give an insight into the way in which women in the programme were perceived but it also indicates the highly questionable practices engaged in by staff. Spying on women (being *"unaware of an observer"* as the paper would have it) and denying the woman the freedom to leave the programme with her child can only be considered highly questionable and ineffective treatment strategies.

A similar attempt to meet the treatment needs of women who use illegal drugs and who have children is described by West, Frankel and Dalton (1981). The paper is

written by researchers at the Family House, Eagleville Hospital and Rehabilitation Centre (USA). It gives an insight into the Family House's approach to treatment before evaluating it and identifying some of the problems encountered by staff and residents of the programme.

The paper reveals the assumptions which underpin the setting up of the project when it suggests that the focus of treatment attention is not so much on the women themselves as on the family unit and women's responsibilities and role within it. In setting up the project in this way traditional assumptions about women's role and status are confirmed. That a primary aim of the project was to bring about an improvement in women's mothering abilities is suggested by the concern that *"the addicted mother frequently lacks parenting skills and ability to nurture that is essential for healthy development of the child" (p.789).* The Family House therefore aims to teach mothering skills on the assumption that poor parenting results in children being more vulnerable to drug misuse themselves.

None of the assumptions which underpin the setting up of the Family House are challenged by the researchers, despite the fact that their own findings would seem to contradict the assumed equation between drug use and poor parenting. In reporting their evaluation of child development, the researchers say *"We have not experienced the degree of emotional instability, development retardation and social ineptitude on the part of the children which we anticipated" (p.794).* No attempt is made to critically assess the research which is cited as evidence to support their initial assumptions. Further exploration of the contradiction is limited to suggesting that the higher than average I.Q. scores among the children might be a *"quirk"* in the sample. One might have expected such a finding to provoke a re-appraisal of the equation between drug use and poor mothering which underpins the treatment regime of the programme.

An insight into the importance placed on acquiring of parental skills, together with other domestic and traditionally 'feminine' skills can be gleaned from a description of activities that form part of the treatment programme:

> *Women learn housekeeping skills by doing; chores are rotated so that each has the opportunity to practice cooking, decorating, meal planning, cleaning and child-care. Practical experience is supplemented by regular classes on nutrition, parenting, budgeting and child development. (p.791).*

The programme clearly emphasises the socialising - or re-socialising - of women into their domestic roles as traditionally defined, although it also pays attention to self-assertiveness and sexuality in order to *"help women define themselves as responsible, valuable people* " (p.791). No concern is expressed by the researchers as to how far this latter aim is undermined by the emphasis on encouraging the women's traditional domesticity. Nor indeed, how far their drug use is related to their dissatisfaction with the constraints of femininity and domesticity.

While the results of the evaluation seem encouraging in a number of important respects, not least the women's participation in educational programmes during their stay at the Family House, the rate of leaving the programme prematurely remained high. The paper gives some attention to this issue and identifies difficulties with personal relationships between the women residents and the somewhat *"hectic ambience"* of the

house as possible reasons for the low retention rate. No attempt is made to look critically at the programme and the assumptions which underpin it in exploring this issue.

Overall, the problems identified are seen as arising out of the sheer numbers of women and children living together in one house and the inevitable pressures and tensions that this leads to. While the paper captures the group dynamics of such a living situation well, no critical attention is paid to the programme itself, its operation and underlying principles. The evaluation, while exposing some of the problems, ultimately congratulates rather than critically assesses the work of the Unit.

The intervention strategies at Odyssey House and Eagleville Hospital are, in many ways, the very antithesis of a woman-centre approach which feminist inspired services seek. While it must be remembered that these are early (1970s) attempts to meet the needs of women users with children, they are nevertheless symptomatic of the sexism which still characterises many treatment approaches to drug users (see Chapter 9).

In marked contrast to the American paper a much later article written by the publications manager at the Institution for the Study of Drug Dependency (Shapiro, 1990) adopts a very different tone and approach to *"Drug Using Parents"*. Shapiro's short article appears in the Nursing Standard and is aimed at trying to encourage a more sympathetic view and treatment of drug-using pregnant women. It would seem to emanate from a concern by workers in the drugs field about the inappropriate attitudes and responses encountered by pregnant users in their contact with health-care professionals. The article explains why some pregnant users will present late to ante-natal care - because of their fear of loosing their babies into care. Previous unsympathetic treatment confirms their fears and their reluctance to come forward early in pregnancy.

In an attempt to challenge some of the myths and misconceptions about the effects of drugs on the user and baby, Shapiro looks at the evidence with regard to alleged damage done by LSD, crack cocaine and alcohol. He points up the lack of clinical support for the scare stories with regard to the effects on the fetus, of LSD and crack and suggests that the evidence is contradictory in respect of fetal alcohol syndrome. It is a useful article aimed at the professionals charged with the care of the pregnant woman who may be using illegal drugs - professionals who have a key role to play in assisting and supporting her through the pregnancy and the early weeks of new motherhood. That the article was written, indicates an ongoing concern with regard to attitudes among the nursing profession to the pregnant user.

Finally, an article by Kearney and Norman-Bruce (1990) illustrates the tensions which abound in the caring professions between meeting the needs of drug-using women and attending to children's needs. The article is written from a child-care perspective and is essentially two social workers reminding drug workers of their responsibilities towards children. It is interesting and significant that an article concerned with child protection should appear in a journal aimed at workers in the drugs field. It suggests that child protection is still not being sufficiently recognised as the province of drug agencies. The article seems to be aimed at generating policy debates among drug workers in relation to their professional and organisational responsibilities vis a vis child-care and child protection.

The writers point out that drug agencies have traditionally seen their remit as being with adult users who are only incidentally parents and suggest that because

agencies understand how *"their clients could themselves be legitimately viewed as victims"* they have difficulty in seeing them as potential abusers. The article fails to make explicit, however, that seeing clients only incidentally as parents is bound up with the fact that, for many agencies, men are their main client group. If agencies had traditionally worked more with women, child-care and parenting issues would be much more central.

In relation to child-care and child protection, the writers of the article are urging greater sharing of information between social services, child-care staff and drug agency workers, in order that resources can be mobilised to support the family. It points out, but does not address, the tensions in the relationship between social services and drug agencies, who may be reluctant to fuel a woman client's fear of having her children taken into care by forging too close a link with social workers. This is more than drug workers colluding with the stereotype of the social worker as *"bogey man"* as the article suggests, however. It is surely a response to the real fears and anxieties expressed by many women who use illegal drugs.

If agencies are trying to attract more women users to their services, and many of them are, these fears have to be taken seriously. While the article appears to underplay the tensions inherent in the relationship between drug services and child protection services, it is nevertheless a useful and considered analysis of the child-care issues which drug services can no longer ignore. While there are tensions which need to be addressed, the gains for women in making child-care an issue which is central to the work of drug agencies, are substantial. Providing of-course that child protection concerns are not allowed to dominate and thus lead back to the kind of treatment offered at the Odyssey House Women's Centre.

It is clear that the issues which arise when drug-using mothers seek treatment are far from resolved. On the one hand there is a clear evidence to suggest that the response of health care services can be highly inappropriate and condemnatory, as can services provided by drug-treatment centres. On the other, concern continues to be expressed with regard to a lack of attention to child-care issues by drug agencies.

Having examined four important themes which emerge from a reading of the literature - the lack of understanding of women's drug use, the under-representation of women as clients, the sexist bias of services to drug users and the concern to provide treatment for women with children - the final section of this review aims to explore the literature which is concerned to carve out a way forward in relation to the treatment of women who use illegal drugs. The literature derives from both British and American sources and falls into two categories:

1) Literature which is practice based and which describes actual attempts to reorientate existing services to meet women's needs.

2) Literature underpinned by feminist theory and which seeks a radical restructuring of responses to women's drug use, its treatment and control.

Re-orientating practice and redesigning services

An early attempt to design treatment services run for women by women, is outlined in Jeanne C. Marsh's paper (1981) which offers an assessment of an all-women treatment programme set up in Detroit in the mid 1970s. The starting point for the study

is a concern with women's under-representation as clients of treatment programmes. The research is designed to compare women users of mixed methadone maintenance programmes with those admitted to the Woman Centre and aims to determine (a) how far the all-women programme attracts a population which is different from that of traditional programmes and (b) whether the Woman Centre is more successful in treating and rehabilitating its clients. The paper gives no insight into the nature of the two types of maintenance programme. The impression is that they differed only in terms of their staffing and client groups, one mixed-sex, the other all women.

The study's positivist methodology and quantitative methods are characteristic of the American research literature in this area. The research relies on data gleaned from admission forms and on counsellor's assessments of levels of *"functioning"* (e.g. in relation to education/vocational training, care of children, drug use). The researcher offers no critical reflections on the problems of validity which must arise from data based on subjective assessments of counsellors, particularly where they are taking a "*before*" and *"after"* view of a treatment programme they themselves have facilitated.

If we reject the critique of this type of research in terms of its value and validity and accept the findings, they would seem to indicate that the women's programme attracted clients with more complex and entrenched problems, that fewer women dropped out of the programme of their own accord and that they left the programme *"functioning as adequately as clients leaving the comparison programme"*. Such findings would appear to be encouraging as they indicate that by offering all-women programmes, a significantly different client group will be attracted. A race dimension also emerges in the findings in as much as the all-women centre seemed to attract a relatively larger white population than the traditional mixed sex programmes. The significance of this finding is not explored, however, and no attempt is made to account for the *"significantly different racial composition"* of the programmes.

Turning to the literature which seeks to examine and evaluate the U.K. experience of trying to re-orientate treatment services to more adequately meet the needs of women, Sheila Henderson (1990) has edited a collection of papers which provide a valuable insight into recent innovations. A number of the papers in *Women, HIV and Drugs* addresses the issue of services to women, an issue which takes on new significance when women users are at risk of HIV infection and of passing on the infection to their babies. Several of the papers give sustained attention to how services have encouraged women's greater involvement.

While the focus of the papers is on health and social care practice, the descriptions of work being carried out in the various projects are informed by a feminist analysis of women's health issues. All the papers derive from a reflexive practice and a serious attempt to reorientate services to meet women's needs and improve their uptake of services. Some important insights into the strategies being developed to support women and into the feminist principles which underpin them are offered.

The concerns of the papers cover a range of issues, from the need to pay attention to the fact that many women have had to expand and adapt their existing caring role to include a concern with the needs of those with the virus, to the need to address the specific issues faced by women in relation to pregnancy, childbirth and child-care. En route the papers offer an important up-date of developments in services to drug users. Of particular interest here is the way in which agencies have had to redesign their

services in order to attract more women. In an era where drug-using women are at risk from HIV infection, either via their own injecting practices or through sexual intercourse with drug-using partners, women's under-representation in services takes on a new significance and a new urgency.

Jenny Miller and Mary Treacy (1990) look at the work of the Exeter Drugs Project which has made a serious attempt to provide services which relate to women's lives and women's priorities. They point out that in their experience it is increasingly the women in the drug-using relationship who tackle problems with housing, social security and, where children are involved, social services. This means that agencies have to acknowledge the importance of providing a legal advice project to enable women to get help with such problems either in tandem with, or prior to, seeking help with their drug problem. They recognise that for many women, housing or debt may be the most pressing problem, not their drug use. Mary Hepburn in the same collection of papers (p.49) makes a similar point in relation to experience in Glasgow which demonstrates the importance of providing advice and help with a range of non-medical issues in increasing women's take-up of services.

Other ways in which the Exeter Project has tried to demonstrate that their services take women's needs and concerns seriously is by providing creches, women's groups and women only time and space. In addition, women are offered the choice of either male or female worker and the opportunity to have workers visit them at home. The importance of taking the service to women rather than expecting women always to come to them is reflected in the setting up of an out reach service in the local Women's Centre, an initiative which has led to a significant increase in their contact with women drug users.

The need to reorientate services in order to attract women is underpinned by an understanding of the contradictory forces in women's lives. On the one hand they are expected to fulfil a wide variety of expectations and social roles while on the other they are denied the resources to effectively meet these expectations. Miller and Treacy also point up the fact that the portrayal of women's drug use as doubly deviant is imbibed by workers themselves who perpetrate the stigma and stereotyping of women drug users in and through the services they provide.

This understanding of the wider context of women's drug use and their up-take of services is a familiar theme but one which needs to be stressed. A less familiar explanation with regard to women's use of services is also offered. The writers of the paper point to the way in which the traditional preoccupation of drug services with opiate users means that there is a relative lack of attention to amphetamine users. Since amphetamine has been used as a slimming aid, mostly to women, it is suggested that a greater proportion of women drug users use stimulants, particularly amphetamines, compared with their male counterparts. How far this is a general pattern is difficult to know. It is certainly the case that drug-services continue to be dominated by the needs of opiate users. If, as the paper suggests, women predominate as amphetamine users, it may be that their drug of choice is to some extent excluding them from the services.

Like Jenny Miller and Mary Treacy, Sue Ruben, in the same publication, examines how services can best attract women. She is concerned with the reorientation of an existing service, however, rather than with the setting up of a new one. In discussing the operation of the Liverpool Drug Dependency Clinic which was opened in

1985, Ruben's opening remarks have a familiar ring. In common with many similar services, the DDU was experiencing difficulty *"in attracting and keeping women in contact with the service"* (p.52). Ruben was part of the staff group which set about addressing the problem and over a two year period succeeded in increasing the use of the service by women to 35% of all users. The strategies adopted to bring about such an improvement included; work focused particularly in the areas of pregnancy and prostitution, adopting a non-punitive approach towards drug users and moving towards seeing drug use as only one of a number of problems faced by clients of the service.

The work with pregnant women users has attempted to address some of the dissatisfaction expressed by women users with regard to their ante-natal care. A midwife from the local maternity unit attends the clinic's special medical session they hold for women which has led to an improvement in ante-natal care as well as providing important links with the maternity and gynaecological services.

In contrast to the view (Williams, 1989) which stresses the damage to babies caused by women's drug use, Ruben says that feedback with regard to the health of babies born to their clients suggests that *"very few require anything other than observation, and most babies manage to stay with the mother during the post-natal period without requiring special attention"(p.55).*

In addition to improving the service response to pregnant women drug users, a shift in policy to include non-medical referrals also means that women working as prostitutes have ease of access. Other initiatives in this area include working closely with the outreach workers operating the needle exchange scheme and employing a full-time worker to support women wishing to leave prostitution.

Sue Ruben's offers a straightforward account of the way in which traditional services, like the DDU, can be re-designed to encourage and increase women's use. The analysis does not concern itself with what some may see as the inherent limitations of such a service but rather with the ways it can be reformed to encourage women's equal access and treatment.

A third paper which deserves some detailed attention describes the setting up and running of Brenda House in Edinburgh. This paper is particularly interesting as it describes a residential facility for women and their children which contrasts markedly with those described in the work of Denson-Gerber et. al. and of Cuskey et. al. The paper is underpinned by a clearly articulated feminist perspective on the aetiology of women's chemical dependency. Feminist principles can be seen to be operating in an approach which assumes *"that the needs and characteristics of drug dependent women are similar in many ways to those of women who do not become chemically dependent" (p.39)* and in the emphasis placed on women's *"strengths", "abilities", "capacities"* and *"resourcefulness"*. This emphasis contrasts with the pathologising impulse in many of the papers discussed earlier, which see drug dependent women as failed women and which emphasise their weakness, fecklessness and lack of parenting skills. Brenda House, it seems, grew out of a conscious need to challenge the belief that drug-using women cannot be good mothers. Its origins are thus very different to projects set up to improve women's parenting skills and to prevent children from becoming drug users themselves.

It is clear that while Roulston and the team which set up Brenda House, are mindful of the needs and welfare of children, they are also critical of the way in which the relationship between motherhood and drug use is structured, with the focus placed centrally on the child's well-being. The emphasis at Brenda House is *"on seeing the woman as an independent person in her own right"* (p.40). This is a refreshing contrast to the initiatives explored in the U.S. literature (Cuskey et. al., 1981; Densen-Gerber and Rohrs, 1972; West et.al., 1981) which is primarily concerned with women as mothers.

Roulston's paper describes a project which appears to incorporate some basic feminist principles into its approach. It is clear that the initiative was prompted by a concern to carve out a more appropriate treatment service for women and their children. It is equally clear that the challenge posed by the threat of AIDS and HIV in drug-using women has provided a catalyst for the innovation. The paper, though short, offers some perceptive insights into the impact of AIDS and HIV in the lives of women dug-users. It captures the dilemma which women face in wanting a child because it confers social status, is culturally expected and will *"be the spark of their immortality"*, while at the same time needing to protect themselves against HIV infection.

The collection of papers which make up Women, HIV and Drugs (Henderson 1990) - a remarkably modest publication - move the debate with regard to women's drug use and its treatment, forward. This is done not only by recognising the importance of HIV in the lives of women drug users but by taking on board feminist principles of practices.

The final paper to be examined continues this forward momentum. It offers a radical break with conventional thinking with regard to the treatment of women's drug use but emanates from theoretical analyses of the issues rather than from practical attempts to re-orientate services to meet the needs of women.

In a contribution to the debate on women's drug use, Iris Young (1994) takes up the question of developing self-help strategies designed to tackle the problems of drug use at a social and political level. The paper arises out of a concern about current policy developments in the US which have led to a number of states adopting a punitive approach to women who are pregnant and abusing illegal drugs. Young offers an in-depth analysis of the moral and ethical issues this raises. Her examination of this punitive approach leads her to dismiss it as a viable and legitimate option for dealing with drug abusing women. The paper explores two alternative approaches, *"treatment"* and *"empowerment"*, which have much in common with Ettorre's *"clinical"* and *"structural"* self-help models discussed in Chapter 1.

The first part of Young's discussion is devoted to an analysis of punishment and the reason why it is an inappropriate response to pregnant, addicted women. She develops a cogent argument in which she demonstrates that a punitive response is based on the notion that there are contractual responsibilities between an individual and the state. Where the individual fails to meet their responsibilities by transgressing the limits of lawful and/or acceptable behaviour, the state responds. This response, in the form of punishment, serves to remind both the individual and other potential transgressors of their obligations.

Young is critical not simply of the appropriateness of punishing addicted pregnant women, but of the contractual model of relationships in civil society which

legitimises punishment as an option. It is a model which suggests that individuals *"are autonomous and independent"* and that social obligations *"consist of little more than traffic rules to ensure that each person pursuing her own distinct interests will not crash into the others" (p.40).* This image of a society of atomised individuals is, for Young, deeply flawed since it fails to take account of a very different type of social relationship, that which is characterised by inequality and dependency. Moreover, such relationships - parent and child being the most obvious but not the only example - are not voluntary contracts freely entered into but are *"already constituted relations of kinship or community"*. Moral obligation and responsibility in such relationships operates not through contracts and promises but through *"empathy and through the acknowledgement of pre-given interdependence and connectness."* A feminist ethics of care, as opposed to a justice model of social relationships, emphasises the non-voluntary, interdependent nature of relationships in civil society. The logic of this alternative model is to render a punitive approach to women who are pregnant and dependent on substances irrelevant. Young concludes that a more relevant and appropriate alternative is treatment.

At this point in the paper it is tempting to feel disappointed that such a stimulating critique culminates in the familiar call for *"greatly expanded public and private funding for therapeutic drug treatment and social services specifically for pregnant women, mothers and their children" (p.42).* However, this is only the first stage of a discussion which subsequently proceeds to critically examine current approaches to treatment and to explore radical alternatives.

In the second and third sections of the paper Young relies on a Foucauldian analysis to develop a critique of conventional therapeutic approaches which rely centrally on the *"confessional"* and on an individual's abilities to embark on a personal journey of self awareness. Young's use of Foucauldian thinking to develop the critique allows her to emphasis the disciplinary and normalising nature of much treatment as well as its heavy reliance on surveillance. Young also draws on a feminist inspired analysis to present a critique of therapeutic programmes which de-politicise and individualise the problem and its solution. This critique leads on to an exploration of an alternative model of treatment.

In this respect the paper treads familiar ground in identifying the shortcomings of traditional therapeutic programmes and in calling for a more empowering model of treatment which relies on consciousness-raising as opposed to *"the confessional"* and which is concerned to identify and challenge the wider structural dimensions to women's problematic substance use. The themes - therapy versus empowerment, individualistic versus political solutions - are key to an understanding of the gender issues in relation to substance misuse and its treatment.

In exploring an empowering model of treatment, Young gives a useful example of a Headstart programme which rather than focusing on problems of parenting, (i.e. mothering) encouraged women to come together to identify their problems and frustrations with schools, healthcare organisations, social services etc. and to put pressure on agencies to improve service delivery. While such an illustration is a useful way of demonstrating how feminist principles can, and are, put into practice, a more detailed analysis of the Headstart programme would have been useful. This might have enabled the development of a clearer insight into how such strategies can be mobilised with women who misuse drugs. The challenge for workers in the drugs field is precisely

that of adopting the empowering strategies of intervention which have been used successfully elsewhere. Young's paper is to be welcomed for its rigorous approach to marking out the terrain which new models of intervention must occupy. It is up to others perhaps to erect clearer signposts which lead to the development of empowering models of treatment with women who use illegal drugs.

Summary

The papers examined here develop some of the concerns identified in Chapter 1 and also reveal some additional ones. In particular, they point up:

- A lack of understanding of the meaning and significance of drug use within the particular context of women's lives.

- A concern, related to the above, that treatment strategies might be based on false assumptions about the origins and meaning of women's drug use.

- A concern to break into the masculinist ethos of the Therapeutic Community in order to enable it to meet women's needs.

- A willingness on the part of some service providers to collapse women's and children's needs together and to respond to women primarily as (incompetent) mothers.

- In contrast, a lack of sufficient understanding of and attention to, child-care issues in some services.

- An awareness of a new urgency with regard to increasing women's access to services, related to the spread of AIDS and HIV.

- A concern to adopt empowering models of treatment which shift the emphasis from the individual to the wider social and political institutions.

Of the papers discussed, it is the work of Karen (1989), Young (1994) and Henderson (1994) which offer the most explicit and clearly articulated feminist analyses of the issues, although some of the papers emanating from an earlier era - Perry (1979), Mandel etc. al. (1979) and Schultz (1974) - are also informed by a feminist perspective on treatment services to substance misusers.

All of the themes identified here and in Chapter 1, are reflected, to a greater or lesser extent, in my own findings. The willingness to read drug abuse as child abuse and to collapse the needs of women and children together, is particularly marked on one of the research sites. The dominance of a "clinical" over a "structural" model of self-help (Ettorre 1989) is also very apparent. These thematic links between the literature and my findings are further explored in Chapter 10.

CHAPTER 3

METHODOLOGICAL ISSUES

Introduction

The stated aim of my research is to bring a feminist perspective to bear in developing a critical analysis of the support services available to women who use illegal drugs. In order to achieve this objective, it is necessary to carve out a research methodology and research techniques which will reflect and be congruent with, a feminist approach to social enquiry.

An exploration of the extensive and growing feminist literature makes it clear that there can be no 'off-the-peg', neatly packaged model of feminist research which a would-be researcher can adopt. Feminist research is not about establishing a new orthodoxy, its hallmark is and must remain, its flexibility and willingness to encompass a wide range of subject matter and research techniques. It is equally clear, however, that the feminist critique of traditional academic scholarship has been an important springboard in defining the parameters of an alternative, feminist approach to scientific enquiry.

Established research methods and epistemologies have come under sustained attack in recent years from feminist scholars who have questioned the adequacy of modes of enquiry which are hide-bound by patriarchal bias in a number of important ways; in the areas deemed worthy of attention, in the research techniques employed and in their analysis and interpretation of data.

> *We echo Adrianne Rich in insisting that 'objectivity' is the term that men have given to their own subjectivity.* (Stanley and Wise, 1993 p.59).

Feminists argue that theories derived from male scholarship are not only inadequate in explaining the experiences of women but in reflecting the complex reality of the social world. The main target of this critique is positivism although this is not always acknowledged and a willingness to collapse positivism and androcentric bias together, is apparent. Nevertheless, we have to recognise that social researchers who espouse an alternative research paradigm which seeks to discover the subjective meanings that are attached to social behaviour, have also be charged with androcentric bias. McRobbie and Garber (1976) examining the British and American ethnographic studies of youth culture in the 1970s are struck by "the absence of girls from the whole of the literature in this area" and consider that it "demands explanation" (p.209). Where girls do appear they are "portrayed through the eyes of the 'lads'" (Heidensohn, 1985 p.139) and research thus incorporates sexist bias. It is suggested that the dominance of men in academia and a value system which involves "looking at boys and away from girls" results in the construction of a partial social reality, what Oakley describes as "a way of seeing (which) is a way of not seeing" (Oakley, cited in Heidenshohn, 1985, p.142).

The feminist critique has not only demanded that women's experiences be taken into account, it has challenged the entire foundation on which knowledge is constructed. Out of this critique has emerged a concern to develop a research practices and

orientation which breaks with the dominant mould and which generates knowledge about the social world which is less partial and more able to encompass women's experiences.

An early example of the feminist challenge to androcentric research and scholarship came from Ann Oakley (1974) when she embarked on an enquiry into women's experiences of housework, thus breaking with the sociological preoccupation with the public realm of work and areas of relevance to male interest. Oakley's work presented a challenge to what were considered areas worthy of social enquiry.

The discussion which follows aims to examine the epistemological and methodological issues which feminists have grappled with in an attempt to carve out research principles which challenge androcentric bias and assist the development of feminist scholarship. Having suggested some key principles which underpin a feminist approach to research, the discussion moves on to consider how far they are realisable within the context of my research.

A feminist epistemology?

Feminist 'standpoint' theorists (Harstock, 1983; Harding, 1987) take the view that an alternative, feminist epistemology is both possible and desirable since it offers a less distorted view of the social world than that which has been inherited from the androcentric theories of the past. They argue that knowledge originating from women's struggles against male domination is a privileged knowledge which more adequately reflects social reality.

While it is clear that the feminist critique has revealed the male bias of traditional 'scientific' scholarship, claims for an alternative feminist knowledge, derived from women's different experiences of the social world are not without problems. The notion of women's epistemic privilege becomes problematic, for example, if one considers that they are just one of many marginalised groups in society:

> *The theorised dispersion of power among multiple centres makes it hard to attribute epistemic privilege to just one of the many socially marginalised groups cohabitating in one society. (Bat-Ami Bar On, 1993 p.94)*

Differences within the category of women have to be grappled with. Halberg (1989) is critical of the notion that a 'special women's knowing' can arise out of their experiences. While different experiences clearly do give raise to different perceptions and different ways of knowing, Halberg argues that these differences cannot be divided along gender lines. She argues that given the differences between women (race, class, culture, sexuality) and given the diversity of their experiences generated by these differences, a feminist epistemology based on shared experience is distinctly problematic. The emphasis placed on diversity and difference between women has been a prominent theme in feminist discourse since the late 1970s when Black women and women of colour began to question the idea of sisterhood and a common oppression. This has resulted in the argument for shared experience as a basis for knowledge being seriously undermined.

Liz Stanley (1990) suggests that once a feminist standpoint is identified it opens up the possibility of a multiplicity of competing feminist standpoints arising out of the

experiences of black women, working class women, lesbian women and women of colour. In attempting to address the differences between women, while retaining the notion of gender specific knowledge, Stanley argues for the recognition of feminist standpoints - in the plural - from which "*a plurality of feminist epistemologies*" are possible.

Clearly, the epistemological issue is an important one for feminist research and one which continues to receive attention. It is not one which is resolvable within the context of this study, however. Indeed, the search for a distinctively feminist epistemology may detract from other more important questions as Sandra Harding suggests (1987). Perhaps the more pertinent questions to ask are " *what have been the most interesting aspects of feminist research processes?"* (Harding, 1987) and

> *are some ways of doing research more conducive than others in making visible a) women's needs and interests and b) the importance of gender relations in welfare provision. (Finch, 1991 p.194).*

The quest for a research methodology which is sympathetic to and arises out of a commitment to feminism need not rest on the identification of a distinctively feminist epistemology. The question of whether we can accord "epistemic privilege" to the objects of feminist knowledge can be separated from the need to develop rules and procedures for the development of feminist research scholarship. At the very least the researcher can ensure that her methodology does not undermine the basic tenets of feminist politics, at best, the rules and procedures governing the research process should actively challenge the oppressive social relations which perpetuate women's dependent and subordinate status vis a vis men.

Doing Feminist Research

Perhaps the first and most obvious defining characteristic of feminist research is its focus on women, their experiences, needs and interests. It should be **woman-centred** and not merely add women into an existing male-defined analytic and conceptual framework of enquiry. If researchers merely turn their attention to female voters, female drinkers etc. they are merely adding women onto a predefined agenda. As we have seen, feminist research is characterised by a commitment to rewriting the research agenda, to bringing experiences other than those conventionally considered as worthy of attention into the spotlight. Explorations of women's experience of housework and motherhood (Oakley, 1974) and women's experience as carers (Finch and Groves, 1983) break with and challenge the male sociologist's agenda by identifying new subjects and lines of enquiry based on the experiences of women rather than on those of men.

A number of writers suggest, however, that it is not sufficient for feminist research to confine itself to a concern with women's experience and women's issues. The research must also be **for** women - to provide them with the explanations they seek rather than to provide the answers to the questions of social administrators, advertisers etc.

> *I define research for women as research that tries to take women's needs, interests and experiences into account and aims at being*

instrumental in improving women's lives in one way or another. (Bowles and Duelli Klein, 1983 p.90)

Too often the questions asked about women have been for the purposes of social control, exploitation and manipulation (Harding, 1987). In order to ensure that research is not just about but for women, "*the subjectivity of those being investigated*" must be taken into account (Gelsthorpe, 1990) and not predefined solely by the researcher.

In addition to being on and for women, there is also a requirement that feminist research has a commitment and orientation towards social change. In this way it breaks with the politically neutral claims of positivism in its search for objectivity and instead requires that the researcher to be politically engaged and to acknowledge the political dimensions of her research.

Feminist Research on men?.....by men?

What, or who, is being researched and its political implications are key questions for feminists. Methodological issues are thus raised at the point of inception and initial identification of research topic. There is a clear requirement to centralise women, their concerns and interests and while this would seem perfectly legitimate in terms of a commitment to feminist politics, it does raise some problems with regard to research on men and indeed, research by men.

The question of research on men is a pertinent one for a number of feminist researchers, particularly those working in the field of criminology where the majority of potential research 'subjects' e.g. prisoners, prison officers, lawyers etc. are men (Gelsthorpe, 1990). It is a question which deserves some attention in this discussion since my research will necessarily bring me into contact with male providers and users of services and I need to ensure that my research design can encompass men while remaining firmly grounded in feminist principles.

Gelsthorpe and Morris (1988) argue that men cannot be excluded from the feminist research enterprise but that involving men and male experience as subjects of legitimate enquiry need not entail "*conceding the whole terrain*". Similar, Stanley and Wise suggest;

Feminist research must be concerned with all aspects of social reality and all participants in it. It seems obvious to us that any analysis of women's oppression must involve research on the part played by men in this. (1993 p.31)

I concur with this argument. It is perfectly possible to have a feminist perspective on men and masculinity and a willingness to extend feminist research to include men is crucial in some areas - including my own. The feminist political project relies on women gaining and taking power from men but it also relies crucially on men giving up some of their power and control, their exploitative behaviours and attitudes. While I would not wish to suggest that women are entirely dependent on male concessions in order that they themselves can become empowered, it must be recognised that until men are prepared to concede some of their power and authority then serious structural imbalances and oppressive relationships will persist. For these reasons I would argue that feminists must at least hold out the possibility of the inclusion of men and

masculinity as a legitimate focus of feminist research aimed at bringing about social change. Sylvia Walby is quite clear on the issue:

> *The analysis of the political behaviour of men as patriarchal agents has been little studied. It needs to be." (1988 p.229)*

It may be too, as Sandra Harding (1987) suggests, that male researchers can make an important contribution to feminist scholarship. The ways in which masculinities are socially constructed and the mechanisms by which male domination is perpetuated would appear to lend themselves to enquiry by men who have direct experience of the patriarchal pressures and ideological processes through which gender inequalities are sustained. Men have access to particular places and personnel - the boardroom the military etc. which could yield crucial insights into male relationships and the formation of masculinist cultures. Harding argues that there is a strong case for valuing and using the privileged position that men have vis a vis such settings in order to subvert male privilege.

> *If men are trained by sexist institutions to value masculine authority more highly, then some courageous men can take advantage of that evil and use their masculine authority to resocialize men. (1987 p.12).*

An argument for the acceptance of the role of men in feminist scholarship does pose some problems for a definition of feminist research as being "*by, on and for women*" (Stanley and Wise, 1984). But the insistence that research be 'by' and 'on' women emanates from an early feminist awareness of the invisibility of women in social research and the willingness to generalise from experiences of and knowledge about men. Since then, the feminist critique has developed a stronger voice and sound research practices which have begun to make women, their work, their concerns, and their interests visible and deemed worthy of attention. There is now an argument, as David Morgan suggests (1981) for bringing men back into the picture in order that gender relationships can be fully explored.

I would suggest that the key feminist issue is no longer that of whether the research is focused on men or on women, but whether it is underpinned by the theoretical concerns arising from a feminist analysis of women's oppression and by a political commitment to social change.

Methods : the 'Quantitative'- 'Qualitative' debate

Having established what might be some guiding principles in determining the overall conception of the research process, a further set of questions now needs to be asked regarding appropriate research techniques. Key themes here would appear to be the relative merits of 'quantitative' and 'qualitative' research methods in aiding feminist enquiry.

There has been some considerable debate about whether quantitative research techniques which rely on the collection of social facts and on statistical techniques to reveal causal relationships, are consistent with feminist values. The role of the detached observer/interviewer is felt to conflict with the emphasis placed by feminists on non-hierarchical relationships. The authority rested in the interviewer as the 'knower' and the

passivity required from the research 'subject' also contradicts some basic feminist values and theoretical analyses of how knowledge is generated.

In addition to these concerns feminists have also drawn attention to the way in which social surveys which present their finding in statistical form, have the effect of fragmenting experience in order to render it comparable and amenable to being presented in statistical form. Analysing her research into young people's leisure Denise Farran comments;

> *My practical purpose wasn't to understand 'Susan' as a whole, but to examine how bits of 'her' compared to bits of other people. (1990 p.96).*

Other feminists have also criticised the social survey method as it de-contextualises individuals thus rendering gender relations invisible and beyond the scope of the survey method.(Graham, 1984) [1]

While it is clear that quantitative methods and the social survey (which can be seen to exist in the intersection between quantitative and qualitative methods) pose some serious problems for feminists and undermine feminist values in significant ways, there are arguments put forward to suggest that they should not be jettisoned entirely. Research which is generated by quantitative methods can be a valuable source of information about women which could then be used in their interest. For example, research indicates that HIV positive women are likely to approach support services later than their male counterparts, resulting in them getting less health care and dying sooner after an initial diagnoses (ACT UP, 1990). This would seem to indicate the value of quantitative research methods in alerting women and service providers to the impact of gender inequalities on women's health. It would seem that quantitative methods can demonstrate the impact if not the structure of gender inequalities and would appear to have some considerable value in alerting women to areas of need and political action.

It has been suggested (Jayaratne, 1983) that women can reclaim and reconstruct traditional quantitative research techniques in order to fit them for their own purposes. Other feminists, however, remain pessimistic. Janet Finch contrasts the two approaches:

> *Qualitative methods are seen as soft, subjective and speculative.....quantitative methods are said to be hard, objective and rigorous (1986 p.5)*

This contrast highlights how much more in tune with feminist values qualitative research methods would appear to be. Indeed, the two approaches would appear to relate

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[1] Catherine Marsh, in a rigorous analysis of survey as a research method, asserts that the charge "that surveys are fundamentally incapable of perceiving structural effects...simply will not hold water" (1982 p.60). While not specifically answering the feminist critique, Marsh argues that it is possible to collect survey data on relational issues although she admits that the technology for unravelling such data is relatively under-developed. Her argument suggests that the survey method is limited by poor or inadequate design and data analysis rather than by being intrinsically flawed as a research instrument.

directly to the stereotypical male/female dichotomy in relation to value systems and personal qualities.

A number of feminist writers have argued that qualitative methods are superior in their ability to assist feminist research on women (Oakley, 1981). Qualitative methods emphasise the importance of subjective experience and the meanings which people attribute to their actions. This involves handing over a good deal of the control of the research process and ensures that limited constraints are imposed on what is revealed and the information gleaned. As a result, a much richer insight into women's lives, experiences and relationships can be achieved. Adherents of this anti-positivist research tradition claim that knowledge about the social world generated in this way is a more valid knowledge than that generated through the collection of social facts.

There is of -course nothing intrinsically 'feminist' about qualitative research methods which can include a wide variety of information-gathering techniques from unstructured interviews and life-stories, to group discussion, participant observation and the use of documents, letters and diaries. They are closely related to but cannot be simply equated with, a philosophical tradition which includes symbolic interactionism and phenomenology and they also draw on the techniques developed by anthropologists. Feminist researchers have successfully developed and to some extent appropriated this tradition in order to carve out research practices which are more sympathetic to feminist values and which result in a truer reflection of the social world.

The Research Relationship

One of the reasons why qualitative research methods are attractive to feminist researchers is that they allow for a collaborative style of information gathering where the boundaries between the researched and the researcher are deliberately blurred. A distinguishing feature of feminist research, as we have seen, is its emphasis on establishing non-hierarchical relationships between the researcher and the researched in order that information can be shared rather than extracted or solicited in a one-way process where the researcher is firmly in control.

It is also important for feminists to ensure that the research process is not an exploitative one. One way of achieving this is to endeavour to make it rewarding to the individuals who participate. Another is to ensure that the research has political aims and is not research purely for the sake of academic scholarship.

Feminist research aims to achieve a collaborative, non-exploitative research style, "*where the person being studied is not treated simply as a source of data.*" (Maynard, 1994 p.16). To a researcher espousing a positivist methodology this style of research would appear to transgress all the boundaries of neutrality and to deliberately sabotage the very process of rational social enquiry. A feminist approach to research seriously challenges the positivist paradigm by exposing the issue of power and control in the research relationship and insisting that the power of the researcher be minimised in order to empower the researched.

The 'democratisation' of the research process is not without its problems. There are some practical difficulties with this approach. Considerable social skills are required to negotiate the boundaries of a 'feminist' research relationship while ensuring that the research actually gets completed on time. At a more theoretical level there are clearly

problems in assuming that the gender link between researcher and the researched can overcome class, culture and racial divisions between women. Angela McRobbie (1982) expresses a concern that

> *feminism shouldn't be taken as a password misleading us into a false notion of 'oneness' with all women purely on the grounds of gender.* (p.52)

Links have to be forged, they are not given as of right.

A further problem with carving out a more equal relationship between participants in the research process arises where research focuses on women. Precisely because of their powerlessness and vulnerability some women will be flattered by a researcher's attention and will invest her with all the authority and control that she is trying to relinquish. As a result they will be willing but passive subjects.

In suggesting that a feminist research process must be characterised by an equal partnership between researched and researcher, the problems inherent in achieving this relationship must not go unrecognised or unaddressed. At the same time one must recognise that the relationship question is not unique to the feminist research process. It is also a crucial factor in establishing a feminist practice in social work where the authority divide between social worker and client has to be overcome or at least minimised. The emphasis on the importance of establishing relationships of equality which are based on mutual respect and lack of exploitation are clearly central to a feminist ethic.

Researcher as subject

An important aspect of blurring the boundaries between the researcher and the researched centres on the importance of the researcher acknowledging her presence as intrinsic to the research process. Again, this is directly contrary to the position of the researcher as a neutral observer as it requires an explicit awareness of the researcher's presence within, and her affect upon, the research process.

It is what Sandra Harding (1987) refers to as the insistence "*that the inquirer her/himself be placed in the same critical plane as the overt subject matter*". The very process of knowledge creation must be opened up and put under the microscope for examination alongside the subject matter which forms the focus of the research. Only by including an analysis of "*how I understand what I understand* " (Stanley, 1990 p.120/1) as an integral part of a report, can the research be made accessible to the reader - and presumably to the researched.

A related requirement is articulated by writers who stress the importance of the researcher's ability and willingness to acknowledge and draw on her own experiences at all stages of the research process. By making a personal investment in this way the researcher makes herself as vulnerable as those being researched.

Applying feminist research principles

The guiding principles outlined above, provide the methodological framework for my research. How far they are attainable and the issues they raise provide the focus for the final part of this discussion.

Research FOR women

My study grew out of a concern that health and social care services were failing to meet the needs of women who use illegal drugs, a concern generated by my own experience as a social care practitioner and reflected in the literature on substance misuse. The requirement that feminist research be women-centred is thus met.

My research is best described as being **for** women but not **on** women since the study is directed at service providers rather than women users themselves. It is an attempt to critically examine policy and provision designed to support women users and control their illegal drug use. The value of feminist research which does not directly focus on women is recognised by McRobbie (1982) when she asks:

> *Is there a case for arguing that some research works more effectively and avoids being condescending by addressing itself to making demands of and challenging the institutions, structures and those who inhabit them, and occupy positions of power within them? (p.52)*

View from below

By adopting a critical perspective on current service provision - one which goes further than asking how current provision can be made more 'woman-friendly' - I consider that I am seeking to examine the 'view from below' rather than aligning myself with the perspective of policy-makers and service providers. The research may nevertheless remain open to the charge of seeking reformist solutions which fail to challenge the way in which illegal drug use is socially constructed as a problem requiring treatment. The orientation of the research is one which seeks to explore health and social care practice rather than to critically analyse the state's response to drug use. To this extent I am working within, rather than critically analysing, the construction of drug use as a problem which needs treating. This orientation is, I believe, justified as services to drug users are expanding rapidly and if they are to operate in women's interests, feminist principles of practice need to be operationalised. In addition, account must also be taken of the fact that individual women, and men, as well as policy-makers, perceive chemical dependency as a problem in their lives and seek effective services which meet their needs..

Commitment to social change

My research is politically engaged inasmuch as it echews the neutral stance of detached observer and aligns itself with feminist political theory. A basic premis is that society is structured by divisions of gender, race and class and that research should both recognise and challenge these divisions. My research aims to challenge the subordination of women, by revealing the part played by service providers in perpetuating gendered power structures.

While the research is politically engaged it is difficult to see how it can claim to be a vehicle for social transformation. It may bring about some incremental change through raising the awareness of service providers but its claim to be underpinned by feminist principles is weak in this respect. Maynard (1994), however, is reluctant to accept that "*studies which cannot be directly linked to transformational politics are not feminist*" (p.7). She suggests that the researcher may not be in a position to control the extent or direction of change and this is most certainly true in my case.

Maynard goes on to suggest that different kinds of change are involved in feminist research. One way in which change can occur is through empowerment generated by participation in a research project. This might serve to render visible social issues or it might enable reflection and re-evaluation as part of the interview process. In terms of these more limited aims for feminist research my study might stand up to scrutiny. There is some evidence - discussed in Chapters 8 and 10 - to suggest that my presence in the agencies generated a heightened awareness of the impact of gendered power relations on service provision.

'Quantitative' versus 'Qualitative' research

If my claim to be engaged in feminist research is at its weakest in relation to its contribution to bringing about social change, it is at its strongest in terms of its commitment to qualitative research techniques. In-depth interview, used extensively in the research, gives service providers a good deal of control over the research encounter. Transcripts of interviews demonstrate a willingness on the part of the interviewer to 'hand over' to the interviewee. Participant observation, while allowing the researcher some control over the selection of what she considers to be significant events, nevertheless serves to equalise relationships between the researcher and the researched. Again, there is evidence (see Chapter 7) to suggest that there were occasions on which a partnership approach to the research was established.

Ultimately, however, the research remains ambivalent in relation to establishing non-hierarchical relationships with service providers and the subjects of the research. The reasons for the ambivalence are explored in Chapter 7 and centre on the problem of doing feminist research in a situation where men predominate and where an allegiance to feminist politics cannot be assumed.

The researcher in the research

The study demonstrates a clear commitment to locating the researcher in the research and to exposing the knowledge creation process to critical scrutiny. Chapters 5, 6 and 7 offer a sustained analysis of the impact on the research of the researcher's previous identity as a social care practitioner, of the fragmentary nature of data collection and of the problems of doing feminism while doing research. Chapter 7 in particular grapples with issues arising from this discussion of feminist research principles. It is at attempt to 'pin down' some of the abstractions outlined here.

CHAPTER 4

FEMINIST PRACTICE

The previous chapter has outlined some guiding principles of **how** the research should be conducted. Chapter 4 attempts to identify **what** the researcher might be looking for in considering how far the services under scrutiny succeed in challenging women's subordination. The feminist literature provides an obvious starting point for marking out the contours of a feminist social work practice, against which the services can be measured.

The following discussion aims to establish the principles which underpin feminist social work and social care practice before considering how they might be discernible in the two research sites. A necessary starting point for this exploration is the feminist critique of mainstream social work/social care which forms the backdrop to the development of a feminist practice.

Feminist critique of social work and health care practice

The feminist critique of social work emerged with the growth of the women's movement in the 1970s and is rooted in a Marxist/Feminist analysis of the Welfare State. Elizabeth Wilson's work (1977) developed and re-orientated the Marxist critique of the role of welfare in a capitalist society by focusing on the ways in which the state, through its welfare policies, structures women's subordination.

A radical critique of welfare stresses its function as a mechanism of social control and Wilson's analysis points up the many and varied ways in which women's lives are structured and constrained by state policy and practice. At the same time, her analysis draws attention to the contradictory nature of welfare state provision, since it has also brought many benefits to women and improvements in their quality of life. This is a theme developed since by a number of feminist commentators who suggest that it is the form in which welfare is provided which is oppressive. Women need welfare, but not necessarily in the **form** in which it is offered. Elizabeth Wilson makes the point when she draws attention to the ideological aspects of welfare policy;

> *... the Welfare State is made up both of the welfare polices and the ideology in which they are wrapped.* (1977 p.12).

The aim of state welfare, she maintains, is the maintenance of the status quo with regard to gender relationships and differential access to power and status. By examining the ideological underpinning of state welfare, these aims are revealed.

In Wilson's analysis we have a clear articulation of the problems raised by welfare state policy and provision for women and for feminists. One of the specific areas of welfare provision she focuses on is social work, which is seen to be instrumental in maintaining women's oppression by emphasising their role in the family, as wives and mothers. The analysis is critical of the fact that social work embodies a particular set of values with regard to the importance of the family and its healthy functioning. It also assumes a particular family form in which women are the primary carers and nurturers.

Social work's focus on supporting the healthy functioning of the family unit emerged in the immediate post-war era and has continued to be a dominant motif in social work policy and practice ever since. The feminist critique suggests that much social work fails to recognise that the family itself may be the root of a woman's problems, preferring instead, an analysis which identifies a woman's inability to fulfil her role within it, as the problem. This value position may lead to a reluctance to give help to women wishing to escape from intolerable family situations. A much-quoted national survey of women in refuges revealed that a quarter of the women had experience of social work intervention which tried to reconcile them to violent partners or endeavoured to stop them leaving home (Binney, Harkell and Nixon, 1981).

The family orientated nature of social work policy and practice poses a number of problems for feminists. By emphasising the importance of establishing or re-establishing stable family relationships, the importance and possibility of other close relationships are given insufficient attention. By emphasising the significance of the mother/child relationship within the family, alternative, perhaps more communal, forms of child-care are not encouraged. Feminists take issue with the ways in which social work privileges family care over other forms of care and draw attention to the implications this has for women's lives. The introduction of Community Care policies has further concentrated feminist attention on the willingness of social policy to exploit women as natural unpaid carers and on the role of social work in implementing such policies. Care in the community, as Janet Finch (1984) points out, in fact means care in the family, which usually turns out to mean care by women.

The feminist critique of social work can be seen to revolve around three key concerns: the family-orientated nature of mainstream social work practice; social worker's concerns with the mother/child relationship; and a too great a willingness of social work practice to reflect uncritically the view of women as 'natural carers'.

The feminist analysis of the family underpins the first of these concerns and has been fundamental to the development of a feminist analysis of women's oppression. The family has been identified as a key institution in sustaining women's dependency and inferior status. Women are largely economically dependent within the family and the domestic and child-rearing work that they do is unpaid and carries low status. Because state policies and dominant attitudes see the rearing of children and the running of the home as primarily a woman's responsibility, there is little help available to relieve women from their private burdens. Nurseries for the under-5s are scarce and where they do exist they are a 'targeted' resource aimed at supporting families with children 'at risk'. Significantly, many nurseries have been re-named 'family centres' as they aim to work to support the family rather than merely provide care for the under-5s. Similarly, facilities for looking after children in the late-afternoon and during school holidays are virtually non-existent, as are collective forms of preparing and eating food. Women are thus confined to the private, domestic sphere, handicapped by their responsibilities when they want or need to participate in paid work outside the home. When they do become involved in paid work women predominate in low-paid low-status jobs which are often an extension of their private domestic work (e.g. cleaning, caring, servicing.).

Drawing on this critique of the family, feminists express concern that social work principles result in a practice which colludes in the maintenance of women's dependency by adopting an uncritical view of the family and its role in creating and perpetuating women's subordination. Of particular concern is the way in which the mother/child

relationship dominates the social work encounter with women. Feminist critics point up the ways in which social work focus is often predominantly, if not exclusively, on women's responsibilities as mothers rather than their needs as individuals, or on the self-responsibility of adolescents and young adults in the family.

Social work perspectives on motherhood are heavily determined by theories of child development which emphasise the importance of mother/child bonding and the nurturing role of mothers. It is a perspective which sees the relationship between mother and child as central in determining healthy growth and development. Any problems which arise in the child's emotional, social or intellectual functioning tend to be defined in terms of a malfunctioning of the mother/child relationship. The social work response is thus to offer advice and assistance to enable women to function more effectively as mothers.

Much of the work done in this respect is described as 'family support' but in reality it is predominantly work with women, as visits to Family Centres and parent's groups will demonstrate. The view that children are best cared for by their mothers, in the home, strongly influences social policy decision-making. A main thrust of the feminist critique of social work is that it colludes with rather than challenges this view.

In colluding with the dominant view of women and femininity, social workers not only confirm women in their traditional roles, they also subtly undermine them. This is not a characteristic peculiar to social work. Indeed, it is feminist commentators on health care who have pursued this theme most rigorously and have developed a sustained critique of the medicalisation of child-birth, with the pathologising of motherhood as its corollary. Jane Calvert (1985) and Ann Oakley (1980, 1981, 1984) have identified how the process of childbirth is structured by the medical profession to ensure that the lessons learnt by women are that they need help and protection and that motherhood equals passivity. It is possible to see how this view is subsequently fostered by other helping professions, including social work, which steps in when things go wrong. Ehrenreich and English (1979) have argued persuasively that women's traditional talents and skills have been usurped by the male expert, resulting in the diminishing of women's status and responsibility and confining them to a secondary and dependent sphere. Social workers, armed with their own expertise and that of other experts (in particular, the child psychologist) can be seen as part of the process which maintains and perpetuates a system in which women as mothers remain passive recipients of expert advice. This prevents them taking control over their own lives.

> *The 'feminine' client of the social services waits patiently at clinic, social security offices and housing departments, to be ministered to sometimes by the paternal authority figure, doctor or civil servant, sometimes by the maternal yet firm model of femininity provided by nurse or social worker. In either case she goes away to do as she has been told - to take the pills, to love the baby.* (Wilson, 1977 p.118)

An important theme in the feminist critique of social work, then, is its potential for undermining women in their mothering role while at the same time confirming them in it. The notion of women as natural child-carers which pervades social work and health care theory and practice, is clearly a key concern for feminists. So too is the fact that women's caring role is extended to other members of the family and the wider

community, a principle which social work and health care policy both embrace and embody.

Women expect and are expected to shoulder the burden of care for adults as well as children in the family in a way that men are not. A study by the E.0.C. in 1984 (cited in Community Care 18.9.86) shows up glaring inequalities in the provision of public support services. Meals on wheels, home-helps, hospital rehabilitation and long-stay care were all provided much more frequently to clients cared for by men. Male carers, who make up 40% of carers of disabled and elderly relatives, received help at an earlier stage in the onset of dependency than did female carers, who received relief much later and in different forms. The findings of the EOC report confirm the view that social workers, together with other welfare professionals, rely heavily on traditional views of women as the primary carers. This view determines service provision as it is assumes that women need less help with 'caring' because it is seen as their natural province.

In bringing this brief overveiw of the feminist critique of social work and health care practice to a conclusion, it is also important to note that it is a developing critique which has moved on from an analysis of what is 'wrong' with social work and health care, to explorations of how feminist principles might revolutionise, or at least seriously overhaul, current practice. It is to these feminist principles of practice to which the discussion now turns.

Principles of Feminist Practice

There is an existing and growing body of literature which is concerned with how the delivery of social work, health and social care services can be transformed by an adherence to feminist principles of practice. (Bricker-Jenkins et al., 1991; Dominelli and McLeod, 1989; Hanmer and Stratham, 1988; Brook and Davis, 1985; Foster, 1991).

The starting point for these analyses is the idea *"that there are not two sorts of people in the world, the superior and the inferior, or in terms of power relations, the dominant and the subordinate"* (Dominelli and McLeod, 1989 p. l) and that social relations need to be transformed in order that subordination can be overcome and equality in terms of gender be established. Increasingly, the feminist analysis has also taken on the need to recognise diversity and difference among women in terms of race, class, sexuality and culture. This has led to a feminist commitment to resisting and challenging all forms of domination and subordination.

The challenge for feminist health and social care is how to embody and reflect these basic tenets of feminist politics in the helping relationships and interventionist strategies which characterise the professional task. The challenge moves beyond a concern to equalise access and to include women and women's issues. Feminist practice "*aspires to be a practice of personal/political transformation*" (Bricker-Jenkins, 1991 p.272)

In taking up this challenge, writers and practitioners have developed a range of strategies which are underpinned by an identifiable set of principles derived from a commitment to feminist politics. This is not to suggest there is a blue-print for feminist practice. Principles are still emerging and as practitioners develop their work, the body of knowledge about what constitutes feminist practice and what ensure its success, is

continually expanding. Feminist practice is "*work in progress*" (Bricker-Jenkins, 1991 p.5).

A developing set of feminist principles are increasingly available to practitioners and service providers. In addition, it is possible to identify a degree of commonality between writers and practitioners with regard to what are felt to be important underlying principles in generating an approach to social work and health care which is centred on a concern with gender issues and gender relationships. My reading of the literature on feminist practice in the field of health and social care suggests that the principles of feminist practice can be discussed under the following eight headings.

De-individualising and re-defining social problems

This is a crucial element in social work practice and one given particular emphasis by Lena Dominelli and Eileen MCLeod (1989). It is a principle which emphasises the importance of moving away from a definition of social problems which centres on personal and family problems to one which reveals the origins of social problems as being firmly located within a patriarchal social structure. In order to redefine social problems women's welfare needs to be taken seriously and women's experience of social problems centralised. In this way, the social relations responsible for problems are exposed and the patriarchal social structures in which women are enmeshed are held up to scrutiny rather than the women themselves.

Judy Hale (1983) reflects a similar concern when she stresses the need to move away from a medical model of social problems which individualises women's problems and results in a concentration on their psychopathology. The medical model fails to acknowledge the experiences that women have in common and serves to deny and obscure the extent to which problems are derived from the social structure and women's position therein.

The concern here is with de-individualising women's problems and subjecting them to an analysis which takes account of unequal power structures, their effects on social relations and on the definition of social problems. In a similar way, account needs to be taken of other structures of oppression, based on race and on class, if the social origins of individual problems are to be fully recognised.

In short, there is a requirement that feminist social work practice is underpinned by an analysis of social problems which recognises the extent to which problems are socially caused (Fooks, 1986) and which challenges definitions which blame the victim (Hanmer and Stratham, 1988).

This recognition of the need to re-structure and re-focus social problems to take account of their social and political dimensions is not, of course, exclusive to feminist social work practice, it is a basic tenet of the radical critique and approach to social work practice expressed in the work of, for example, Bailey and Brake (1975, 1980) and Corrigan and Leonard (1978). However, the feminist analysis is significant for the way in which it injects the radical analysis with a gender perspective and a concern with patriarchal as well class structures. In doing so, it insists on a resistance to pathologising women's behaviour and sexuality in favour of an approach which recognises that women's problems may be caused by social definitions of - for example - appropriate behaviour for young women (Hanmer and Stratham, 1988).

This approach to women's problems is perhaps best illustrated by the way in which domestic violence has been redefined.

> *In the feminist framework, domestic violence becomes a social structural problem rather than a personalised or private one. (Otter, 1986 p.110).*

The Women's Aid Movement has been largely responsible for shifting the analysis of violence against women away from a concern with the pathological relationship between individual man and wife within the private domestic arena, to one which stresses the problematic nature of male violence for all women.

The feminist insistence on the need to re-define social problems can be seen to be rooted in the reliance on consciousness-raising in the early feminism of the late 60s and early 70s. Consciousness-raising is a technique which encourages the sharing of individual problems, perceptions and experiences in such a way as to reveal the social nature and origins of problems which women experience. The need for feminist practice in the social and health-care field to be underwritten by an acknowledgement of the socially and politically constructed nature of women's problems, is thus rooted in a feminist awareness of the importance of revealing the true nature of the problems women face in order that they can be challenged as a common oppression rather than carried as an individual burden.

Mary Bricker-Jenkins testifies to the continuing value of consciousness-raising groups in her comments on a "*women in recovery*".

> *First we attend to the political dimensions of the issues that are reverberating in and often confound our lives.* (1991 p.1)

Consciousness-raising characterises much of the feminist inspired work that is done with clients - not so much in respect of setting up groups specifically for this purpose, although this clearly is an option, but more as "*type of dialogue*" (Dominelli and McLeod, 1989).

The above has drawn attention to the emphasis that is placed on the redefinition of social problems to take account of the white supremacist, capitalist and patriarchal power structures in which they are located.

Challenging the power of the professionals

Both this principle, and the one discussed above, rely on the questioning of the power of the expert to define the problem, its cause and its treatment, in favour of a definition derived from the experience of the client/patient. Challenging the power and control of the professional has been extensively explored by workers and analysts in the field of health care. An extensive literature documents feminists challenges to malestream medicine over the whole spectrum of women's health care. Ann Oakley's work on childbirth (1984, 1981,1980), Germaine Greer (1991) on the menopause and use of HRT, Renata Duelli-Klein (1985) on self-insemination and Pauline Bart (1981) on a feminist abortion collective are just some examples of the ways in which the medical profession's approach to women's health care has been scrutinised and challenged.

These works, and many others, together with the establishment of well-women clinics and the Women's Therapy Centre add up to a concerted attempt to articulate and cater for the needs of women. The focus is on helping women re-appropriate medical expertise from a male-dominated, male-orientated profession in order that women can re-gain control over their own bodies. Women have sought to establish self-help groups and literature, (Philips and Rakusen, 1989) to disseminate information and designed to enable women to learn more about their mental and physical health, their sexuality and their reproductive cycles.

The concern to challenge professional power and expertise is not confined to the field of medicine and health care, although we do find a powerful and sustained critique in this area. It is a concern echoed by feminists working in other fields, for example, in relation to domestic violence where the response of the social work profession (Binney, Harkell and Nixon, 1981) has been criticised. Women have also responded to the challenge of inadequate housing and child-care services (Mayo, 1977) by implementing their own problem-solving strategies and self-help networks.

Feminist practice relies crucially on diminishing the power of the professional to define women's needs in favour of an approach which privileges the view of the client and receivers of services. Enabling this challenge to emerge relies on a third principle of feminist practice to which I now turn my attention.

Equalising relationships

The establishment of non-hierarchical, equal relationships are fundamental to feminism and are as important in the field of feminist health and social care practice as they are in the area of feminist research. Achieving non-hierarchical relationships requires that workers make their values and assumptions explicit in order to share them. In this way the professional process is demystified and the knowledge base between client and profession equalised (Marchant and Wearing, 1986).

The establishment of non-hierarchical relationships also depends on the willingness and ability of women workers to share their experiences as women, with their clients and patients (Hanmer and Stratham, 1988). This is not to suggest that a professional worker can assume a commonality with her client who may not share a similar class, ethnic or racial background or a similar sexual orientation. What is required is a alliance in the helping relationship which is mindful of difference and diversity but which nevertheless seeks to establish a common ground on which experiences may be shared and related to.

Of concern here is the problem of what Barker (1986) has identified as a "*false equality*" trap which operates when middle-class professionals assume a correspondence between their own intentions and the way in which client's perceive them. It may also lead to a denial on the part of middle-class women of the skills and abilities which they possess, in the interests of a 'false equality' emanating from a false modesty.

The establishment of non-hierarchical relationships which rely on the sharing of experiences between worker and client, which have less to do with the well curing the sick and more with the sharing of knowledge, is clearly one fraught with difficulties in the social work/health care field. Nevertheless, it is a basic tenet of feminist thought and

one which must be translated into social and health care practice if a feminist model of care is to be achieved.

In addition to carving out non-hierarchical relationships between client and worker, Hamner and Stratham suggest that it is important to empower women by involving them in the decision-making and policy-making processes of the agency.

> *A commitment to a woman-centred approach to social work practice must also involve finding ways of involving clients in agency processes.* (1988 p.37).

This suggests that the establishment of equal client/worker relationships needs to be backed up at the agency level by involving women clients in policy-making.

A further issue related to equalising relationships and one which is also at the heart of the principle of redefining social problems, is that of encouraging the sharing of experiences between women clients. This not only results in the de-individualising of problems, as was seen in the discussion of consciousness-raising techniques, but also results in the diminution of the power of the worker by encouraging women to become a resource for one another. It also enables women to offer support as well as to receive it and thus challenges a woman's idea of herself as social work client.

The issue of establishing non-hierarchical relationships is not one confined to the client/professional relationship, it is also an issue for relationships between colleagues in the workplace. Dominelli and McLeod (1989) suggest that any commitment to bringing about feminist social work practice is seriously undermined unless it is underpinned by a commitment to redressing gender inequalities in the workplace. A commitment to feminist practice therefore, must be mirrored in the organisational structures which are responsible for the provision of social care and social work services. Commitment which does not extend this far can only be partial and superficial.

Establishing relationships of equality must therefore extend to a restructuring of working relationships in order to ensure that women and their concerns are not subordinated to a management hierarchy which buttresses and reinforces male privilege and masculinist assumptions regarding the provision of services and the allocation of resources. This is not necessarily, or primarily achieved by increasing women's access to the management structure. Feminist concerns in this area are not about promoting women into the management hierarchy but about changing the institutional norms and practices which result in women's access to essential resources being restricted. (Bricker-Jones et. al., 1991)

The principle of equality, then, refers both to relationships between client and worker and to relationships between workers themselves. The achievement of non-hierarchical relationships in both areas requires a radical restructuring of accepted modes of practice and organisational arrangements. This raises the question of whether the principle can only be achieved outside the confines of statutory health and social work agencies which are heavily dependent on hierarchically structured bureaucracies.

Rejecting sex-role stereotyping

A fourth principle of feminist practice is the rejection of sex-role stereotypes which see women primarily as occupiers of social roles, i.e. as wives, mothers and daughters, rather than as individuals in their own right. Rejecting the stereotype is, however, not tantamount to dismissing it and its effects on women. In rejecting the stereotype there is a parallel need for a critical awareness of the effects of stereotyping in determining women's unequal access to power, privilege and status (Hanmer and Stratham, 1988). Women's behaviour may only be fully comprehensible when seen in the context of their subordinate status and limited opportunity structures. Manipulative behaviour, for example, may become redefined as the most successful strategy available to a woman whose lack of power and status gives her limited control over her life and her relationships.

The principle demands an understanding of the effects of sex-role stereotyping and the constraints this places on women's lives but at the same time a rejection of a view of women which locates them firmly within the context of the family and familial relationships. A rejection of this view will enable workers to encourage women to set limits on their responsibilities and help them find ways of lifting some of them. It will encourage women to expect and demand time for themselves, to recognise they have rights as well as responsibilities (Hanmer, 1988).

There is also an issue of sex-role stereotyping with regard to working with men, although it seems to have been given little attention in the literature. We cannot assume that feminist practice can only be carried out in work with women, although developing feminist practice is rightly concerned to prioritise work with women. Many social work and health care situations require work to be carried out with men as well as with women. This is particularly true of work in the drugs field and work with offenders.

Work with men, particularly perhaps with male offenders, demonstrates the way in which, even where women's needs and behaviours have not led to the social work intervention, they often become the focus of attention. When faced with an intransigent and unco-operative male client, social workers and probation officers will often turn their attention to the offender's wife, partner or mother in an attempt to harness their reforming and moderating influences. The shift that occurs is as a result of stereotypical views about the nature of masculinity and its proclivity for offensive and offending behaviour unless restrained by the civilising influence of women. It is also a result of stereotypical views about women's responsibilities to and for their men in the context of the family.

I would argue, then, that the principle of rejecting stereotypes is as pertinent to work with men as it is to work with women. A feminist commitment to social work and health care practice must incorporate a willingness to challenge masculinity and its social construction, a challenge perhaps most appropriately undertaken by pro-feminist male social workers and health care workers. Work with men which is centred around confronting stereotypical ideas about men and masculinity and on encouraging a restructuring of masculine identity which is not premised on the oppression of women, is arguably the most significant social work challenge yet to be taken up.

The rejection of sex-role stereotyping applies to both work with men and to work with women. It relies on developing a critical awareness of the family, its prescribed

roles and responsibilities. More specifically, it relies on a rejection of the notion of women as natural carers and of men as natural breadwinners. It requires a critical approach to both 'masculinity' and 'femininity' and a willingness to engage clients in articulating and developing their own critical awareness in this respect.

Increasing Self-esteem

An important principle of feminist practice is identified by all writers analysing and commenting on feminist-inspired work with women. This is the principle which stresses the need to focus on women's strengths rather than on their pathology (Hale, 1983).

Women are particularly prone to self-blame and guilt at what they perceive as individual failing. They see themselves as failing in their responsibilities as mothers, daughters, wives and partners because of their inability to carry out their caring responsibilities. This sense of failure has a particular resonance for women drug users but applies equally to women who experience other mental and physical health problems. Since women's identity as women relies heavily on their caring skills, a failure to develop these adequately may have serious repercussions in terms of their self-respect and their personal identities. Women carry a double burden of failure; as individuals and as wives/mothers etc. in the context of a society which privileges male values and men over women. It is not surprising therefore that a commonly cited problem in working with women is lack of self-esteem and self-confidence (Hanmer and Stratham, 1988).

Women can be helped to decrease self-blame by workers who encourage anger (Fooks, 1986) and who use consciousness-raising techniques to explore the wider context of the problems women experience. It is crucial that women's strengths are validated in the social work encounter, that workers seek to build on these strengths and that they resist seeing women as being out of control and in need of treatment.

A further dimension to the work of encouraging increased self-esteem and affirming women's strengths, is discussed by Lindsay Otter (1986) when she identifies the importance of confirming the steps that women take, however small. Otter's discussion is rooted in work with women experiencing domestic violence but her observations have a much wider relevance. The view taken is that offering alternatives, to be taken up when women are ready, allows gradual empowerment.

The principle of increasing women's self-esteem then, relies on the incorporation of a number of strategies into the social work/health care task. It relies on women being listened to and being believed, either in women's groups or in individual case-work relationships. It relies on strengths being identified and built upon and on the confirmation of the steps women take, however small these might be.

Aiming for change, not adjustment

A further principle of feminist social work and health care is one which relies heavily on the building of self-confidence and self-esteem. It is the principle which stresses the importance of a focus which centres on women's capacity to bring about change rather than to adjust to the circumstances in which they find themselves (Fooks, 1986).

In working with women to bring about change, to increase their self esteem and self confidence, women's groups can be of enormous value. They can offer women the opportunity to share experiences and strategies and to value other women as potential sources of support. Women's groups are not always set up to promote change, however. Groups are often set up to encourage a greater level of adjustment to women's traditional role and responsibilities and will focus on, for example, encouraging better mothering and more involvement in children's play.

Women's groups clearly have the potential to either further or subvert feminist aims. Only when they are underpinned by aims which seek to empower women and support them in changing the situations which are the source of their unhappiness can they form a central feature of feminist practice. Women's groups also need to embrace a commitment to redefining social problems, to challenging sex-role stereotyping and to building upon and validating women's strengths and coping strategies, if they are to fulfil the aims of a woman-centred approach to health and social care.

Recognising the complexity of women's problems

This principle requires a recognition of the multi-dimensional source of women's problems and a willingness to use the full range of methods to tackle them (Hanmer and Stratham, 1988). Again, an example can be taken from the field of domestic violence where the need to address the problem on a number of fronts is evident. The police, the law and housing services are all implicated in both generating and potentially containing the problem. Any intervention therefore needs to be prepared to work on a number of fronts simultaneously. Women not only need safety and refuge but more responsive policing strategies, housing services and law reforms. Thus, the police, housing services and the law all become legitimate objects of challenge in a perspective which stresses the complexity of women's problems and the interconnectedness of the public and private sphere.

Campaigning and making alliances with other agencies

Inextricably linked to the principle of recognising the complexity of women's problem is that of building alliances with other agencies, particularly those committed to ways of working which are designed to empower women, i.e. Rape Crises, Women's Aid, Well Women groups. There is also a need to work to increase resources for women by bringing pressure to bear within agencies and on the broader political front, a strategy which depends on broader alliances being forged in order to bring pressure to bear in the policy-making arena.

The above principles are not intended as an exhaustive guide to feminist practice. They merely illustrate the main thrust of a feminist approach to social work and health care practice which stresses the importance of locating women's problems in the context of a patriarchal social structure which ultimately must be the focus of change. At the same time they point up the disabling effects of women's subordination in terms of their self-esteem and self-confidence. The result is a challenge for feminist practice which requires both a recognition of women's special needs and a willingness to work towards transforming the structures which are the prime source of the problems that women experience.

The next stage of this discussion will be concerned to show how these principles might be translated into practice and how they might be discernible within the context of the two services which are the focus of my field research.

Operationalising the Principles of Feminist Practice

The principles of feminist practice outlined above provide a useful starting point for developing an analytic framework for the collection and analysis of data. In constructing the framework I have considered how the principles might operate and how they might be discernible in the research sites.

I have added ACCESS as a principle, as the literature on drug use and service provision (see literature review) identifies women's under-use of services as an issue. In contrast, the literature from which the above principles of feminist practice are derived, assumes women's access to health and social care services and indeed, often expresses a concern that women receive too much medical and social work attention.

Analytic Framework

Table 1 is intended as a guide for considering the operation of feminist principles of practice. It sets out how they might be discernible in the two research sites. The principles of feminist practice are set out in Column 1, and Column 2 suggests ways in which they might operate. If services are underpinned by a concern to *'re-define social problems'* for example, this would be reflected in the ways in which staff viewed the professional task and in the orientation of their interventions.

Column 3 suggests research techniques which might be used in order to reveal, for example, staff attitudes towards clients, or worker's views of the professional task. Column 4 suggests more specific questions which the researcher might pose, either to herself or to service providers, in order to gain insight into how far a particular principle of feminist practice is operating.

Summary

The above discussion has briefly outlined the feminist critique of a social work discourse which prioritises women's roles as mothers and the maintainers of family welfare. It has explored the principles of a feminist social work and health care practice which aim, among other things, to challenge this dominant discourse. Finally, the discussion has examined how feminist principles of practice can be translated into an analytic framework for the collection of data in the two research sites.

Table 1 : DATA COLLECTION : ANALYTIC FRAMEWORK

PRINCIPLE	LEVEL OF OPERATION	DATA COLLECTION TECHNIQUES	KEY QUESTIONS AND CONCERNS
Re-defining Social Problems	Professional Ideology	Taped Interviews; Policy Statements; Participant Observation at Team Meetings and Informal Staff Discussions.	* How far is women's drug-use seen as being related to / intimately bound up with social construction of femininity? * How far is challenging oppressive structures in people's lives seen as being central to the professional task? * Why do people become involved in drug -misuse? * Do men and women become involved for different reasons? * What is the role of the agency? How can it best help / support its women clients?
	Intervention	Participant Observation; Case Records (or narrative account of case where confidentiality is an issue).	* In assessment interviews : how much concern / information is elicited about relationship issues as opposed to type, length, amou of drug-use? * What is the orientation of counselling / case-work? Is it aimed at 'rehabilitating' women as wives / mothers/ daughters or raising awareness of external / social / familial pressures which may have a bearing on their drug-use? Does it aim to make lin with pressures experienced by all women? * Orientation of group work : is it consciousness-raising or role rehabilitation?
Challenging the Power of the Professional	Professional Ideology	Taped Interviews; Policy Statements; Participant Observation.	* What model of professional practice is adopted : doctor / patient or partnership? * What is the status of 'expert' knowledge? * How are treatment programmes devised? Imposed or negotiated? * What is the professional there to do? How can they best help their clients? * What can be gained from attending to client's own accounts of needs and problems? * What mechanisms exist for clients to challenge professional decisions?
	Staff Attitudes	Participant Observation (particularly team meetings / discussions); Responses to Vignettes.	* How far are client's views of their problems / needs sought and acted upon? * Do clients challenge professional view of problems / needs / treatment? What happens when they do? * Who is deemed to be 'the knower' in the staff / client encounter? * Is there a commitment to demystifying the professional encounter? How is this achieved?
	Interventions	Participant Observation; Taped Interviews.	* Is there an emphasis on generating women's self-help networks? * Is group work orientated towards establishing mutual support systems among women? * In assessment interviews are clients encouraged to give their account of problems / needs? * Does counselling and case-work operate on a partnership principle? What are the gender dimensions of this partnership?
	Access	Taped Interviews; Policy Statements.	* Does the agency operate an open-door policy? What is the effect of 'gate-keeping' in respect of access, eg. how flexible a appointment systems? Do they accommodate children and child care responsibilities? * Where access is limited to bed-space, who decides who gets in? Is this entirely a professional decision? Is it shared? Is it hand over to users? Are women's interests maximised in this process? * Are there any external constraints on access (eg. funding / finance)? Are they discriminatory in any way?

Rejecting Sex-Role Stereotyping	Staff Attitudes	Participant Observation : staff/client interaction staff/staff interaction staff discussions of clients. Case Records; Responses to Vignettes.	* How do staff view partners/ wives / mothers? * Is promiscuity in adolescent girl users a cause for concern? What is the focus of this concern? Health? 'Moral danger'? * Is there a similar concern with adolescent boy's sexuality? * How are women users who are also mothers viewed? * Are women users viewed as being 'devious' and 'manipulative'? Is there any attempt to understand 'devious' a 'manipulative' behaviour as a coping strategy adopted by the powerless? * Do staff confront male clients on sexist behaviour and attitudes? * Do staff see/ understand need for 'men's' and 'women's' groups?
	Interventions	Participant Observation; Taped Interviews; Case Records / Group Work Feedback; Staff Discussions; Responses to Vignettes.	* Are women incorporated into treatment / intervention programmes as partners/ wives / mothers of users? What is the aim her Support for drug-using client? Support for partner / wife / mother? * What responsibilities are partners / wives / mothers encouraged to take vis-à-vis drug-users? * Are legal sanctions used / considered for controlling the sexuality of adolescent girls? * Where is the social work emphasis with regard to women who have children and use? Interests/ needs of child? Mother / ch relationship? Women's autonomy and need for child-care support? * Does group work challenge or confirm stereotypical roles? * Are women encouraged to be assertive and angry? * Are women encouraged to limit the demands made on them by others? * Are women encouraged to explore their own needs and take time for themselves? * Are women encouraged into education / work / training? * Are men encouraged to express emotions, express love / care for each other?
Increasing Self-Esteem	Staff Attitudes	Participant Observation; Taped Interviews; Responses to Vignettes.	* What is the reaction of staff when clients fail to fulfil expectations / contracts? * How far does agency recognise different needs of men and women? * Do staff challenge women's sense of failure - as wives and mothers? Do they seek out and confirm aspects of clients' lives whe women are coping / succeeding?
	Interventions	Participant Observation; Taped Interviews; Responses to Vignettes.	* What are the goals set by the agency? Are they easily attainable? * Do the agency's goals and interventions take account of women's greater vulnerability in terms of their self-esteem? * Does counselling / group work focus on women's strengths?
Aiming for Change - Not Adjustment	Staff Attitudes (Awareness)	Taped Interviews; Participant Observation.	* See sex-role stereotyping. * Are staff aware of the oppressive features of women's lives? Do they adopt a critical perspective in this respect? eg. Do y think the problems faced by women clients are substantially different to those faced by men?
	Interventions	Responses to Vignettes; Taped Interviews; Orientation of Group Work / Counselling.	* See sex-role stereotyping. * Are interventions designed to empower women? * Do they encourage change in the wider aspects of women's lives - not just in their drug-use?
Recognising the Complexity of Women's Problems and Campaigning and Making Alliances	Interventions	Participant Observation; Taped Interviews; Policy Statements.	* Does agency participate in any campaigning issues on policy-making arenas (locally, nationally) with regard to, for exampl women and health, women and employment, women and community, child-care. * Do staff at the agency readily refer women to Women's Aid, Rape Crisis? * Does the agency have links with the services over and above individual referrals?

Research Methods

Tools and Techniques

The research relies on the techniques of participant observation (Burgess, 1984; May, 1993; Mason, 1996 Shaffir and Stebbins, 1981) and in-depth interview (Denzin 1978; 1997; Oakley 1981). Some use is also made of documentary evidence (Scott 1995). I have used qualitative research methods since I am concerned to adopt a wholistic view of the services in order to consider how feminist principles translate into social care practice and how far they are operating in the services under scrutiny. I have rejected the view that the services under scrutiny can be understood by fragmenting them into discrete parts that can be labelled and quantified. I am not concerned with generating an analysis, using quantitative data, which would allow me to compare particular aspects of the services to each other or to other services. To paraphrase Denise Farren (see p. 45) I am concerned to understand the services as a whole, not to examine how bits of them compare to bits of others.

In order to know the service I need to understand how service providers view their clients, experience the social care task etc. This knowledge can only be gained from an 'insider' perspective. My position is similar to that articulated by Reinhartz (1979) who suggests that "....social behaviour is continuous...social life is greater than the sum of its parts...social phenomena are ambiguous rather than clearly definable and unique rather than replicable" (p.6)

In order to understand the way in which services are delivered I have observed events as they unfolded and considered them in relation to the principles of feminist practice. I have adopted the role of participant, since to do otherwise would have had a distorting effect on the social interaction under scrutiny. The observer in the busy social environment of health and social care services is inevitably part of the action. By embracing rather than resisting this fact, the researcher can ensure that she remains as unobtrusive as possible and does not substantially alter the interactions she is studying.

I have used the technique of in-depth interview in order to gain further insight into aspects of the service which are more difficult to observe. In-depth interviews have been designed to elicit further information about the professional ideology which underpins the service, about the way in which illegal drug-use is constructed, and about the willingness of the service providers to en-gender the response to drug misuse. The interviews have also been used to strengthen the researcher's understanding of the way in which the service is delivered and of the nature of the social work encounter. An aide memoir (appendix 1), derived from the principles of feminist practice, provided a focus for the interviews.

A number of vignettes have been constructed (see appendix 2) in order to provide a further stimulus for discussion in the interviews. They were designed to strengthen the data in relation to a number of aspects of service delivery e.g. how services respond to wives, partners, mothers (Vignette 1); how they respond to failure

to complete a programme of treatment (Vignette 2); how they respond to evidence of wife/partner abuse (Vignettes 3 and 4). The vignettes were created out of cases which I had encountered in my past experience as a social care practitioner and in my current fieldwork experience. I reflect on the role and value of the vignettes in Chapter 10.

I have made some use of documentary sources, e.g. statements about the service and its aims, staff day books and diaries. Policy statements about the services, their aims, etc. were available for the Community Drug Team only in an informal format as the service was still a relatively new venture. The Therapeutic Community, in contrast, had produced a number of booklets and statements about the organisation which I had access to. These have enabled me to see how the service presents itself both to potential funders and to clients of the service.

I have also made use of the 'Day Book' which is kept at the Therapeutic Community. It allowed me to catch up on events which I might have missed over a weekend or evenings and gave an insight into what staff deemed worthy of attention and how they interpreted events. I was disappointed to find that reflections on the more formal therapeutic groups were not routinely written up. This hampered my understanding of the men's group in particular (see p. 222). Folders containing plans for workshops on, e.g. assertiveness training, were available however, and gave some insight into this aspect of the groupwork programme.

On both sites I have made use of the access to client's files that I was able to gain. Files provided useful background on clients which I might only have met once or twice and they offered an insight into the ways which the service interacts with client over time. For example, I have been able to understand more fully the nature of the Community Drug Team's relationship with one of its clients currently serving a prison sentence by having access to copies of their correspondence with her and I was able to gain an insight into the nature of the information sought about clients prior to their admittance into the Therapeutic Community.

Period of Fieldwork

The field work was carried out over the period April 1992 to December 1994. Blocks of time lasting from two to six weeks were spent in the organisations;

April 1993	2 weeks	Community Drug Team
July 1993	2 weeks	Ditto
August 1993	4 weeks	Ditto
September 1993	2 weeks	Therapeutic Community
July 1994	3 weeks	Ditto
August 1994	3 weeks	Ditto

In between these blocks of field work I spent time in the projects, on a regularly basis, checking out and strengthening data (e.g. spending time in the Therapeutic Community over the weekend), observing events that had escaped me since they happened only intermittently (e.g. parent's meetings, staff working parties and resident progression or graduation from the TC) and conducting interviews with staff.

Interviews

Full, taped interviews were conducted with the following staff:

Family Unit - Phoenix House	4 interviews (all full-time staff)
Re-entry House - Phoenix House	4 interviews (all full-time staff)
Main House - Phoenix House	2 interviews
Community Drug Team	5 interviews (all full-time staff, clinical, staff)

Most of the interviews took place on the research sites, although two staff at the Community Drug Team invited me to their homes to do them. The interviews were long - 1 1/2 to 2hrs. and all but one (which was 'lost' due to a faulty tape) were transcribed. My aim was to interview all permanent, clinical staff on each of the research sites. This did not prove possible in relation to the Main House (Phoenix House site) since one member of staff was very newly appointed, one was on long-term sick leave, one was unable to find the time during the working day to complete the interview and another was unwilling to be interviewed on tape. I was, however, able to conduct shorter, un-taped interviews with the latter two members of staff. Since completing the fieldwork and the interviews I have kept in touch with project staff through informal meetings and social gatherings.

PART 2 : IN THE FIELD

The following chapters are reflections on my fieldwork experience. Their purpose is to render visible some of the processes at work in the data collection stage of the research. This concern with reflexivity derives from my commitment to a research tradition, explored in Chapter 3, which seeks not to transcend the researcher's own subjectivity but to reveal it and by so doing, demystify the knowledge creation process.

Chapter 5 looks at what happens to the research encounter when the researcher revisits issues and situations she has previously encountered from the perspective of a social work practitioner. The aim is to consider the impact of this role-switch on the researcher's presentation of self and on how the research experience was digested. A secondary aim is to examine the boundaries between a researcher's and a practitioner's perspective and to explore the ways in which they overlap and interrelate.

Chapter 6 focuses on a problem inherent in doing participant observation, that of 'seeing' multiple events which are being played out at any one time. It derives from a concern to render the research process visible, to reveal the partial and fragmentary nature of the data collected and, more generally, to demystify the ethnographic concept (and rhetoric).

Chapter 7 relates to my commitment to undertake a feminist analysis of services to drug users and to adopt methods and techniques derived from feminist principles of research. (See Chapter 3). It explores the limits to the researcher's ability to engage in a style of research which openly acknowledges her identity and fully reveals her intentions. In particular, it questions the extent to which the researcher's feminist identity and feminist politics can be shared with research subjects. In doing so, it points up the contradictions inherent in attempts to adhere to feminist research principles in a setting where an understanding or commitment to feminist politics may be weak or absent. Furthermore, it puts into sharp relief many of the practical methodological issues raised in Chapters 5 and 6.

These three chapters are an attempt to reveal the processes at work in developing a feminist analysis of health and social care services to illegal drug users. They focus explicitly on research practice and engage with;

- the problems and possibilities of making the transition from practitioner to researcher,
- observing parallel events on multiple sites of action
- the problems of doing feminism while doing research.

To assist the reader, the context of my research and a description of the research sites is given below.

The Community Drug Team

The Community Drug Team whose work I observed and participated in serves a town of average size in the Yorkshire region. It is one of a number of teams established throughout the country in the mid-to-late 1980s in response to a growing awareness of the need to provide preventative treatment services for an increasing number of drug users. The need to provide readily accessible services in the community became more apparent as the spread of HIV among the injecting drug-using population was acknowledged. The aim in setting up these teams was to reduce the harm caused by drug use rather than to eradicate it altogether.

Teams vary in their character and make-up but all seek to provide a range of services. Many now operate needle exchange schemes in an attempt to ensure a ready supply of clean needles to injecting clients in order to prevent the spread of HIV infection. The team which is the subject of my research is interdisciplinary in nature. It brings together health professionals, social workers and the Probation Service. This enables it to offer a range of interventions to support its clients. It is formally 'owned' by the local Hospital Trust but operates as a separate and autonomous unit, setting its own policies and goals. It is a dedicated and skilled professional team which works with a wide range of clients, from young 'recreational' users of cannabis and amphetamine to older, more established users of heroin. A number of clients are maintained on methadone prescriptions which are administered and monitored by the team.

The service operates from converted premises close to the town centre. The building consists of a small waiting room, a general (and very busy) office, two small counselling rooms and a larger room from which the needles exchange is operated. There are also two loos and a small kitchen.[1] Much of the team's work is carried out in this building but they also make home visits to clients where necessary and have close links with the local Psychiatric Ward where clients can undergo detoxification if and when this is deemed necessary.

A Residential Centre for Drug Users

The second site provides a very different service to that of the Community Drug Team. The Centre was established in the early 1980s and was part of a rapid expansion of residential services to drug users at that time. Unlike the Community Drug Team, it is run by a voluntary sector organisation. It employs a team of paid staff, some of whom are professionally qualified but the emphasis is as much on self-help as it is on professional intervention. The Centre operates an abstinence rather than harm-reduction model of treatment. This means that those seeking treatment must be committed to giving up their drug-using lifestyle.

The Centre operates as a Therapeutic Community, modelled on the principles of the 'concept house'. This model offers a highly-structured approach to treatment and contrasts with an older model of the Therapeutic Community based on the ideas of Maxwell Jones and used in the treatment of mental illness. The earlier model places

[1] Since I completed the field work for the research the Team has moved into much larger premises. It now operates from a large refurbished four-storey Victorian House, still close to the town centre but occupying more spacious premises.

emphasis on the democratic participatory group process. This is seen as an important therapeutic tool. In contrast, the 'concept house' uses a structured hierarchy amongst its residents and a system of privileges as central therapeutic tools. Residents are expected to work as part of a hierarchically-organised team to ensure that the house is clean and well-maintained, meals are cooked and residents' emotional needs are attended to. Encounter and other group techniques are used to encourage residents to reject their drug-using lifestyles. The 'concept house' style of Therapeutic Community was imported from the U.S. in the 1960s and is the dominant approach to residential care in the drugs field. (For a detailed exploration of the origins and development of the Therapeutic Community, see Kennard, 1983).

The premises which the Centre occupies are on two main sites. One is a large Victorian house in its own extensive grounds in the suburbs of a city in the Yorkshire region. It has room for thirty residents, men and women, who stay about nine months before moving on to a 're-settlement' house nearer the city centre. A recent addition to the Centre has been a Family Unit. This occupies newly-built premises in the grounds of the main house and offers accommodation to three or four families and their children. It has a separate staff group and residents follow a separate therapeutic programme. Children are cared for by their parents, with the support of child-care staff, and children of school age attend the local primary school. Even more recently, the work of the Centre has been enhanced by an outreach worker whose brief includes the provision of ongoing support to residents once they are settled in the wider community.

It is important to note that my relationship to each of the research sites is somewhat different. I have an established relationship with the Residential Centre since I worked there for a period of some five years. This meant that I was returning in a new guise rather than entering a new situation. The Community Drug Team, on the other hand, was unfamiliar territory. Access was made possible by my acquaintance with one of the team members and her willingness to introduce me to her colleagues.

Ethical Issues

Researching health and social care services dealing with vulnerable people whose successful treatment depends upon them revealing intimate details about their personal lives and their involvement in illicit drug use, means that the researcher has to pay close attention to a number of ethical issues. Confidentiality is a prime concern and to this end I have used pseudonyms for all staff and clients referred to in all discussions. I have used the actual names of the services, i.e. the Garage (Community Drug Team's base) and Phoenix House (Residential Centre) but I have not identified the towns/cities in which they operate. The issue of confidentiality also means that I had to ensure I did not get drawn into critical and detailed discussion of different organisational styles and practices with the workers on the two sites.

As a participant/observer I had to remain sensitive to the needs of both staff and clients. I had to ongoingly assess the impact of my presence on staff/client encounters and be prepared to withdraw if I felt that my presence was jeopardising the client's access to the treatment they needed. Where clients intimated a dissatisfaction with the service in their conversations with me, I had to remain detached, while taking their views seriously. Further insight into these research dilemmas and how they were addressed are revealed in the following chapters and are picked up again in Chapter 10.

CHAPTER 5

RESEARCHING PRACTICE AND PRACTISING RESEARCH : reflections on the transition from practitioner to researcher and its impact on the research process.

Introduction

Stanley and Wise are clear on the issue of research practice:

> *'Research' is a process which occurs through the medium of a person - the researcher is always and inevitably present in the research. This exists whether openly stated or not; and feminist research ought to make this an open presence.*
>
> (Stanley and Wise, 1993 p. 175)

My initial concern to adopt an appropriate methodological framework for my research led me to a commitment, derived from my reading of feminist explorations of methodological issues, to place myself, as subject, under scrutiny. The commitment to do so suggests a particular approach to research and the knowledge creation process. It is one which is concerned to examine the developing consciousness and awareness of the researcher through her involvement in the research process. In its most developed form, it is an approach which suggests that the only knowledge we can be sure of gleaning from our research is that which is concerned with the researcher themselves and with the impact of the research process on the researcher's own consciousness. The researcher thus moves centre stage, personal issues become a significant motor in the research process and a legitimate focus for attention.

It is a commitment to making the personal visible which leads me to a consideration of the importance of placing my research experience within the context of my own personal and professional development. A significant autobiographical fact is my transition from practitioner to researcher and the following is an attempt to explore some of the tensions and contradictions generated by this shift in status and perspective. The exploration is prompted by a concern to understand the intellectual and emotional processes which have shaped my recent experiences 'in the field'. An important consideration here is the way in which my experience as a social work practitioner in the drugs field has had an impact on the way I negotiated and made sense of the research encounter, and, on the way, *it* made sense of *me*. But this is to suggest that the impact was confined to the actual research process, whereas, in fact, it was a determining factor in the choice of research topic in the first place. An exploration of the practitioner-turned-researcher issue then, needs to begin with an examination of its impact on my choice of research topic. From there, I move on to consider what effect the role shift had on how I conducted the research encounter and on how the subjects of my research encountered me.

Deciding on a topic for research

In order to understand the way in which my previous experience has had an impact on my choice of topic for study, some autobiographical details are a necessary and appropriate starting point. I moved into the drugs field from community-based social work with young offenders and their families in 1985 when a residential

rehabilitation facility for problem drug users, modelled on the 'concept-house' approach to treatment was opened. From the start, I was apprehensive about the model. It seemed to be an authoritarian approach to problem drug use which was out of kilter with the social work principles I espoused and which had always underpinned my practice. I was persuaded into post by the then Project Director who shared many of my own misgivings and who was committed to making changes to the treatment programme. Some change did, indeed, take place, but never sufficiently radical enough to attack the authoritarian nature of the organisation or to impact upon an abstinence model of treatment which, in many ways, is the foundation on which the programme's authoritarian structure and hierarchy is built.

I became increasingly concerned about the gender issues raised by the concept-house model of intervention and alarmed by an inability to attract, retain or meet the needs of women users, despite some determined attempts to target them. A research scholarship which funded a visit to Italy to study the response to the drug abuse there, only served to confirm for me how entrenched the concept-house model of residential treatment for drug users is. I finally left the drugs field in 1989 feeling exhausted and frustrated by the lack of any real change in the organisation's approach to drug users, this despite the onset of the AIDS/HIV 'crises' and the shift to a harm reduction model of treatment in the drugs field, more generally. In short, my experience of social work practice in the drugs field was a frustrating one and it is against this backdrop that my choice of research topic - an examination of the gender issues which permeate the provision of services to drug users - must be set and understood.

When initially considering the topic for research some five years on, my stated concern was to develop my interest in feminist social work and health care practice by examining service provision for drug users. By this time, drug use was creeping back up the 'social problems' agenda because of its links with AIDS and HIV and my contacts in the drugs field made it possible for me to gain access for research purposes. As a research topic then, it was appealing: a) because it was practicable; b) it was topical, and c) it resonated with a long-standing interest in feminist health and social care. What I did not sufficiently recognise at the time was that my choice of topic was also motivated by a sense of 'unfinished business' and a need to confront, if not to resolve, some of the personal and professional frustrations I was left with in 1989. The recognition of this motivating factor emerged fully, only when I had embarked on my fieldwork and I was provoked into a concern that this previously unacknowledged agenda would contaminate the research in some way. I was forced to consider the implications of attempting to turn a researcher's eye onto a field of enquiry which carried a legacy of failure for me as a practitioner.

There was clearly a risk of using the research as a platform on which to mount a critique which had already been formulated. It would be dishonest to deny that some critical insights were already in place and if I was seeking merely to confirm rather than to explore, question and revise these insights, then my research endeavour would, indeed, be a risky business. I felt confident, however, that my interest in and understanding of the area was sufficient to ensure that my previous experience provided merely a starting point, albeit a partial one, from which to pursue some existing insights. I have little doubt that some of these will prove to be fruitful avenues for further exploration; others will need to be radically re-appraised while others will have to be abandoned altogether.

As well as being alerted to the dangers of my previous experience as a practitioner in the field I was now researching, I also became increasingly aware of its advantages. In particular, I became aware of how much I was able to draw on my identity as an ex-worker in order to mitigate the power of the researcher and, thus, equalise the relationship between researcher and researched.

Entering the Field

I was very aware of trading on my ex-practitioner credentials to ease my way in any contacts I had with the users of the services I was studying. Whenever I was asked to introduce myself and explain my relationship to the agency, I 'played up' my ex-drugs worker status and 'played down' my research intentions. Thus, I traded on my association with the workers with whom clients had already established a relationship of trust and avoided the risk of alienating users of the service who might be alarmed by the perceived power of a researcher. This is not to say that my role as researcher went unacknowledged, but that I explicitly related it to my previous role as drug worker. This was a clear attempt at legitimating my presence in the agency and establishing a rapport with service users who were understandably reluctant to disclose potentially incriminating details about their lives to someone they did not know. It also established my status as someone who, although 'straight' and therefore not entirely to be trusted, was familiar with the language and culture of the drug scene. In short, my ex-worker status established my credentials and my right to know and was useful in ensuring that my presence in the agency was not disruptive. It also meant that the power differential was limited to that which was already familiar, i.e. between worker and service user. A wholesale re-negotiation of relationships, which an emphasis on my identity as a researcher would have entailed, was thus avoided.

I was equally aware of playing up my ex-practitioner status in relationships with agency staff. This was clearly related to my desire to mitigate the power of the researcher over the researched and to equalise the relationship between us. It was also a way of legitimating my presence in the agency and of establishing my abilities to contribute to rather than disrupt the working day. I was often conscious of the desire to be 'useful' and to 'help out' with, for instance, answering the telephone, or operating the needle exchange service. Much of this was aimed at making myself and the team comfortable with my presence, thus enhancing the research experience and ensuring a free-flow of information and data. At least some of it, however, derived from a source other than a desire to reduce power differentials, for it also derived from my lack of confidence in my abilities as an ethnographic researcher and from a reluctance to take on the mantle. I sometimes felt acutely aware of my lack of experience in the role, although I did gain confidence as the field work progressed. For the most part, however, I felt very much the apprentice ethnographer. My lack of commitment to the researcher role may also derive from an inherited value system which accords greater 'use value' to 'getting the job done' as opposed to thinking or writing about it. To some extent, I was also grappling with class and gender-bound notions of what is a legitimate and useful way to spend one's time and what is not.

This willingness to align myself with practice and reluctance to see myself as a fully-fledged ethnographic researcher led, not surprisingly, to a degree of role conflict. At several points in my fieldwork notes, I find myself expressing concern about losing the distinction between practitioner and researcher in my concern to 'help out' and 'fit in'. How far this divide is a real or useful one awaits the discussion I intend to develop

in the second part of this paper. Nevertheless, however 'real' the distinction turns out to be, it had an important bearing on how I experienced the fieldwork and the problems I identified. In my field notes, I write:

> ".. it has become increasingly difficult this week to resolve these tensions (i.e. between my role as researcher and role as practitioner) and remain in the role of researcher. Last week, I felt my interjections in the client/worker situation were nothing more than token acknowledgements of my presence. This week I had difficulty in not becoming the co-worker/ experienced practitioner. This has probably come about because I am now much more familiar with the work/cases that the team is involved with - my opinion is also being solicited by team members. My willingness to take on the practitioner mantle is also related to the confidence I have in my abilities as an ethnographer.
>
> The desire to participate in events as a team member has been very strong at times. I had to resist querying R's assumption that 'L' (new female client) was heterosexual. I felt she was communicating a degree of ambivalence in relation to her sexual identity which 'R' wasn't picking up on. To have challenged him would have been too much like acting in the capacity of a colleague and fellow worker".
>
> (July 1993)

However, in resolving one tension (or what I am perceiving at this stage as a tension pending the second half of this paper's discussion) and in drawing back from the temptation to 'go native', I was merely creating a further contradiction. In not questioning the assumptions of one of the (male) workers regarding a female client's sexual identify, I was caught between my stated desire to adopt a feminist perspective, which must be active if it is to be effective, and my perceived need to draw back from acting in the capacity of a colleague and fellow practitioner.

This led me to consider whether my previous experience as a practitioner had led me to overstate the need for role clarification and, as a result, had led me to renege on my commitment to feminist principles and the need to challenge sexist and heterosexist assumptions. Had I jeopardised feminist principles in the search for 'uncontaminated' research - a search which may well turn out to be futile?

Encountering the Researcher: The Response to being Researched

Up to now, I have been concerned with my own responses to the research encounter and have explored my reluctance to fully embrace the role of ethnographer. It is important to point out that at least some of my reluctance to present myself, unambiguously, in the researcher role, was also coloured by the response of the (Community Drug) team whenever I produced my notebook, an experience common among ethnographers. Extracts from field notes illustrate this 'suspicion' of the notebook which, in many ways, has to be seen as the badge of my identity as a researcher.

> "The first time I produced a notebook and began to write things down in 'quiet' moments, Sue responded (twice) by 'warning' other team members that I 'was writing everything down'. Although this was said with some humour, it alerted me to the fact that Sue was concerned about my note-taking. On Friday, therefore, I only used my notebook to take notes on the files I was reading. This note-taking while reading, didn't provoke comment. It seemed, perhaps, more acceptable and safe as it was confined to what I was reading rather than aimed at the general direction of events in the office".

The concern about my notebook emerged early in my fieldwork and continued throughout:

> "... I have persisted with taking some notes in situ .... and there have been further comments on my note-taking. Harry has, on more than one occasion, insisted that it made him feel paranoid".
>
> (July 1993)

The complaints were always made into a joke. Harry's feelings of paranoia were a standing joke in the team and the fact that I was giving him further cause was considered to be very entertaining. Nevertheless, I did feel that the comments signalled an unease with my note-taking and I therefore made limited notes in situ which I then expanded on when I returned home. What this suggested, then, was some unease on the part of the team about being researched, but the suspicion of the researcher's notes has to be set against a real willingness to enter into the research process in other ways. In particular, by engaging with me in comment and critical analysis of the work of the team, by including me in interviews, visits and training sessions, team meetings and in the work of the team generally. The response of the team to me, as researcher, was therefore somewhat ambivalent, rejecting my note-taking but welcoming my presence as a stimulating force overall.

The problem of note-taking is a general one and not confined to my particular experience. The issue of the way in which my background as an ex-practitioner impacted on the research relationship, while not unique, is less general and warrants fuller attention. The following is designed to provide this 'fuller attention':

As the background to this discussion suggests, the ethos and aims of the work of a Community Drugs Team differs markedly from that of the Therapeutic Community. My previous experience as a practitioner in the latter had an impact on the way in which I was perceived by the former. I had an early insight into the impact of my status as ex-TC worker when I made the initial approach to the Community Drugs Team. Harry felt it necessary to point out that the team did not adopt an abstinence model. Their aim was to prescribe, maintain and ensure safe use of substances. It was the way in which this information was presented - almost as a warning - that first alerted me to the fact that, as a would-be researcher in the drugs field, I carried a very particular legacy. My ex-practitioner status meant that I was associated with the very approach to problem drug use which I have already criticised as being authoritarian, wedded to an abstinence model and resistant to change. Harry was, in effect, asserting the value of a different approach to drug users and needed to feel assured that I had sympathy with this approach before he could agree to co-operating with the research. I clearly reassured him - and the team - sufficiently to be accepted in the role of researcher.

Nevertheless, the early days of fieldwork with the team were characterised by what must be seen as initiation into an alternative (i.e. alternative to TC's) approach to problem drug use. My notes confirm this:

> "I felt a good deal of the day was being devoted to my 'initiation'. This was certainly my own intentions but also seemed to reflect Jackie and Harry's agenda. A focus for the initiation was provided by the comics produced by Lifeline (a well-developed drugs project in the Manchester area). Jokes and characters from these comics figure a good deal in the team's interpersonal interactions and I felt that Jacky and Harry were keen for me to be initiated into the 'in jokes'. But it was a bit more than

this. The comics take a very particular anti-establishment line on drugs and see drug use as an inevitable part of youth culture. The aim of the comics is to encourage safe drug use, not prevent it and I felt that I was being encouraged to read them in order to confirm that I could accept this view. I was struck by how much the comics conflicted with the values I had been socialised into during my time in the drugs field and felt sure that such literature would not be allowed into the Therapeutic Community (a view which was later confirmed)."

(July 1993)

What is interesting here is that, while I was always critical of the T.C's approach to problem drug use, my views had been clearly moulded by an abstinence model and a view of drugs as being 'a problem' and not OK. By presenting me with the comics and other similar literature, by freely discussing the extent of their own alcohol use and articulating liberal views on the use of cannabis, the team exposed any resistance I had to seeing drugs and drug use through a much less didactic and rigid lens than the one encouraged by my TC 'upbringing' or socialisation.

In summary, then, the impact that my ex-practitioner status had on the way I was been encountered as a researcher, was to alert the CDT to a potential clash of values and to ensure that my early days with them were punctuated by a concern to re-socialise me into a more progressive view of drugs and drug misuse.

Observer or Participant?

The above discussion of the impact of the past on the present has been an attempt to explore what, for me, has been a key element, and key tension in my fieldwork experience. Moreover, my experience indicates that, while there are some landmarks, there is no clear map of how research, particularly in its fieldwork stage, should be carried out. In the absence of clear markers, I reverted to what I did know how to do, i.e. give social work support in the context of a service dealing with problem substance users. That I had these skills to fall back on when floundering with the researcher's brief allowed me to remain afloat, but it also provoked a degree of doubt and uncertainty about whether I was engaging in *practice* or *researching* it.

Such feelings of doubt and concern about losing the distinction between researching and participating in the activity under scrutiny is by no means unique to my own experience. It is clear that a number of researchers express similar concerns. For Simon Holdaway (1983), the risk of 'going native' was particularly acute since his research on the police was done from the position of a serving officer, newly-returned from secondment to study a degree in the social sciences. He refers to a constant drift into taking too much for granted. Julia Hallam (1993), on the other hand, identified a somewhat different set of issues when she examined the problem of her bringing her past experience as a nurse to bear on her current research. This involved her grappling with the place of objectivity in the research process when the practitioner becomes the researcher. Hallam initially saw her 'insider' knowledge of the nursing profession as a guarantee of authenticity in her research into how women have been represented and how they represent themselves, as nurses. Increasingly, however, she found the notion of objectivity problematic.

... how do I find a place to speak from that does not assume an objective (masculinist) view but, at the same time, does not reduce what I saw to be subjective relativism? (Hallam, 1993 p.67).

An examination of the way in which my own concerns are reflected in the work of others is a reminder of the fact that the phenomena of the practitioner-turned-researcher has a respectable tradition within sociological research which can be traced back to the classic ethnographic studies of the 1960s. The most notable, perhaps, is Howard Becker's study of dance musicians (1963) begun in 1948 when he was, himself, a professional musician. Ned Polskey's study (1969) of poolroom hustling is also grounded in his own experiences as a professional pool player. Studies which involve the researcher in scrutinising experiences and events from an 'insider' perspective raise a number of problems, some of which have been considered in the above discussion. But they also hold out a number of possibilities. Commenting on Becker's research method, Bulmer (1982) describes it as *'experience recollected in academia'*. This description prompted me to examine my research experience on my second site, i.e. the Residential Centre and to consider the ways in which the revisiting of my former worksite in the role of researcher allowed me not only to observe the current work of the service but also to recapture and re-work some of the experiences I had had as a service provider myself.

The status of this 're-worked' experience as data could be held up to question since it confounds the traditional boundaries between the researcher and the researched. I would argue, however, that in becoming a participant observer, I was able to unlock and open up to scrutiny my own past practice and that this enhanced rather than distorted, the research. It enabled me to 'fill out' the partial view that the researcher inevitably has of the events she is researching and to extend my view of the present into the past. This resulted in a more substantial insight into the nature of the service. It offered a depth of understanding not normally available to the participant observer and enabled me to extend my view of events beyond those I was able to observe during the course of my fieldwork.

The Practitioner/Research Divide - Fracturing the Boundaries

Having considered the somewhat schizophrenic and complex nature of the research experience as I encountered it, I now turn my attention to a critical examination of the assumptions underlying some of my concerns, i.e. that clear boundaries between research and practice can be erected and sustained. The intention here is to look critically at the distinction between researcher and practitioner in order to consider how far and in what ways the two are distinct identities with separate and divergent perspectives. I begin by identifying some obvious areas of differences in terms of *accountability, aims and outcomes*. In each of these areas I hope to demonstrate how, in my experience, roles and perceptions overlap and how the boundaries between researcher and practitioner start to blur and become entangled.

Accountability

In terms of accountability, there are clearly some marked distinctions between researcher and practitioner. The staff at the Community Drugs Team are accountable to the organisation which employs and funds their work, i.e. the Hospital Trust, the Social Services and the Probation Service. My accountability, as a researcher, lies elsewhere, since I have not been commissioned by the Health Authority, Social Services or any other agency to do the research. I therefore have an autonomy and independence which

ultimately the staff of the Community Drug Team do not have. My accountability is to myself, to the academic community and to the principles of academic rigour which underpin my research.

There may be said to be clearly demarcated lines of accountability between the researcher and the practitioner, but further investigation reveals that the autonomy enjoyed by the researcher is also a dominant feature of the CDT's work. To a large extent, they have been able to develop services which reflect their own particular skills, expertise and interests while meeting the broad aims of their funding body. The development of Community Drug Teams generally is a relatively new initiative and no two CDTs are alike. Some, for instance, will work with benzodiazapam users while others confine their resources to work with only illegal drug users. The team whose work I am researching works with steroid users and so includes within its orbit work with a client group that other drug agencies may ignore.

In addition, the way in which CDT has been set up as a shared enterprise between three agencies: Health, Social Services and Probation - ensures its lack of clear accountability structures. It is located in its own building and it services a marginalised, difficult and 'unattractive' client group. These factors result in a service which lies somewhat off the beaten track in terms of accountability structures and which has, accordingly, been allowed to develop its own professional culture and working ethos. In terms of their everyday practice, the CDT are accountable to one another and to the principles of the service which they themselves have largely defined. They are, of course, also accountable to their clients and client group and here there is some overlap with the researcher's responsibilities. I, too, have an accountability to the team and to their client group since one of the aims of the research is to consider how far the needs of women users in particular, are being met. It would seem, then, that in this respect, both the researcher and the practitioner share an accountability to the clients of the service.

With respect to the issue of accountability, it can be argued that, while on one level the lines of accountability are clearly differentiated - the researcher's to the academic community -the practitioner's to their funding body and professional agencies, there is also a degree of fusion. The practitioner's accountability allows a good deal of autonomy and is, therefore, not that dissimilar to researcher's position vis-a-vis Health and Social Services and both the practitioners and the researcher share an accountability to the client group and users of the service.

Aims

The aims of the CDT, very broadly, are to provide a service to drug users in the area which is designed to reduce harm rather than achieve abstinence. The team is concerned both with individual well-being and with the safety of the wider community. Clearly, these are not the researcher's aims. My aims are to analyse rather than provide the service - a scientific rather than therapeutic enterprise. Nevertheless, in order to meet the demands of feminist scholarship, the research must be politically committed research aimed at challenging women's subordination. It is not so much a voyage of scientific discovery which the researcher is engaged in here, as a project designed to confront the gender inequalities which characterise the provision of services to drug users in an attempt to ensure that services are as useful and appropriate to women as they are to men.

Politicising the researcher's aims in this way opens up the possibility of there being a degree of convergence between what both the researcher and the practitioner are trying to achieve, a possibility which the notion of the researcher as detached scholar denies. While in this particular case the researcher's aims differ from those of the practitioner inasmuch as the CDT see their task in individualistic and gender neutral terms, this need not be the case. The researcher's aims *could* be shared by the practitioner. Indeed, where research is underpinned by feminist principles, it is possible to suggest that not only *can* the researcher's aims and outcome coincide with those of the researcher, but that this coincidence should be actively sought. (Meis 1983).

'Insider' and 'Outsider' Perspectives

A further area for consideration when reflecting on the distinction between the role of researcher and the role of practitioner, is that of the relationship to and status within the organisation under scrutiny. The researcher is clearly a visitor and is there for a relatively short period of time in terms of the overall life of the organisation. The practitioner, on the other hand, is on home ground. S/he has a different temporal relationship to the organisation and also to the client group. On returning to the CDT to interview staff after an absence of some six months, I, as the researcher, was mindful of having to spend time 'catching up' on staff workloads, relationships with clients, etc. This emphasised the differences between us in terms both of my relationship to 'their' clients and to the ongoing work of the agency. Perhaps the important point to consider is what this position, as visitor and outsider, means. Does it mean that the researcher has a more detached and objective view of the services provided or does it merely afford the researcher a very partial and, perhaps, distorted view? The researcher as 'outsider' holds out the prospect of bringing an analytic and critical eye to a situation in which the real participants, i.e. the practitioners, are, perhaps, too embroiled to achieve a critical perspective.

This explanation of the researcher's 'objectivity' needs treating with some care, however. Certainly, I felt that I was, and continue to be, welcomed in the capacity of a critical eye by the CDT. However, I also felt that the team itself possessed a degree of critical awareness which has, to a very large extent, facilitated my analysis. In other words, the critical analysis has been generated not solely, or even largely, by my view from the outside, but through a dialogue with the team who themselves demonstrate a good deal of critical insight into their work. Often, my critical capacities as researcher would be triggered by the team's insights as practitioners. In this way, practitioner and researcher identities have merged from time to time and enabled the research to develop into the joint enterprise which feminist research should ideally be.

Clearly, my position as researcher and 'outsider' offered me the opportunity for ongoing critical comment since I was unfettered by organisational constraints, by structures of accountability (however weak) and by professionally collusive relationships which inevitably develop over time. I have neither the commitment to the project which the team have, nor the professional investment in its success. Nevertheless, I hope that I have demonstrated how, in my experience, critical insight is by no means the exclusive preserve of the researcher and that the practitioners have offered me much in this respect.

Conclusion

The above discussion has attempted to look critically at the boundaries between the roles of researcher and practitioner and while clear distinctions have been recognised, clear areas of overlap and fusion have also been identified. The discussion, as a whole, has been generated by my concern not to contaminate the research process by an over-involvement in the practitioner role. I have tried to explore some of the difficulties encountered by the researcher, anxious to escape the constraints of the positivist paradigm and its emphasis on the researcher's objectivity, but needing to be able to 'see with new eyes' the events being unfolded. I have also tried to demonstrate how my previous experience as a practitioner in the field I am now researching has introduced an element of risk in terms of the research's validity and I have attempted to reveal how this risk has been negotiated and understood. That the researcher is, herself, caught up in the very social processes she is trying to understand, is apparent from my fieldwork experience and from these reflections on it.

The discussion suggests that my attempts to achieve a view of events in the field which were uncontaminated by my previous experience as a practitioner were misconceived. What was needed, and what, I hope has been achieved, is an exploration of how my previous experience provided a lens through which my research experience was refracted. My previous 'life' as a practitioner was just one of a number of identities I took to the research. It was an identity which had an impact on what I saw and on how I made sense of the situations I was presented with.

CHAPTER 6

PARTICIPANT OBSERVATION AND THE PROBLEM OF PARALLEL EVENTS

Introduction

> *Fieldworkers would like to believe that whatever they see, hear and write up as a result of their research experience in a particular setting is what any other similarly trained and situated fieldworker would also see, hear and write up. This is the ethnographic conceit and, to a certain extent, it has kept the enterprise going for the past fifty or so years. Such a conceit has had its day, however.*
>
> (Mannen, Manning and Miller cited in Warren, 1988 p5)

My fieldwork experience was characterised by a growing awareness that what I was hearing, seeing and noting was a very particular set of events. It was with interest, therefore, that I noted Mannen, Manning and Miller's observations on what they term 'the ethnographic conceit'. Not only did their observations on fieldwork reflect my own experience, they also served to legitimate, to some extent, the fact that my account of the projects under scrutiny would, ultimately, derive from a very particular and personal set of experiences.

My discussion here focuses on my concerns with the limits to the single researcher's view of events and the problem of observing and participating in parallel events. Like my examination of the transition from practitioner to researcher in Chapter 5, it derives from my commitment to a research orientation which emphasises the importance of making visible the processes by which knowledge is produced. The discussion is centred around two interrelated issues. The first is a concern with what happens when the researcher's potential field of vision is such that it takes in a number of events being acted out simultaneously. The second is the researcher's response to the knowledge that, at any one time, a number of parallel events, all potentially relevant to the research, are being acted out in different arenas.

One of the problems in trying to scrutinise the social world is the way in which any one event is embedded within a multitude of other events, happening simultaneously. This presents the researcher with a number of problems. The first is the need to make instant decisions about which events to focus on at any one time. A problem typically encountered by ethnographers. It involves the researcher in making spot decisions about which events might be the most significant for the purposes of her research. Such decisions have to be constantly made and remade as events move on relentlessly at their own pace, taking no account of the researcher's agenda or energies.

A second set of problems relates to the difficulties of remaining committed to the decision to focus on one particular event and avoid the temptation to be enticed into potentially more revealing episodes being played out simultaneously. An enormous

effort of concentration is sometimes necessary in order to resist other demands on the researcher's attention and the feeling that the research field may be greener on the other side. This temptation to distraction is exacerbated by the need to pay attention to suggestions from the researched about what the researcher might usefully observe. These two sets of issues provide the framework for the following discussion of my fieldwork experience which illustrates some of the dilemmas faced by the sole researcher.

Coming to Terms with a Limited Field of Vision

The over-riding experience I was left with after the initial weeks of my fieldwork was that of being bombarded by events which, in turn, led to a growing awareness of just how limited and partial the researcher's gaze is. The collection of data, far from being an organised and active process, often seemed to be a somewhat arbitrary, reactive and fragmented affair. An important part of the purpose and process of the analysis of this data would seem to be that of bringing about some coherence to the fragments I observed and recorded. It is important to recognise this as something which is imposed after the event, rather than something that is inherent in the events observed. It is a coherence created by the researcher herself rather than a reflection of what actually happened, resulting in a socially constructed text.

The issue of the limitations on the researcher's field of vision was one which concerned me, to a greater or lesser extent, throughout the whole of the fieldwork stage of my research. The following discussion focuses centrally on the issue in an attempt to explore the implications of the researcher's inevitably limited view of the proceedings under scrutiny.

Four Arenas of Action and One Researcher

My experience of observing the work both of the Community Drug Team and of the Residential Centre was characterised by an awareness that, at any one time, I was observing and participating in only a small part of the action that was being played out at any one time. At the CDT, I spent a good deal of my time sitting with the goldfish (a highly-appropriate place for an observer, I suppose), since this was clearly the hub of the organisation and I had a good view of the proceedings from this vantage point. However, there were also a number of other important arenas where action was taking place. There was the room where clients sat who were either waiting to see staff or waiting for friends to collect clean needles or complete their counselling sessions. It was possible to see, but not to hear, what was going on in the waiting room through a window in the office. Since my concern was to study the work of the team rather than the actions and behaviours of clients, I made little use of this vantage point into the waiting room and only entered that space on the occasions when I helped staff to serve tea or coffee to waiting clients.

A third, more action-packed arena from my point of view, was the Needle-Exchange. This was where staff would take clients who wanted to pick up clean needles, syringes, swabs, disposable canisters and condoms. This was a space to which I had fairly easy access, although staff would usually introduce me to Needle-Exchange users and ask if they minded my presence. None of them did. Exchanges between staff and clients here were fairly brief but from my point of view it offered some valuable insights into the nature of staff/client interaction and the profile of the client group. From time to

time, more long-term users of the service would come into the exchange and their interactions with staff were often much more extensive. In such cases, I would glean further details about work with various clients, not only through first-hand involvement in and observation of, the encounter, but also through questioning the staff further, where opportunities arose, about their relationship with their clients who I had met in this way. To this extent, the 'casual' encounters in the Needle Exchange provided a focus for gaining more detailed insights into on-going work with long-standing clients.

The Needle Exchange, then, was a useful space for me to be, since it yielded some valuable data about the users of the service, the response of staff to 'casual' clients as well as opening-up relationships with the more established client group. However, it was also characterised by some fairly routine encounters with some 'anonymous' clients who just wanted a supply of clean needles. So one of the decisions I was constantly having to make was whether to leave the office and participate in the other main arena of action, the Needle Exchange. Sometimes, the decision was easy to make as there was a lull in activity in the office and, since I had easy access to the Needle Exchange, I would hang around there. But this was not always the case and often some fairly instant decisions had to be made as to whether to continue with the action in the office or whether to pursue potentially more interesting action in the Exchange. Sometimes, my hand was forced, since when staff made specific invitations to join them in the Exchange, I found it hard to refuse.

These two arenas of action presented problems for me, the sole researcher, since it was impossible to observe them both at the same time. On many occasions, I was aware of feeling that the grass might have been greener and more fruitful in the other room. This, in turn, meant that my attention was not always fully on the proceedings in the arena which I had chosen to be, or to which I had been relegated for reasons of confidentiality. So, not only was I unable to attend to other interactions in the other space because I was not physically there, I was only partially attending to the action in the space to which I *did* have access because I was fantasising about the potentially invaluable material I might be collecting were I in the other room. The problem does not end there, since there were other arenas of significant action besides the office and the Needle Exchange. These were spaces I had only limited access to, but which were potentially very fruitful arenas. One of these was the counselling room at the CDT, where the interaction between clients and worker was a more extended and less superficial encounter than that in the Needle Exchange. Access to this space had to be carefully negotiated with the client and with the worker concerned. In the initial stages of the fieldwork, I waited to be invited, but, as I became more confident in my relationship with the team, I would make requests for access to an interview or counselling session. On the whole, I gained fairly regular access to this space and it yielded some important insights into the nature of the service and the client/worker encounter.

I had access to the counselling room most Friday mornings when the consultant ran his clinic and saw a number of both new and long-term clients of the service. Sitting in on these sessions gave me access to data which was not readily available at other times or in other arenas. One morning, I voluntarily withdrew from one of the interviews because I felt it was overloaded with 'staff' and the young woman client was in some distress. In the event, I had to be content with observing the consultant's 'off-stage' remarks about the case when he came into the office after the session. These remarks

were undoubtedly revealing but I felt they were a poor substitute for the real 'on-stage' action which had been denied to me. In reflecting on my experience that week, I noted

> "Felt frustrated that I hadn't been able to participate/observe Martin's, (consultant) interview with Marie and Danielle on my last day at the CDT. Nevertheless, I found Martin's reaction and obvious exasperation revealing and noted how I used my presence in the general office to pick up 'off-stage' comments on clients".
>
> (August 1993)

This illustrates the way in which the 'drama' which is the subject of the researcher's attention is being played out in more than one arena. The sole researcher has access only to that part of it which happens to be played out in her presence.

It is tempting, but a little dangerous perhaps, to identify one arena of action as *the* arena since this might lead to a failure to capitalise on alternative vantage points offered in other arenas of action. In the particular case under discussion, although I was unable to observe the actual encounter between consultant and client, I was able to observe the consultant's exasperation with the proceedings which, I suspect, was not revealed in the actual interview with the client. However, I was then left trying to explain the consultant's response and relate it to an encounter which I had not observed. Further probing - by questioning a member of staff who *had* been present in the interview - revealed some further clues, but such a second-hand account ultimately seemed a poor substitute for the researcher's own participation in the event as it was being played out. In order to get the fullest possible picture here, I would have needed to be both 'on-stage' participating in the consultant/client encounter *and* waiting in the wings to catch the consultant's remarks as he came out of the interview. As it was, I had to try and put together a coherent account of events from my position 'in the wings'.

The above example is just one of the many occasions when I was acutely aware of being absent from what I felt were significant happenings and events and potential sources of rich data. My main device to try and overcome these gaps in my experience of the service under scrutiny was to try and capture such events by asking workers who *had* participated, to describe them. This device was only a very limited solution and inevitably meant that my understanding of events was refracted through someone else's perceptions and someone else's editing processes. A further consideration about using such a device is that, in trying to gain insight into *past* events, the researcher jeopardises her full participation in current events.

More Arenas of Action!

So far, I have identified four arenas of action at the CDT - the general office, the waiting room, the Needle Exchange and the counselling room. Parallel dramas were being played out in each of these areas at any one time and as a sole researcher, I had to content myself with observing and participating in only one of them at any one time. Fantasising about what was happening elsewhere and trying to gain insight into events that I had not been present at, only served to jeopardise my attention to current events.

However, in addition to the four main arenas of action at the CDT, there were also numerous other places where workers might be delivering the service which I was researching. The team Co-ordinator, for instance, regularly visited the psychiatric ward

at the local hospital where clients of the CDT were being detoxified. I accompanied him on a number of occasions and found the visits extremely fruitful in terms of my research interests. Home visits were another potential arena of action and service delivery, and, again I had a good deal of opportunity to participate in this aspect of the work. Both the visits to the Ward and to clients' homes yielded some very rich data, as did the conversations in the car to and from such visits. However, these visits also served to remove me from the CDT's main premises and other arenas of action. As a result, the question of what might be happening back 'at base' was never far from my mind.

My experience at the Residential Centre was very similar in terms of my awareness of the fact that significant events were being played out in a number of arenas at the same time. I tried to deal with the problem here by taking an early decision to concentrate on discreet areas of the work at any one time, eg. two weeks observing the work of the Family House, two weeks in the Main Programme, two weeks with the Resettlement Team, etc. This cut down the options, to some extent, but it by no means eliminated the problems created by concurrent events. Not only did it fail to resolve the problem of observing parallel events *within* the sub-site, it took no account of the many ways in which the different aspects of the Centre's work are linked. Staff and residents regularly moved between the sub-sites, Family Unit business was reported at meetings in the Main Programme and issues often arose which were common to all sites.

An example of the way in which my attempts to separate out my research attentions were confounded, serve as further illustration of the problems I am exploring in this discussion. Having completed my observations at the Family Unit, I transferred my focus to the Main Programme, only to discover, via an observed 'morning handover' meeting, that an issue which had been of particular interest to me the previous week had taken a new turn. This resulted in me taking a fairly instant decision to re-focus my attention on developing events at the Family Unit and temporarily suspending my observations in the Main Programme.

The problem of doing field research on multiple sites is one which has been given some attention in the literature. Straus et al cited in Burgess (1984) recognised that, in a hospital setting, the field researcher will constantly need to make decisions about, for example, what wards to observe, whether to stay in the nurses station or move around on the ward. However, while Burgess recognises the problem of site selection as a complex one which the researcher must address and resolve, there is little indication of the fact that it is an ongoing problem. Far from being something which the researcher resolves once and for all at the outset of the research, my experience is that site selection is an ongoing issue and an important dynamic of participant observation. It is, however, a dynamic which appears to be glossed over rather than investigated. Summarising the tasks of the participant observer, Becker cited in Burgess (1984) states:

> *The participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversations with some or all of the participants in these situations and discovers their interpretations of the events he has observed.*
>
> (Becker, cited in Burgess 1984 p.79)

There is little indication here of the fact that the participant observer constantly has to decide which groups, which people, what situations, and how to "*enter into conversation*" with half a dozen participants all at the same time. Becker seems to be supremely in control. My grasp of the situation on the other hand was much more slippery.

Multiple Action in One Arena

As I stated at the outset of this discussion of my experience of field research with the CDT, my main anchor in the maelstrom of events was my seat next to the goldfish in the general office. In taking up this vantage point, which I regularly did, I was limiting my experience of the service to events which occurred in the general office. But even from this position, there were choices to be made with regard to what I should attend to - a conversation between two members of staff about a client? A member of staff's telephone conversation with one of her clients? A member of staff's encounter with a client at the door? For not only were different scenarios being played out in different rooms within the building, often many scenarios were being played out in the one room. In the early stages of my fieldwork, when I spent a good deal of my time in the office, the issue of conflicting demands on my attention was very difficult to handle. It is a dominant theme in my notes for the first week:

> **"I often feel bombarded from all directions - someone is having an interesting telephone conversation, two workers are discussing a client and clients are coming through for counselling or to use the Needle Exchange. Where do I focus my attention?"**
>
> **(July 1993)**

Even within the one arena then, it was sometimes difficult to know what to pay attention to in respect to the collection of data.

As the research progressed, it was possible to take more control over what I observed and participated in. I was able to pursue particular lines of enquiry deriving from the 'hunches' I was increasingly identifying and wanting to check out, as can be seen in the above illustration of my observations at the Residential Centre. Nevertheless, my control of the data collection remained tenuous and reactive as I had little power to determine events or to insist on being in places where staff felt my presence inappropriate.

Piecing together the Fragments

My awareness of the issues I have raised in the above discussion has alerted me to the highly-fragmented nature of my experience of the services I am researching. My view has been limited, to a large extent, to those actions to which I have been party and, at any one time, other actions have been underway, actions to which I have had access only through the second-hand, edited and partial accounts of others. In addition, of course, my view of proceedings has spanned a very short space of time in the ongoing life of the organisations under scrutiny. Not only has the time spent in the organisations been limited, however, it has also had to be squeezed into the spaces left by my full-time work and domestic commitments. As a result, the length and timing of my fieldwork has paid only limited attention to ensuring that my view of the organisations is a

representative one. Certainly, had I been engaged in the research full-time, I might have been able to address more thoroughly some of the concerns expressed by Hammersley (1984) with regard to the representative nature of the (staff room) interactions he recorded. He makes a number of suggestions to overcome his concerns, including sampling interactions over time, on randomly chosen days and at randomly chosen times.

My fieldwork, in contrast, had to be tailored much more to the time I had available rather than taking account of the ebb and flow of events in the two agencies under scrutiny. This did not, however, precluded me from making further visits where I felt the need to strengthen or check my data. Nevertheless, I am aware that my view of events in the two research sites has been limited to those I was able to observe or participate in, and to those I was able to gain insight into by using other strategies.

A significant amount of data has also been gleaned from lengthy and informal interviews with staff. These were done after the bulk of the fieldwork observations had taken place and were useful in supplementing, clarifying and generally adding to my understanding of the nature of the services I am researching. Where time and access to staff permitted, I also used a number of 'vignettes' as part of the interview process. This involved presenting staff with fictional scenarios and asking them to respond. Responses to the 'vignettes' often triggered workers' accounts of actual cases and events they had been involved in. They were thus very effective in increasing my insight into the services, their operation and the underlying principles which drive them. Both the interviews and the vignettes were an important part of the process of making sense of a rather fragmented view of events gleaned through participant observation.

Conclusion

Being attuned to the aspects of the research process outlined in the above discussion, particularly perhaps, the initial attunement to feeling 'bombarded' by data, has enabled me to gain insight not only into the process of collecting data but into the services which I am researching. The field notes quoted earlier continue:

> "The feeling of being bombarded from all sides much of the time, is not just a problem for me as researcher. It is, in many ways, an inherent feature of the work at the CDT and something which workers (not just researchers) have to deal with. The team have to respond to conflicting demands on their time for much of the working day. This contributes to a feeling of being under siege and on the verge of loosing control, from time to time".
>
> (July 1993)

and in relation to the work of the Residential Centre:

> "Staff seem to fight to bring order into the chaotic lives of the drug user - the chaos seems to have a way of insinuating itself regardless of attempts to keep it at bay".
>
> (July 1994)

By exploring my experience of the research process, some important aspects of the dynamics of the service I am researching have been revealed. Such insights will, hopefully, feed into the process of analysing the data and might, for example, go some

way to explaining a seeming resistance to re-orientating services to take greater account of gender issues. If staff are constantly fighting to keep control and on top of a relentless stream of demands upon them, reappraisal and re-orientation of services remains on the horizon rather than on any immediate agenda for action.

CHAPTER 7

REVEALING ALL? COVERT INTENTIONS AND PARTIAL DISGUISE IN THE RESEARCH PROCESS

Introduction

The literature reveals a wide range of roles which the researcher can embrace or have thrust upon her, some more flattering than others. Researchers have wilfully gone in disguise (Humphreys, 1970) or have been cast in the role of Mata-Hari (Warren, 1988). They have been portrayed as ethnographic vampires (McLaren, 1991) consumed by their own narcissism and they have embraced the role of outlaw biker as a reflection of their own 'dark side' (Wolf, 1991).

Such images seemed remote and unrelated to my own experience and intentions. I was committed to an approach which overtly acknowledged the researcher's identity and agenda and which was mindful of the need to establish a partnership with the service providers whose work I was scrutinising. As the fieldwork progressed, however, I became increasingly aware that the distinction between overt and covert research is not an easy one to make. I made no attempt to 'pass' as anyone other than a part-time student engaged in research. Nevertheless, the nature and orientation of the study was not always clearly acknowledged. Bulmer (1982) has suggested that the distinction between overt and covert research gives way in practice to something much more fluid. He suggested that much overt research involves deception of one kind or another. The notion of a continuum from overt to covert strategies is a more accurate characterisation of the research process, as the researcher responds to the complexities and nuances of the research encounter. This suggests that there may be aspects of participant observation which militate against continued 'overtness' in ways which do not apply to other research methods. Certainly, I was aware of the continuum which Bulmer identifies and the following is an attempt to explore some of the ways in which it operated.

"I'm Denise and I'm a Part-Time Research Student"

At one level, I was quite open about my intentions. I introduced myself as a part-time student doing post-graduate research and produced written evidence from my supervisor in support. On the whole, no attempt was made to 'pass' as anyone other than a researcher overtly engaged in an examination of the services available to drug users. Nevertheless, there were times when the exigencies of the situation made introductions either inappropriate or too cumbersome and events rolled on without any clear explanation to *all* those involved about why I was there. At such times, I consciously attempted to 'pass' as a staff member, or, more vaguely, as a visiting professional or volunteer helper. Even at the level of acknowledging my identity as a researcher then, there was not always complete clarity.

When it came to spelling out the aims of my research more precisely, the picture became even cloudier. I was reluctant to wholeheartedly embrace the feminist perspective which I was adopting lest it jeopardised my acceptability as a researcher in the projects. In negotiating access, I did acknowledge that I had a particular interest in

services available to women but I was chary of using the word 'feminist' to describe my approach to the study. When I did own the feminist thrust of my research, I was at pains to stress that this did not preclude a concern with men as both receivers and providers of the service. Throughout the fieldwork, I struggled with my feminist identity, sometimes overtly discussing my commitment to feminist politics and analysing situations accordingly but often being much less clear about my research orientation and analytic perspective.

Just as I had to continually negotiate and re-negotiate my access to research sites and situations (see Chapter 6) so I had to continually introduce and re-introduce myself and my research intentions. It was not simply a case of discussing my research intentions when I initially negotiated access to the two research sites. As I encountered new situations and new personnel in the projects, I was asked to introduce myself and my research. So, each time I negotiated access to a group session at the Residential Centre, for instance, I was asked to introduce myself to the group and explain why I was there. This was, of course, the proper way to proceed, as staff and residents had every right to know.

In addition to such formal statements of who I was and what I was doing in the project, I was also often asked, informally, about my research. So, if I was sitting in the general office at the Residential Centre and a resident was on telephone duty, he or she would introduce themselves, ask me about myself and express interest in the fact and nature of my research. The normal rules of social intercourse, then, required me to regularly give an account of myself and explain my presence in the organisation. But, as with my initial introductions, while I was very open about my identity as a researcher undertaking post-graduate study, I was often less than clear about the precise nature of the study. I usually admitted to a particular interest in women but always added that this did not preclude a concern with men. I rarely described my research as a study informed by feminist theory and politics.

A Reluctant Feminist?

My coyness with regard to my feminist credentials raises some important questions. The first and most obvious, perhaps, is why I felt the need to keep my feminist identity, at least, partially in the closet. Secondly, if feminist research is politically committed research, am I not compromising this commitment by partially disguising my true intentions? Finally, there is a need to consider what impact my reluctant feminism had on my analysis. Could I retain a focus on the impact of gendered power relationships if I was underplaying my political interests? i.e. does underplaying political interests effectively undermine them?

Taking first the question of why I felt the need to present myself as being less clearly committed to a feminist political agenda than I in fact was, it is useful to turn to the work of Christine Griffin (1991). Her research on *Young Women and Work* took her into schools where, she says, she intended to give away "*the minimal amount of information about my research job at a Centre renowned for Marxist-feminist work*". (Griffin, 1991 p.133). Her reflections on why she felt she needed to present a neutral front in order to be taken seriously reveal a concern not to be seen as "*political, biased and subjective*". She questions why she should be so concerned, however, when "*male researchers and/or those who focus on men's experience can pass as objective, unbiased, apolitical and rigorous*". (Griffin 1991, p.133). Her comments highlight the

way in which 'malestream' research sets the agenda and her experience underlines the difficulties involved in leaving this agenda behind. Christine Griffin's experience offers an insight into why feminists may seek to disguise or, at least, downplay their research intentions. Certainly, my sensitivity to being seen as biased led me into partially disguising my identity.

A second and related reason for coyness was my concern that in a research setting where men predominate, I could not trust my feminist commitment to be respected or tolerated. The feminist political agenda derives from the fact that women are subordinated by men. Not to take this into account and to naively assume men's (and other women's) wholehearted support for the feminist agenda would be to ignore the very premise on which feminist research and feminist politics is based. While I would not advocate a position which sees all men as 'the enemy', it would seem sensible to remain sceptical with regard to the issue of men's support for feminist aims and objectives. Even where there is support and sympathy, as there clearly was among many of the men working in the two projects I studied, I considered it wise not to take too much for granted.

Partial disguise, then, may be necessary and justified where there is a conflict of political interests. In this respect, my position is similar to that of Simon Holdaway (1982), whose research on the police prompted him to consider the question of political standpoint and the researcher's interests,

> *if I were a Marxist and wanted to research the police and declared my Marxism, I know that I would be denied research access .... yet to 'front' myself in a different research guise is surely dishonest.*
> (Holdaway,1982 .63).

In being coy about my feminist identity, then, I was responding to a perceived need for caution in the face of resistance to a feminist political agenda. There were times when this resistance was manifest and many when it was thinly disguised. My decision to proceed with caution was based on what I felt to be a realistic assessment of the risks involved in adopting an overtly feminist stance.

There were yet further reasons for this cautious approach which revolved around my concerns about the validity of my findings. I was concerned that if I stressed the feminist aims of my research, this might lead to service providers being alerted to the issues and to presenting a 'politically correct' image of their work to a feminist researcher. It is a phenomena which Shaffir and Stebbins (1991) refer to as *'role selection'* where subjects *"choose to emphasise one of several selves that they sense is most appropriate given the observer's presence"* (p.13). Certainly, the staff of one of the agencies I studied were very aware of issues of racism and sexism and had a range of sophisticated satire on the subject of political correctness. This alerted me to the possible dangers of getting a biased account of their work and this concern is reflected in my fieldnotes:

> "My gender and my stated aim, ie. a feminist analysis of the service, taken together, have the potential to distort the interactions I am examining. Workers may be circumspect in their discussion of clients, etc., knowing that they are under scrutiny from a feminist observer. Sexist remarks or derogatory comments about women may be censored in my presence. I have no doubt that some of this goes on. This may not be a deliberate or conscious attempt at censorship. However, it may be a social

care worker's sensitivity to the values of others and/or an awareness of what and what is not 'politically correct'.

(July 1994)

It is possible to be over-cautious on this issue, however. In addressing the problem of bias in the research encounter, it has to be recognised that, even if there is some attempt, either conscious or otherwise, to present a distorted picture of events to a researcher, it is very difficult to sustain this distortion over a period of time and in all situations which the researcher observes. As Punch (1993) observes:

> *people do not keep up .... an act for long ... what they are engaged in is often more important to them than the fact that an outsider is present".* (Punch, 1993 p.195)

It would have been extremely difficult for staff in the projects whose work I was observing to have censored all telephone conversations, interactions with clients, group discussions, etc. I also consider that, had any one individual worker attempted to present a very different face to me, others in the team would have either challenged their colleague openly or alerted me to what was going on.

Conflicts and Contradictions

While I recognised that the chances of me being presented with a consistently distorted picture were slim, I nevertheless felt inhibited about entering into lengthy discussions about the nature of my research with those whom I was studying. But this reticence led into conflict and contradiction. On the one hand, I was committed to making the research process into a partnership with those I came into contact with. On the other, I was failing to fully reveal the assumptions on which I was working, lest this should distort my findings. This contradiction was thrown into sharp relief when I was asked by workers for feedback on my observations of the service. My commitment to feminist research principles was such that I wanted, intuitively, to engage in a full and open discussion of the issues I was identifying and certainly in respect to some issues, for example the CDT's lack of coherent policy and practice with respect to men's violence towards women, I was able to have this kind of discussion.

On other occasions, however, I resisted being drawn into a thoroughgoing feminist analysis of the service: a) because I feared encountering opposition and possible obstruction to further investigation and b) because I feared distorting the research by having a 'politically correct' set of attitudes presented to me.

My reticence, or at least, vacillation, in respect of entering into a dialogue with those whose work I was researching raises two problems. The first is that an unwillingness on the part of the researcher to share her 'findings' contradicts feminist research principles. Relationships between the researcher and researched cannot be equalised unless the researcher is willing to share her analysis of the situation. A partnership did occur on some occasions, most notably with staff whom I knew understood and were sympathetic to my agenda. Among the Re-settlement Team at the Residential Centre, for instance, there were a number of women staff with whom I could openly discuss the feminist political agenda which underpinned my research and I felt most staff at the CDT to be broadly sympathetic to the aims and orientation of my

research. Nevertheless, in general, I found myself erring on the side of caution with respect to what and how much I revealed of my feminist agenda. In doing so, I created a contradiction but a contradiction which, I would argue, is inherent in attempting to do feminist research in a setting where men participate or where a commitment to feminism cannot be assumed.

My reluctance to share my analysis and, in doing so, expose my interests, derived from a realistic assessment of workers' commitment to, and tolerance of, feminist politics. The fact that this reticence then undermined my commitment to feminist research principles suggests that the requirement for the researcher to enter into a partnership with those she is researching takes little account of research situations where those under scrutiny may be men and may not be sympathetic to a feminist political agenda. The power of the researcher in such situations is mitigated and changed by the broader gender power structures which put women, and particularly feminists, on the defensive. The requirement to enter into a partnership with one's 'subjects' works where research is being conducted on, by and for women. Where it is being conducted on men, not necessarily pro-feminist men, the researcher cannot enter into a partnership and must develop other tactics to cope with the complex power relationships which are operating. These tactics will include testing out how far her 'subjects' are sympathetic to feminist aims since this will determine how far the researcher can safely reveal her feminist identity. The ethics of the research thus became inextricably linked with and constrained by the broader political power structures within which the research is being conducted. Some degree of dissembling and disguise is made necessary where the researcher is attempting to expose gendered power relationships and where she is unsure of who her allies might be.

The issue of research on men who may have little sympathy with, or understanding of, feminist politics is sharply exposed in Diane Sculley's research (1990) on convicted rapists. She was unable to acknowledge her agenda, or enter into a partnership with the men she interviewed. Neither was she able to express her horror at some of the events the men described to her. Similarly, Julia O'Connell Davidson (1994), in discussing her work on prostitution which involved interviewing a male client, describes how she *"felt constrained to appear neutral and non-judgmental"* in the face of racist and sexist descriptions *of* experiences with Thai prostitutes. To have done otherwise would have had the effect of preventing the disclosure of the information she sought for her research. Nevertheless, it raised some serious ethical issues, as she points out:

> *If I appear to accept his appallingly callous attitudes towards and and exploitation of these women, will he see it as somehow more legitimate? Am I endorsing his activities by failing to outrightly and vigorously condemn them?*
>
> (O'Connell Davidson, 1994 p.216)

While my experiences are not of the order encountered by Sculley and O'Connell Davidson, the issues and dilemmas are similar. I often felt unable to risk the free-flow of information by an overt acknowledgement of my feminist political stance, but, at the same time felt that my apparent acceptance of sexist attitudes and practices legitimated and confirmed them.

The third problem raised by my reluctance to 'reveal all' is also linked to the aims of feminist research. I suggested earlier that one of my fears was that I would invalidate the research by too open an acknowledgement of my analytic perspective and too great a willingness to enter into discussion with regard to the service provision I was observing. I was afraid that I would have a distorted image of the work presented to me, but, by closing avenues to possible distortion, have I not also foreclosed on the possibility for change by allowing practices to go unchallenged? Since an important aspect of feminist research is its commitment to bringing about change, this is an important point. By trying to avoid the threat of distortion, have I built in a further contradiction by blocking the possibility of debate which might have led to change?

In exploring my fear of distortion more closely, I have already considered that it may be an ill-founded fear. It is also important to consider that it is a fear which derives from a particular view of research, one which stresses the need to ensure as unbiased a view as possible of the events under scrutiny. This positivist approach to researching the social world has been heavily criticised both from a feminist and an interpretivist perspective. Feminists stress the emancipatory potential of research and, therefore, emphasise the researcher's partiality, not objectivity. An interpretivist perspective acknowledges that the researcher is part of the social world that she is studying and should be concerned with subjectivity rather than objectivity and with how individuals attach meaning to social relationships.

Given that both feminists and interpretivists need to remain self-critical if their research is to have any value, I do not believe my concerns about contamination through bias were inappropriate. Nevertheless, by pursuing these concerns, I may have ruled out possibilities for change which might have occurred had I been more willing to share my analysis of the services as I was observing them.

In retrospect, it is possible to see that there may have been more potential for change in actual practice than I was prepared to acknowledge, since practitioners were often keen to enter into discussions of their work and welcomed a fresh perspective on it. It may be, of course, that some change has taken place since my reticence to comment on the practice I observed fell far short of silence and did not preclude me contributing some strong feminist insights on some aspects of the work. Any change will, however, have been incidental to, rather than an explicit aim of, the fieldwork.

Out of Sight, Out of Mind?

I have tried to give some insight into why I felt that partial disguise was necessary and to some extent justified by the nature of my research. I have also explored some of the contradictions in which my reticence resulted. I now want to turn my attention to the third question I posed at the outset of this discussion and consider how far a reluctance to embrace a feminist identity may have jeopardised my ability to 'see' the gender dimensions of the services I was observing. In fact, my reluctance to wholeheartedly embrace a feminist identity may have aided rather than jeopardised the analysis because it meant that I was able to see events which may not have been strictly confined within a feminist framework of analysis. For example, I became interested in how the CDT presented itself as the 'young Turk' offering a progressive alternative to services which its members perceived to be run by the 'old maids' responsible for the psychiatric wards and outpatients departments. This was not a clear gender issue but it helped me understand the way in which the team perceived itself and what it had to offer to drug

users. It was also an important key to understanding some of the dynamics on the team and their relationship with other agencies. I was able to see this and other non-gender issues partly because I was concerned not to allow my perspective to become an iron cage but partly because I was not seen as only interested in the gendered aspects of the organisation. A clearer statement of my intentions might have resulted in me having access only to those parts of the service which service providers deemed relevant to my interests.

To some extent, then, my *vague* rather than *explicit* feminist identity assisted the freeflow of action and ideas I came into contact with in the field. It also maximised opportunities to be open to the unknown and unforeseeable. It must be remembered too, that my 'weak' feminist identity was an assumed identity. Having constantly to consider how much to reveal of myself and my intentions, only served to remind me of the issues I wanted to explore. It was not a case of leaving my feminist identity in the car to be picked up again once I had left the research site, it was a case of taking it with me but partially concealing it. I had to make on-going assessments of how much or how little to reveal which served to keep my feminist agenda constantly in view. In some important respects then, my partial disguise assisted rather than diluted my ability to engage in a feminist analysis of the services I was observing.

The above discussion has identified some of the issues which arose in my attempt to do feminist research. The problems are particularly apparent in a research setting where there is no unequivocal commitment to feminist political principles and which does not focus solely or even primarily on women. I have argued that a certain amount of disguise is necessary, if continued access is to be assured and that it does not ultimately compromise the research although it does produce contradictions. It is not, however, a position which I felt entirely comfortable with. There were times when I felt deeply compromised by not revealing my true feelings where I'd been party to some highly sexist practices. On such occasions, I was left feeling impotent and angry at having reneged on my feminist principles but ultimately accepted that this was the personal price I had to pay for my research.

A Double Burden of Disguise

How much or how little to reveal of my feminist identity was probably the most difficult and significant dilemma I experienced in the fieldwork stage of my research. It was not the only one, however. A second set of dilemmas, related to my personal biography rather than my political stance, centred on my reservations with regard to the principles and philosophy of the concept house approach to the treatment of drug misuse, concerns which I outline in Chapter 5.

In embarking on the fieldwork stage of my research at the Residential Centre, I had to grapple with how I might handle my reservations and feelings of unease with regard to the organisation's policy and practice. Such feelings of unease are characteristic of many research situations and Martyn Hammersley (1984) in particular, expresses many of my own concerns. He acknowledges the strains of doing research in a school setting where "*there was a conflict between my political opinions and the views and practices of teachers ....*" and where he was

shocked by the way in which the pupils were treated; in particular, the extent of control over their behaviour, the teachers claimed, and the insults that were constantly hurled at them.

Like me, he felt unable to express these concerns in the research setting.

I thought it clearly necessary to conceal my purposes and views from the teachers; I implied to them that I was primarily interested in the pupils. The deception was a source of strain and guilt.

(Hammersley,1984 p.44)

Just as I did not feel able to reveal my feminist agenda to all I came into contact with, so I did not feel able or justified in revealing my reservations about the concept house approach to drug users to all I came into contact with at the Residential Centre. To have shared such reservations with residents, for instance, who I had a good deal of contact with, would have been unethical as it would have undermined the treatment process. Similarly, to have been entirely open about my concerns with ex-resident staff might have undermined their confidence in their own recovery process.

Adopting this position of self-censorship however, led me onto some difficult and uncomfortable terrain. On more than one occasion I found myself alone with the women residents in the Family Unit who were angry about the way in which staff had treated them. I often felt the women were right to be angry but I could not say this as it would have undermined the staff and betrayed the trust they had placed in me by allowing me free access to the women in the Unit. On such occasions I had to tread a very fine line. I had to let the women know I heard their complaints and took them seriously, while adopting a neutral position vis-a-vis the practices which had generated the anger. Given that I was sometimes incensed by the practices, this was not an easy balancing act to sustain and I was left with the feelings of guilt and strain that Hammersley identifies. Moreover, other, more complex dynamics were at play here, since I recognised some of the practices as *my* past practices. The anger I felt about current practice, therefore, also partly 'belonged' to and was generated by a recognition of my own former practice. Perhaps it was this recognition which enabled me to avoid being drawn into explicit criticisms with regard to staff actions and decision-making.

My fieldwork at the Residential Centre then, was characterised to some extent, by a lack of openness and honesty with regard to my reservations about their approach to the treatment of drug users but, just as I was able to project a 'strong' feminist identity with some staff in some situations, so I was able to share at least some of my reservations about their style of work with many of the staff. I was also willing to 'suspend disbelief' in as much as I was aware that it was over five years since I had worked at the Residential Centre and much had changed in that time. The Family Unit had been set up, the appointment of an outreach worker had been made and Community Care legislation had come into effect. All these changes had the potential for making a significant shift in both the policy and practice of the Residential Centre. Partial disguise then, was just one of the strategies I employed to cope with the tensions I experienced in returning to the Residential Centre, an organisation whose aims I have had difficulty with in the past.

Other strategies were to approach the organisation, particularly its newer developments, with an open mind and to share some of my reservations with staff where

this felt appropriate. That my critical stance was partially rather than wholly disguised is confirmed by the willingness I encountered among some staff to openly discuss their reservations about some aspects of their work with me. On at least two occasions, following a taped interview and after the tape-recorder had been switched off, staff seemed grateful for the opportunity to discuss some of their fears (but also some of their hopes) to someone who they recognised as a sympathetic ear.

Conclusion

I have tried to give an insight into some of the ethical dilemmas I encountered in carrying out my fieldwork. The dilemmas hinge largely around my stated intention to carry out a feminist analysis of the projects I am researching. Doing feminism and doing research is not necessarily an easy combination to achieve. At one of the research sites my dilemmas were compounded by my critical stance towards the overall aims and policy orientation of the organisation. How to manage my critical perspective without undermining both residents and staff and jeopardising my continued access produced some tension and some discomfort. A critical perspective, which I made overt at the CDT in order to aid my acceptability (see Chapter 5) had to be partially disguised at the Residential Centre.

The discussion as a whole points up the lack of clear boundaries between overt and covert styles and the need for the researcher to accept a degree of fluidity in her approach and in the way she presents herself. Perhaps the problem of 'role selection' is a real one after all, but perhaps it is a more appropriate description of the way in which the researcher operates in the field than of the way 'subjects' do.

Data Analysis : Organisational Framework

Before embarking on a discussion of my findings, some reflections on how far my analytic framework, constructed from the principles of feminist practice, has aided the collection and analysis of data is necessary. It was felt important to construct the framework because although I was adopting ethnographic research techniques, I wanted not only to understand the world from the perspective of those I was studying but to engage in a feminist critique of that perspective. I was aware that as a woman in a patriarchal society and as an ex-practitioner in the drugs field, I had spent a large part of my life striving to understand and take on dominant masculinist values and standards. Had I sought only to understand the world of the drug-worker without reference to some alternative, feminist value-position, I would once again merely have replicated rather than revealed the masculinist bias embedded in much social and health care practice with drug users.

It was evident from the outset that the framework would provide a springboard for observation and analysis rather than a rigidly defined set of principles into which all data would fit. In the event it proved a useful anchor in a field-work setting where I often felt bombarded by events, where decisions as to where to focus attention had to be made regularly and where the gendered nature of drug misuse and its treatment was often obscured and resisted by service providers. Overall, the framework proved a useful beacon in what often appeared to be very muddy water, a way of keeping in sight the feminist values which might otherwise have been submerged.

In respect of the analysis of data, the framework has proved a valuable tool but has been used as a loosely organising structure around which to hang the data rather than a strict coding mechanism. Three of the principles - '*Campaigning and Making Alliances*', '*Increasing Self Esteem*' and '*Challenging Sex-role Stereotyping*' have provided key themes into which interview material and field notes have easily translated. Other principles have been subsumed under broader headings or been used as analytic handles with which to understand and discuss the data. This is the case in relation to '*Challenging the Power of the Professional*' and '*Equalising Relationships*' which are discussed under the broader heading of '*Client/worker Relationship*'. The principle of '*Aiming for Change not Adjustment*' has largely been addressed within the context of the discussion of '*Challenging Sex-role Stereotyping*' although it has also provided some useful insights into examining professional ideology and practice.

Sometimes it has been more useful to discuss the indicators rather than the principles, so, for example, the heading '*Professional Ideology*' provides the focus for discussing the principle of '*Redefining Social Problems*' but it also allows for the identification of other pertinent issues which are not directly related to the principles of feminist practice. Some data has no immediately obvious relationship to the principles from which the framework was derived but nevertheless raises important issues. This has necessitated the construction of further analytic categories, i.e. '*Organisational Culture*', '*Professional Practice*', '*The Family Unit*' and '*Prescribing Policy*'.

In order to develop a coherent discussion of the findings I have adopted an approach which examines each research site separately but which makes appropriate links between them. By and large the discussions are developed by drawing on both field observations and taped interviews. Where only one set of data has been used this is made clear.

CHAPTER 8

THE COMMUNITY DRUG TEAM

To assist the reader, I give below an indication of the role of the various 'actors' referred to in the following discussion of my observations of the work of the Community Drug Team. Pseudonyms have been used to protect the identity of all concerned.

Staff Members :

- Harry: Team Manager
- Jackie: Team Member (Social Worker)
- Dave : Team Member (Probation Officer)
- Sue: Team Member (Community Psychiatric Nurse)
- Pat: Team Member (Community Psychiatric Nurse)
- Karen: Team Secretary
- Martin: Consultant Psychiatrist
- Richard: Psychiatric Nurse (on placement from hospital)

Clients:

- Claire: Young woman in late teens
- Will: Long-term heroin user in late 30s
- Sarah: Long-term user, late 20s, Will's partner
- Diane: Ex-client
- Christine: Client in Prison, mid-30s
- Helen: Young woman client
- Sharon: Client, early 20s
- Marie: Client, early 20s
- Danielle: Young woman in late teens
- Bob: Client and long-term drug user
- Jayne: Bob's non-drug using partner
- Jean: Client
- Sally: Ex-client
- Craig: Young client
- Lisa: Craig's non-drug using partner

PROFESSIONAL PRACTICE AND ORGANISATION

1. Professional Ideology

In analysing the work of the CDT one of my concerns has been to discover a) how the team defines and understands drug use and b) the model of professional practice which underpins its work. In particular, I have been concerned to assess how far the view of drug use as being rooted in the psyche of a gender neutral individual is challenged and how far the social and gender dimensions of drug use are identified and attended to. This concern relates to the feminist critique of health and social care practice which sees the need to re-define and engender social problems if women are to be responded to appropriately.

My findings in relation to the model of professional practice which informs the work of the CDT rely on individual team member's articulation of how they view drug use and how they view the team's role and function. These views were elicited through loosely structured taped interviews which took place either in staff's homes or in the office at a pre-arranged time.

Individualising Social Problems

Since the service is characterised by its inter-disciplinary structure, I had not expected to find a single, coherent and clearly articulated model of professional practice. I had expected the work to be underpinned by a set of competing ideologies, negotiated and accommodated within the team. This did not prove to be the case entirely. While there were differences within the team in terms of how they viewed the problem of drug use and how they responded to the needs of their clients, a dominant model was discernible.

The team operated on a bifurcated model of drug misuse which distinguished recreational, experimental use from problematic, chaotic use. This resulted in an analysis which normalised drug use while recognising that it became a problem for a minority of individuals. Drug use was likened to the team's own drinking, seen as an integral part of youth culture and resulting from increased opportunity.

> **"I think a lot of people get involved when they're young, as experimenters....." (Pat)**
>
> **"...it's the old experimentation and peer-group pressure". (Jackie)**
>
> **"...I think that opportunity plays a large part...the availability over the years has spread. At one time it was a fairly close underground sub-culture but I don't think that's true now." (Dave)**

I was struck by the team's concern to relate drug use to alcohol use and to emphasise the links between the team's own social drinking and their recreational use of drugs more generally. This had the effect of de-mystifying drug use and de-stigmatising the user by defining drug use as part of a spectrum of substances available for recreational and social purposes. There was an acceptance of the fact that drugs, like

alcohol, could be used "**in reasonably safe ways**" (Dave) and that young people, after a period of experimentation can

> "**choose a drug of choice and go on to use it recreationally and socially**" **(Jackie)**

In terms of a feminist analysis of the service, this 'normalising' of substance use, seeing it as a legitimate social activity and an inherent feature of youth culture, is to be welcomed. There was no evidence to suggest that young women's drug and alcohol use was seen as being more problematic or illegitimate than men's.

While it was recognised that the majority of drug use is unproblematic, it was also recognised that some young people are more vulnerable than others and that this can lead to "**getting in a mess with drugs**". An important distinction made by one worker in respect of involvement with illegal drugs was between those who use drugs and those who continue after a period of experimentation. Those who continue their drug use were seen as

> "**..looking for a way out because they can't really handle their life as it is, because of their personality or the things that have happened in their life...they are looking for an escape**". **(Pat)**

Similarly, Jackie saw "**other things taking over**" when drugs become a problem. The "other things" are the internal chaos of an individual's psyche brought about by "**poor parenting or abuse or no role models**". Jackie stated her belief in the fact that

> "**Everybody we work with here who is in a mess with drugs has some history of unresolved chaos in their background..a lot of them have been victims of abuse, either physical or sexual or emotional...or a combination of all three.**". **(Jackie)**

While the notion of drug misuse as deriving from the "**unresolved grief and trauma that you take with you**" was a strong theme in Jackie's analysis, it is also reflected in Pat's comments above. Sue spoke more generally of people getting into drugs "**because they are unhappy**" and "**having stress areas in their lives that they are unable to deal with**". Her emphasis, like Jackie's and Pat's was on the internal life of the individual. As Sue continued to reflect on why people become involved in drug use, her analysis brought other, social and external factors into view. "**Boredom and the problems that unemployment creates**" are mentioned but not expanded upon. Interestingly Sue remarked, in relation to this last point, "**I've just done about that in my last essay**". This indicates that her awareness is developing through involvement in further training/education and suggests that an awareness of social/external issues is a more recent awareness and not yet fully integrated into her analysis.

On the one hand, then, the team saw much drug use as being legitimate, acceptable and a normal part of social intercourse. They also recognised, however, that for some individuals it could become a problem. The causes of drug use in this bifurcated model differ. Unproblematic use is the result of peer group pressure and the availability of substances whereas problematic use, which can be recognised and treated,

relies on the notion of vulnerable individuals who lack the personal resources to handle their drug use or to contain it within the limits of social/recreational use.

In contrast to a model of drug misuse which identifies personal, psychological and internal processes, Dave emphasised its social determinants. He stressed the social isolation and poor living conditions experienced by many young people as encouraging a view of drug use as a tempting "**way out**" Dave saw the problems caused by drugs as stemming largely from their status as illegal substances. This made buying them a risky and expensive business and may lead to crime and arrest.

Dave's analysis of the roots of drug misuse were significantly more sociological than his colleagues' analyses. Nevertheless, Dave's focus of attention, like the rest of the team, was the individual, albeit a more social one. He made an interesting distinction between what he felt was his **"sphere of influence"** and what he saw as **"his sphere of concern".**

> **"You might think that a client's homelessness is the most important factor in their chaotic drug use but you cannot address that because you haven't got the resources to house that person." (Dave)**

It is clear that Dave sees his "sphere of influence" as **"plugging individual clients into resources"** and in liaising with housing services on behalf of individual clients. He sees his role as being that of encouraging clients to fit into rather than challenge, existing social arrangements;

> **"You're not talking about the way things ought to be, you're talking about the way things are. And...if people cope and learn about the way things are, that's the best you can do." (Dave)**

As Dave reflected further on the matter he recognised the possibilities of working with clients to raise social and political consciousness but he soon relegated these reflections to **"the realm of fantasy"** since few of his clients stayed around long enough to get to this stage.

Dave, perhaps more than other workers on the team, saw the social circumstances of client's lives as central to his remit. This deviates somewhat from the dominant model in the team which sees inequality, unemployment, poor housing and debt as exacerbating the problems that users face, but which essentially sees the focus of professional attention as being on the internal life of the individual, their relationships with partners (sometimes parents) and with their patterns of drug use. This is where Sue feels she can **"work and have an impact".** She will assist with other problems e.g. DSS, debt, but only as a means to allowing individual clients to focus on deeper personal issues which are seen as lying at the root of their drug use.

In terms of a feminist analysis of the service, this individualising of social problems is problematic since it fails to recognise and challenge the wider oppressive structures in people's, particularly women's, lives. The emphasis on personal adjustment which we see clearly in Dave's analysis of how he can meet client's needs, is similarly problematic as it leaves the status quo firmly in place and encourages individuals to fit round it.

The professional ideology which underpins the work of the team does not approximate to a crude medical model which seeks only to define and treat drug use as a psychological condition. It seeks to adopt a wholistic approach and recognises the social determinants of drug use. Nevertheless, while oppressive social arrangements are recognised, it is the individual's social and psychological maladjustment which is the subject of treatment attention and intervention. How far the individual user is seen and responded to as a gendered subject is the focus of the next part of this discussion.

Explaining drug use - engendering the debate

Feminist critiques of services to illegal drug users (Ettorre, 1989; Sargent. 1992; Henderson, 1990) have emphasised the centrality of the male subject in the design and implementation of services. In responding to drug users there has been a failure to recognise that it is a male user who is being responded to and that women users may have different needs and different routes in and out of drug use. The question of how far service providers, in this case the CDT, acknowledge the gender dimensions of problematic drug use is therefore a pertinent one.

I found a striking resistance to the possibility that women drug users might use for different reasons than men or that they might have different experiences of drug use and different treatment needs. Dave's initial response to the question of gender difference was to stress the similarities between men and women; **"opportunity exists across the sexes".** However he went on to outline some important gender differences both in precipitating drug use,

> **"(women) are not using drugs to get off their face...they're using them to get through the day, i.e. get the kids ready for school, off to school, whizz round the house, pick the kids up..."**

and in the ways in which men's drug use is perceived,

> **...the fact that a woman drug user may be a good mother is almost irrelevant when you go to court because she must be a bad mother for using drugs when kids are in the house." (Dave)**

Inspite of these identified differences, Dave's response to the question as to whether men's needs as clients of the service were different to men's, was again to resist:

> **"I think they can be but they don't have to be."**

This was supported by the suggestion that

> **".. there is a growing class of single male parents who use drugs for the same reason (as women)".**

Still holding on to the notion that there is little difference between the needs of male and female clients, Dave went on to identify some further significant differences in the stigma that is attached to women's drug use but not to men's. He also pointed up men's fear of precipitating child protection mechanisms if they admitted to using drugs.

There are some apparent contradictions in the interview with Dave. He is clearly resistant to the notion of gender-specific problems and needs of drug users but gives a number of examples of the ways in which women experience drug use differently from men. A similar reluctance to adopt a gender-specific analysis of the problems of drug misuse are reflected in other interviews. Sue's response to the possibility of differences in women's and men's drug use elicited a response which emphasised that each individual had different needs. Jackie too resisted the notion of gender differences but went on to outline the potential problem that becoming known as a drug user poses for women with children.

Pat tackled the issue somewhat differently by suggesting that women use different drugs to men. She suggested that women are more likely to use amphetamine than heroin because of the 'less acceptable' image of the injecting heroin user and the fact that amphetamine is associated with weight loss. Pat's analysis, however, appeared to derive less from her actual experience of women drug users than from her wider reading and awareness.

On the one hand the team seemed to have a sophisticated understanding of the gender specific issues associated with drug use but on the other resisted acknowledging the logic of the analysis for the service they provide. Perhaps a key to understanding this apparent contradiction is to be found in Dave's interview. He expressed a willingness to recognise that there may be gender differences in relation to stigma and in coming to terms with drug use and that there was a case to be made for "**handling it...more sensitively, if you like**". However, he went on the say

> **..I'm not quite sure how you'd translate that into practical terms".**

This suggests that the resistance to acknowledging the gendered nature of drug use and its treatment may emanate from a concern about its implications for practice. The awareness is apparent but the implications for practice have not been addressed. This leads to the ambivalence and confusion about the issues which characterised the interview discussions.

2. Professional Identity

Arising out of my concern to understand how the team perceived the problem of drug use and the model of professional practice which underpinned their response other, related concerns have emerged which warrant attention. The first of these is the issue of professional identity and the following discussion takes up and develops this. The theme, like '*Team Relationships*' and '*Organisational Culture*' does not easily relate to the principles of feminist practice but it does offer important insights which could be lost were the data to be shoehorned too tightly into a pre-conceived analytic framework.

The CDT's relationship to the Health Trust is an interesting and rather uneasy one. It is 'owned' by the Trust but situated in a converted garage behind a small clinic in the centre of the town. The contrast between the Garage and its 'parent', the prestigious Trust Hospital could not be more marked. This contrast is reflected in professional approach and style, as much as in the physical structure of the two buildings. To a large extent the team's professional identity is constructed out of this contrast and in

opposition to the power of medical psychiatry to define and treat drug misuse. The treatment regime on the psychiatric ward at the hospital has become the main focus for marking out what the team sees as an inappropriate and authoritarian approach to drug misuse in contrast to its more enlightened and effective approach. The team has constructed itself as the 'new turks' against the 'old maids'' of hospital psychiatry.

An important aspect of this agenda is the temporary staff placements offered to Ward staff by the CDT in order that they can have a better insight into the drug users who are also treated on the Ward when they undergo detoxification programmes. The CDT sees this as offering an opportunity for Ward staff to convert to a more enlightened approach to drug use and a chance to participate in the 'real world' of the drug user. One of the current team initially came to the Garage on a placement from the Ward. That Sue subsequently stayed on as a permanent member of staff is seen as a testament to the increased opportunities for professional development offered by the CDT and an indictment of the constraining effects of the Ward.

Sue's interview contains some important insights into the fact that the team's professional identity is constructed in opposition to hospital psychiatry in particular, and the 'medical model' more generally. Throughout her interview the Ward is constructed as atavistic in its approach to drug users. Sue identifies a marked shift in her professional outlook, the key features of which are; a non-judgemental approach to drug users; an acceptance of the fact that drug use may be a freely chosen option for some people rather than an illness needing to be cured; a greater awareness of the complexities of the issues which surround drug use and a rejection of the idea that it is morally reprehensible.

Sue sees her former approach to drug use, as a Ward sister, as naive and has moved away from seeing her role as **"just helping people to give up (drugs)"** and **"trying to make people better"** to one which may include supporting people in their drug use and acknowledging that they may not want to give up. Sue also clearly feels that the CDT give their clients more autonomy and, by implication, more respect:

> **"...(treatment) is more enforced on the Ward, people have to see their key workers. Here, people can choose if they want to see people which is important...it goes back to people needing to be in control of their treatment". (Sue)**

Client control of the counselling agenda and treatment process is a key feature of the work of the CDT, a feature deemed to be lacking in hospital psychiatry. It is a theme which will be explored further in relation to client/worker relationships but is raised here as an illustration of just one of the many ways in which the Ward is seen to offer different and inferior treatment to the CDT.

Sue's interview gives the clearest but not the only insight into the way in which the team has constructed a dichotomous relationship between the Ward and the Garage within which the Team's self-identity is framed. Other insights into how this operates occurred through observing and participating in the work of the team. I visited the Ward with Harry on a number of occasions as he was working with a client towards detoxification which would involve admittance onto the Ward. Harry was clearly 'at home' in the hospital environment as he is a nurse by training. He was nevertheless critical of the methods employed on the psychiatric wing and felt the need to keep a close eye on clinical arrangements for the detoxification programme. It was clear that Harry

did not feel entirely confident that his client's needs would be met or that the detox. would be administered efficiently.

Further insight into the way in which hospital psychiatry was held up as the mirror image of how the CDT saw itself was gleaned from conversations with Harry, en route to the Ward or in one case en route to visiting a recalcitrant client on a maintenance prescription for amphetamine. These car journeys presented a useful opportunity to speak with Harry, uninterrupted by the comings and going of the Garage and it was largely through these conversations that I gained an insight into the team's view of the inability of hospital psychiatry to deal effectively with drug users. It was clear that Harry felt that, in contrast to the young client on whose behalf he was arranging the detox., some older, long-standing drug users had been socialised into a dependency culture which developed around the out-patient drug clinics run by hospital psychiatry. He saw one of the team's tasks as being to break into this culture which was characterised by drug users haggling over their 'scripts' (maintenance prescriptions) and doctors using the 'scripts' as a way of controlling behaviour, control tantamount to 'blackmail' in some cases. Harry expressed a desire to eschew this kind of relationship, to use maintenance prescriptions to stabilise clients so that 'other', and by implication, more important work could be done. In my field notes for that day I reflected on what this 'other' work was. The answer lies to some extent in the above discussion on professional ideology:

> ".. 'real work' is emotional work which focuses on the internal conflicts of the individual and/or the significant relationships in the client's life. This is the work that the team can do but that the 'old' drug clinics, with which the Ward is associated, cannot." (July 1993)

The fact that the CDT has constructed itself as a more effective, enlightened and client-centred service to that offered previously by the out-patients clinics and currently by the Ward, raises two important issues. The first is explored more fully in the discussion below which examines prescribing policy and the use of medication. An exploration of how far the CDT has succeeded in undermining the power of the 'script' to determine the framework of the client/worker relationship will be attempted. Evidence suggests that it is still a dominant issue in the client/worker encounter.

The second issue raised by the team's concern to lay the ghost of the old 'clinic culture' is the fact that it results in the team's ideological framework and working agenda remaining firmly within that set by the medical profession in general and hospital psychiatry in particular. The approach adopted by the CDT seeks to overturn established practices but by using past practice as a standard against which to measure itself, it is locked into the established framework of responses to drug misuse. This does not allow a radical re-think and restructuring of treatment responses to drug use, a restructuring which would focus more centrally perhaps, on the social as opposed to individual dimensions of drug use and on the gendered nature of its definition, treatment and control.

3. Team Relationships

One of the things I set out to discover in relation to the principles of feminist practice, was how far relationships among the staff were equalised. Formally, the team

did not operate as a co-operative, there were salary differentials, Harry had recently been appointed as manager and a consultant psychiatrist was involved in the team on a part-time basis and had overall control of maintenance prescribing. Informally, a hierarchical structure was difficult to discern. The interdisciplinary nature of the team ensured that lines of accountability were defuse. Both Jackie and Dave were accountable to managers outside the team structure, in Social Services and the Probation Service respectively, as well as to the CDT itself. This ambiguous position not only gave them an added autonomy and confidence to assert their views within the team but provided a model of professional autonomy which other staff could, and did, emulate. It was noticeable that a commitment to a co-operative style of leadership and decision making was most vigorously defended by these two members of the team.

All staff interviewed described the team in much the same terms, as 'interdisciplinary' and 'non-hierarchical". Pat's comments were:

> **"We try to be a non-hierarchical, multi-disciplinary team where every person's view is as important as the next...and every person is basically equal". (Pat)**

These views are echoed in Jackie's interview: **"I think we all have equal input"** She recognised that there were external constraints bit says **"the day to day running is fairly democratic"**. Harry, recently appointed as the team manager spoke of an **"unofficial hierarchy"** related to professional competence:

> **"....there is an unofficial hierarchy based on skill and experience...I suppose it's a meritocracy more than anything." (Harry)**

The consensus among the staff appeared to be that Harry was the 'figurehead' that was needed in order to fulfil the needs of the Trust and external bodies but that this had little impact on the internal workings of the team. The feeling among staff that they had equal input into team decision-making was strong. Sue, while recognising Harry as **"the boss"** in terms of his management responsibilities said **"that didn't mean he had the last say on everything".** Sue suggested that

> **"..there's often things that he disagrees with strongly that the rest of us want to go on - in terms of treatment or policy or immediate events, and it isn't the case that because he's the Manager, what he says goes". (Sue)**

This was born out by my field observations. My notes for one team meeting include the comments:

> "Harry doesn't get much of his own way. He would have preferred to have done the training day for the University in his own time as an independent consultant/trainer, but he knew he was onto a looser and didn't press it. He and Jackie will do the session and the fee will go into the Trust. Harry didn't get to be the delegate to the Belgium conference and Jackie challenged him about being down to run a workshop at a forthcoming conference which the team didn't know about.
>
> (July 1993)

This was just one of a number of observations which confirmed the team's commitment to a joint decision-making process and their ability to challenge each other

openly. The main forum for decision-making was the weekly team meetings which I was always able to observe. Here on-going cases would be discussed, new cases allocated and any requests from clients for an increase in their 'scripts' debated. It was interesting to see how each worker became an advocate on behalf of their clients in discussion around 'scripts', it being their job to persuade the team, the consultant psychiatrist in particular, to increase maintenance dosage. While the consultant had the power of decision in relation to this issue it was clear that he took his cue from the worker concerned and agreed to the increase in all cases where the team felt that it was appropriate. New cases were allocated on a voluntary basis, thus catering for worker's particular strengths and interests and allowing staff some control over their work-load.

Evidence from observations suggested a high commitment to a participatory style of working and the interviews revealed that all members of staff felt they had an input into decision making, that their views were valued and taken seriously. Nevertheless, it was clear that the team saw Harry, the manager, and Martin, the consultant psychiatrist, as two potentially powerful men who could upset the team's equilibrium. In order to deal with this threat the team had devised a number of 'in-jokes' which acted as mechanisms to undermine the potential emergence of status differentials. Harry's mobile 'phone for instance was viewed with some suspicion, as a symbol of the upwardly mobile. On some occasions when he rang into the office he would be grilled as to whether he was using a public telephone (legitimate) or 'posing' with his mobile (illegitimate). Such mechanisms were subversive but not malicious and thus served to increase team cohesion.

The fact that the team valued and protected its participatory style resulted in individual staff members feeling supported and for one of the women staff in particular, this led to a significant growth in self-confidence. Sue expressed the feeling of being valued and explained what this meant in terms of her self-esteem:

> **"I know my opinion is valued...I know that people here have respect for what I do. People come to me and say 'well, what about this then Sue, what do you think?'. And that makes you feel really good and it makes you want to get into other things." (Sue)**

The shared decision-making process also involved the sharing out of tasks such as running training sessions for other agencies, speaking at conferences and on the radio. Women staff were encouraged to take on these tasks which were seen as important opportunities to strengthen their self-confidence. Fieldnotes contain examples of staff sharing experiences of overcoming their fears of public speaking when Sue was expressing anxiety about speaking at a forthcoming awareness day for parents.

The importance for women staff of an organisational culture which emphasises a co-operative style of working was evident. Not only were women encouraged and supported in taking on tasks which encouraged the growth of self-confidence and self-assertion, they were also supported in the difficult decisions they had to make in relation to clients. Drug users are a particularly demanding client group, especially where they are being prescribed maintenance doses of methadone or amphetamine, a practice which seems to invite dissent and disagreement. What level of maintenance is appropriate or desirable can be a constant source of tension between client and worker. Staff at the CDT felt it important that unpopular decisions (i.e. not to increase the 'script', to reduce or withdraw it) were seen as a team rather than individual worker's responsibility. That

this was an issue for both male and female staff was very clear but given that male clients predominate as users of the service, it was arguably more important for women staff to feel supported in making decisions which their male clients might take exception to and want to challenge. Both the issue of maintenance prescribing and that of the power relationship between women workers and their male clients will be given more sustained attention at a later stage in this discussion of research findings. The issue of a team approach to making unpopular decisions is raised at this stage in order to draw attention to the importance of shared decision-making processes in relieving staff of the burden of making unpopular decisions when faced with a potentially volatile client group.

Before leaving this discussion of team relationships, two further observations warrant some consideration. The first relates to the role of the team secretary and the second to the lack of clear boundaries between individual team member's personal, domestic and professional lives.

In emphasising the co-operative style of working and decision-making adopted by the team I am aware I have said nothing of the role of secretary, nor did I include her in the taped interviews. This could be considered a serious omission since it not only reinforces the subordinate status of women's secretarial work, it also misrepresents Karen's role and status which was far from marginal. Her role went well beyond that which one would normally expect of a secretary, but was essentially an administrative not a practitioner role. Had I decided to interview her I would have been imposing a 'flatter' structure on the organisation than was in fact the case.

Turning to the second issue, it was evident that the boundaries between the private and public lives of the team were not clearly drawn. How far this related to the dominance of women on the staff team and the inevitable incursion of, for example, child-care responsibilities and how far it resulted from a small team trying to establish an independent identity is difficult to assess. Child care, domestic responsibilities and personal concerns seemed to intrude into the professional lives of both male and female staff. There was a ready acceptance of this intrusion and a willingness to offer help and support to each other. The result was a comfortable, 'feminized' working environment which could, if necessary, accommodate children, partners and friends within the structure of the working day. Establishing this kind of working environment would seem to be an important and obvious principle of feminist practice. It is a principle which includes but which is not the same as establishing equal relationships. It has been given little attention in the literature on social care.

4. Organisational Culture

As a conclusion to the above discussion of the team, its internal dynamics, identity and professional ideology, some insight into the nature and impact of the pressures of the work of the Garage will be attempted. An important feature of the work was that staff regularly felt 'under siege' from the demands of clients. The chaos of client's lives often seemed to intrude on the service. A brief description from my notebook of a typical busy day at the Garage gives an insight into the competing demands on staff and might explain why they sometimes feel besieged:

> "I arrived to find Richard who is currently on placement at the Garage from the Ward trying to deal with a telephone call from a distraught woman:

Richard: (with his hand over the telephone) 'I've got a woman here saying her son is a 'speedy' (amphetamine user) and running around the streets naked, what should I do?'

Harry: Tell her to get in touch with the police, there's nothing we can do.

Meanwhile, on the other telephone line Martin is ringing DVLC at Swansea to clarify the legal situation with regard to a client who is being prescribed large doses of Methadone and Benzodiazapam and who has recently started working as a coach driver.

The next call is for Dave, the Probation Officer on the team: does he know that Will and Sarah (two long-term drug users and long-standing clients of the service) are listed for Crown Court today? No he didn't know and neither, he adds, did Will at 5.00 last night when he called in to the Garage to complain that Sarah had disappeared on a 'bender'.

Dave, dressed in sneakers, stonewashed jeans, black shirt and an embroidered waistcoat, asks if anyone has a tie! In the event Dave does not have to attend court as the barrister manages to move the court-date on eight weeks.

Will and Sarah appear, apparently unaware of their court appearance. Sarah looks very much the worse for wear having been involved in a fight with another woman in the early hours of the morning. She relates the incident and events surrounding it in some detail.

While this is going on in the general office and one of the counselling rooms, the waiting room is getting increasingly full as Martin is running late with his appointments. Staff serve tea and coffee to waiting clients. They deal tactfully with the more garrulous and/or barely coherent clients and handle an aggressive client by taking him off into one of the counselling rooms."

(April 1993)

One of the effects of feeling besieged is that the team tries to limit the boundaries of its responsibilities, as can be seen in the case of their response to the woman on the telephone. This gate-keeping of boundaries can also be seen in team meetings where referrals are discussed. Is this referral really someone with a drug problem or is it an alcohol or mental health problem? - was a regular point of concern; a concern deriving from the fear of becoming a 'dumping ground' for all manner of social and psychological problems. The need to clearly identify drug use as the primary presenting problem in order for the team to consider accepting the referral was stressed, since this is where the team's expertise lies.

Two important issues arise from this perceived need to clearly identify the presenting problem as drug misuse and therefore appropriate for the team's attention. The first is that drug use, as a separate problem which requires the intervention of specialists, is confirmed. The second is that drug use is prioritised and other, perhaps more pressing problems from the client's point of view, are deemed to be secondary and have to be presented as such if an individual is to be accepted by the service. My literature review (Henderson 1993) has revealed that women users may not see drug use as their primary problem; debt, housing and child-care might be the primary issues for them. Insisting on clear evidence that drugs are the primary problem, while an understandable response to rationing a limited resource, may act against the interests of women who have a problem with substance use but who do not see it as their most pressing problem. The reality is, that for many drug users, particularly women with

children, drug use is embedded in a myriad of other problems related to poverty, poor housing and social isolation.

ACCESS

Women's access to services for drug-users has been identified as an important issue (Henderson, 1990; Perry, 1979; Watson and Ettorre, 1989; DAWN, 1985; Sargent, 1992). Concern has been expressed about women's limited use of services in contrast to their male counterparts. The following discussion examines the issue in relation to the work of the CDT and attempts to assess how accessible the service is to women. The assessment will take account of: the geographical location of the service; the availability of women workers and women-only sessions; the service's flexibility and willingness to expand its boundaries to meet women's needs and its ability to engender trust in relation to child care and child protection issues.

1. Geographical Location and 'Outreach' Services

The Garage is situated close to the town centre and is easily accessible. It is open each weekday from nine to five and operates a 'drop-in' service where needles can be collected and used ones left. The staff are friendly and make themselves available for further advice and assistance should this be requested. Children are welcome and some toys are provided but no separate waiting room is available for women with children. It was recognised that this could be an obstacle to women's use of the service:

> **"There's no child-care facilities, there's no playroom and on `clinic' days (when the Consultant Psychiatrist has his appointments) - if you want to call it that - it's full of blokes so that could stop women coming through".(Jackie)**

In observing the work of the Garage I was struck by the number of women who did use the service. Men predominated, but women were by no means absent. Accommodating small children in prams did not seem to be a problem, and where older children accompanied their parents, staff who happened to be in the office might engage their attentions while needles were collected or some brief discussion with their key worker took place. So although children could not formally be accommodated while, for example, women participated in counselling sessions, they were not excluded from 'dropping in' with parents calling for a variety of reasons but usually to pick up needles. A number of observations on women's casual use of the service are included in my fieldnotes:

> "Two women, two prams and three children came in this afternoon for condoms. One of the women came in yesterday and had taken some femidoms. She said she had spent ages reading the instructions but hadn't tried them yet!".
> (July 1993)

In an attempt to make the service to prescribed users more accessible and also get away from 'old' drug-clinic practices, the CDT had arrangements with local chemists for the dispensing of maintenance prescriptions. This meant that instead of all users having to pick up their script at set times from the same location, they were able to access a local chemist at times which suited them. Although women were in the minority as maintained clients of the service, the flexibility afforded by local dispensing of medication was of some significance for them, since it meant that they did not have to juggle pick-up arrangements with child-care responsibilities. It also meant that they were

not having to identify themselves with a 'clinic culture' which confirmed their status as addicts. The flexibility of these arrangements and their value for women clients was emphasised by Jackie in her interview with me:

> "We had one woman who couldn't get to the chemist daily..because of a disability actually...we looked at whether the pharmacist could drop it off for her but that would have got horrendously expensive, so she now collects weekly. We've done things like that. We had another lass who couldn't collect daily and she now picks up two or three times a week". (Jackie)

Although helpful to drug-using women, the system did present some difficulties for women counter staff at the local chemists who felt that their low wages and limited training did not justify having what they saw as the onerous responsibility for potentially troublesome and unpredictable customers. These concerns were addressed rather than dismissed as exaggerated and obstructive and the team were able to negotiate with pharmacy managers that two staff would be in the shop at any one time.

In a further attempt to make the service more accessible, again not specifically to women but with clear implications for them, the team had experimented with taking an old ambulance out to local communities. It was abandoned after only a few months due to lack of take-up but it was nevertheless indicative of the team's commitment to increasing user access of the service.

A more successful attempt to ease access to the service was the team's willingness to visit users in their own homes if this is what they wanted. All staff when interviewed, expressed a ready willingness to visit clients at home and Pat drew attention to the importance of doing so in relation to women clients:

> "Sometimes people do need to be seen in their own homes...I like to see people at home because it gives you a truer picture". (Sue)

> "I do a fair amount of home visits and they tend to be women that I visit more than men. I think that's generally because of kids....usually because of kids." (Pat)

In observing team meetings I noted:

> "Jackie in on holiday next week and she asked if a member of the team would visit one of her women clients. She stressed the need to visit as her client had two children and it was difficult for her to get in to the Garage."
> (August 1993)

That home visits, to both male and female clients, were an integral part of the team's work, was born out by my observations. I accompanied staff to client's homes on several occasions and it was clear that their clients both welcomed and expected their visits. The value of home visits for some male clients was identified by Harry:

> "...some people don't like coming to the Garage. There's a couple of guys in their forties and they were using when I was in short trousers. They don't want to

> **be reminded of young drug users because they've not worked it out for themselves, they've got a lot of guilt, a lot of regrets and a lot of pain with it, but they're not ready to give up yet". (Harry)**

While attempts to offer a flexible and accessible service are not specifically aimed at women, they have clear implications for their use of the service.

A more specific attempt to engage women in the service could be seen in Sue's work at a local massage parlour. Sue had negotiated access and visited regularly to discuss safe-sex practices with the women. The service was aimed not at drug-users but at sex workers and was part of the team's work in relation to HIV. But while the service was aimed at the women, I was struck by the way in which the male owner of the premises and the male clients of the service had managed to harness Sue's efforts in their own interests. In discussing Sue's work in the massage parlour, it occurred to me that she was being seen by the male clients, and possibly by the owner of the establishment as a kind of 'health guarantee':

> **"..you get talking to the men when you're in conversation with the girls....and there's been a few who've said 'well we'll come back here because we know they've got a health worker'....they've been quite relieved that there is someone who keeps an eye on them." (Sue)**

From my perspective it seemed that the one aspect of the team's work which was specifically aimed at women was being annexed by men. Not only did Sue spend a good deal of her time with the male owner of the establishment negotiating and maintaining access, but she was also being seen by male customers as reassuring them that the establishment had a clean bill of sexual health. It is important to point out that Sue did not interpret the situation this way. She saw the men's concerns as legitimate. This suggests that Sue saw herself as operating in the interests of public rather than women's health. If this is the case, then the work with the women in the massage parlour is less woman-centred than it at first appears.

Sue's work in the massage parlour was paralleled to some extent by her work in the town's private health clubs with steroid using body-builders. In contrast to her work in the massage parlour, Sue's work here was exclusively with men. The aim was to encourage steroid users to access the service as it was felt that their awareness of the risks they ran was low. Sue had identified a potentially new client group which she felt could benefit from the service and was keen to engage them.

Encouraging steroid users to access the service was supported by the rest of the team. No concern was expressed about the fact that the service was targeting a virtually all-male group which would result in the further skewing of the service towards meeting men's needs. What was important from the team's point of view was that steroid users were a group who could benefit from accessing the service. That this was a male group and would have an impact on the gender balance of the client group benefiting from the service, had not been considered.

Like a number of services to drug-users, the team had developed work in the local prisons and Young Offender Institutions. They were involved in running sessions,

some of which I had access to, designed to raise inmate's awareness about the impact of drug-use on their health and well-being and as a means of contacting potential clients of the service on their release. This work was exclusively with young men as there was no similar facility for young women in the area. It amounted to a regular, weekly commitment for one member of staff and while the value of the sessions is not in question, the impact on the team's work was to further skew their resources in favour of servicing men.

2. Women Workers and Women-only Spaces

It was recognised that there was a need to offer clients a choice of worker. As women staff predominate, the team is able to fulfil its commitment to making women workers available to women clients if this was requested. Women-only sessions did not operate, however, and had never been experimented with, although staff recognised the potential benefits of providing them:

> " ...it would be nice to offer women-only days or whatever. It would be nice to offer that but you can't with the facilities." (Jackie)

The building was certainly very small and offered limited facilities but the lack of women-only slots was also related to staff's reluctance to exclude male clients:

> "I think to offer a women-only day would exclude lads and blokes from coming to use the Exchange and that would be unfair." (Jackie)

The value of offering women-only spaces was recognised but not at the expense of men. Women-only facilities could be offered additionally, if resources were available, but in the absence of these extra resources the team would not exclude men in the interests of women. The fact that women may be excluded because of the predominance of men at certain times in the week, as Jackie recognised, is not seen as sufficient reason for excluding men on occasions, in order to increase women's access. This reluctance to exclude men may relate to the difficulties the team experienced in dealing with the demands of some, predominantly male, clients. If the team needed to present a 'united front' in cases where male clients were pressing for increases in their 'scripts' it is likely that they would almost certainly need to be very assertive in excluding some of their male clients on 'women-only' days. That they should be reluctant to take on such a challenge is understandable and is perhaps another example of the way in which services respond to the needs of the more assertive male client and in doing so sideline the needs of others.

While women-only days or slots were not available, a women's group had been experimented with. It was felt to have been of some value but not entirely successful and was abandoned after only a few meetings.

On the one hand, then, the team expressed a concern about women's access to the service and pointed up aspects of their policy and practice which worked in women's interest, but on the other they were reluctant to exclude men to create women only slots and they did not consider the wider implications of encouraging increased use of the

service by steroid users. At the level of day-to-day operations, women's access to the service was of some concern to the team but at a wider policy level, and certainly in relation to the overall balance of resources, ensuring a gender balance was not a priority.

Overall, there is little evidence to suggest that women's needs are prioritised in order to redress the gender imbalance of the client group. This does not mean that women's needs go unmet. The willingness to extend the service into the community, coupled with the availability of staff who are sensitive to women's needs, have a significant impact on women's use of the service. Moreover, women users are not passive victims who are simply sidelined. Women regularly approach the service, as my observations confirmed, they make demands and get them met.

3. Expanding the Boundaries

The fact that the team was able and willing to expand its boundaries to include individuals who were not using illegal drugs was an important factor in increasing women's involvement in the service. Not only did the team expand its service, as we have seen, to include those involved in the sex industry rather than in illegal drug use, it was also willing to include some clients who were dependent on prescribed rather than on illegal drugs. In addition, the team demonstrated a willingness to work with non-drug using partners and with relatives of drug users. The combined effects of expanding the boundaries of the service in this way was to increase women's share of the resources.

The team was formally established to work with illegal drug users and it was this client group which was the main focus of the work. However, their brief also included HIV prevention and this gave them some leeway to expand their work beyond the narrow confines of illegal drug use, although as other agencies were being established under the AIDS/HIV initiative, this was being reviewed.

Over and above the opportunities afforded by their HIV prevention brief, the team worked with a small number of clients who fell outside the boundaries of the traditional client group. This swelled the ranks of women clients since the non-'street' drug users with which the team worked were predominantly women. An example of the team's willingness to be involved with clients who used prescribed drugs rather than 'street' drugs was the case of a young woman, Claire. I was able to gain some insight into this case when I accompanied Jackie on a visit to a private psychiatric hospital near York where her client was undergoing treatment. It was clear that Claire experienced similar problems to other women clients of the service, she regularly harmed herself and had been abused in the family. Harry too was working with a client who had made some serious attempts on her life and who used large amounts of tranquillisers and sedatives which she had access to through her work as a nurse.

Such cases were exceptions. The team saw itself as set up to deal primarily with illegal drug use and often felt the need to protect the boundaries of its work. The wisdom of separating out dependency on illegal drugs and dependency on prescribed drugs (i.e. tranquillisers, sedatives) has, however, been seriously questioned in the feminist literature (Perry, 1979; Ettorre, 1989). A blurring of the boundaries between 'legal' and 'illegal' drug use is seen as necessary if a full understanding of women's use of substances is to be developed. This clearly has implications for treatment and the evidence from the CDT suggests that where problematic use of prescribed medication

was accepted as a legitimate focus of attention, women's access to services was increased. There is evidence to suggest that women who use prescribed medication and women who use 'street' drugs share many of the same problems and have similar treatment needs.

One of the ways in which women's access to the team's resources could have been increased would have been to abandon the distinction between the use of 'street' drugs and the use of prescribed drugs. Clients who used the service as a result of their use of prescribed drugs, predominantly tranquillisers, were the exception rather than the rule. This contrasted with the fact that the team actively encouraged the use of the service by steroid users, another 'non-traditional' group of drug user. If the service expanded its boundaries to include one group of non-traditional user, why not the other? The answer, I suspect, lies in the fact that steroid users inject their drugs and are therefore seen to be at risk of HIV infection. The brief to work preventatively around HIV was an important aspect of the team's work, it accounted for the Needle Exchange and was part of the thinking behind maintenance prescribing. This focus on the injecting habits and safe sex practices of users resulted in a relative lack of attention to clients who were not at risk from injecting and were not involved in the sex industry, e.g. women dependent on antidepressants or misusing other prescribed drugs. To this extent the team's controlling function in relation to injecting habits and sexual practices took precedence over their concern with more complex mental health problems.

This raises two issues. The first is that the controlling aspects of the team's work makes only very limited use of the extensive skills and insights which they undoubtedly have. Secondly, it results in the focusing of attention on injecting users and, to a more limited extent, on those involved in the sex industry. Women who do not inject 'street' drugs or steroids and who are not sex workers but who nevertheless have precisely the kind of complex personal and interpersonal problems which the team is very skilled at working with, have extremely limited access to the service.

4. Working with Parents and Partners

I have suggested that the team's willingness to expand its boundaries to include non-traditional drug users, while ultimately resulting in a skewing of the service towards men, also resulted in some increase of women's use of the service. Women's involvement as service users was also developed in other ways since women as partners and parents were seen and responded to as recipients of the service. A group had been set up for parents to meet, and while attendance at the group was erratic, it was clear that a core of parents, mainly mothers, valued it as a source of support. Attempts were made to access the group directly but attendance was too low during the time I was at the Garage. In the event, insight into the nature of the support offered by the team was gleaned through conversation with Sue about her work with this group.

> "Sue described her work with one of the parents in the group, the mother of one of the team's clients. She had been helped to distance herself from her son's problems. Her access to the group had enabled her to talk about her feelings towards her son and the pain that his drug use had caused her."
> (September 1993)

From Sue's account of the work of this group, it seemed to offer women, as mothers, an opportunity to share their concerns but also encouraged them to look to their own independent needs as individuals.

The monthly meetings were by no means the limits of the team's commitment to supporting parents. My observations confirmed that parents would be seen by the team if they were concerned about their children's drug use:

> "A parent rang this morning to get advice about their son's drug use, they were invited down to see a team member and I sat in on their discussion with Jackie. Jackie made it clear that she took their concerns seriously but stressed the prevalence of the cannabis use which they suspected their son was involved in".
> (July 1993)

There was also evidence to suggest that the female partners of male clients were seen as clients in their own right and were offered support. So while the boundaries of the team's work were fairly tightly drawn in relation to which clients were appropriate users of the service, it was not the case that non-drug using partners were dismissed as inappropriate. In responding to a vignette devised to assess the extent of the team's commitment to non-drug using partners it was clear that Sue, for instance, would actively encourage the service's involvement with the partner of a male user. It was also apparent that the partner of a male client had been involved in the Women's Group when it had operated. Harry, in his interview, also referred to his work with partners, in this case the partners of steroid users:

> **...we've had a couple of women in who know their partner's are injecting steroids and they've been worried about having sex with them. And they wanted someone to talk to about their anxieties and work it through". (Harry)**

Pat's interview is further confirmation of the team's holistic approach to client's problems and her willingness to take on the support of partners, in this case in relation to male violence and aggression:

> **"And often it's supporting the partner through that, and often working more with the partner to find out what she wants and maybe supporting her in making a decision to leave."**

Pat also spoke of her commitment to supporting the partner of a male client who was about to enter long-term residential treatment:

> **"I've got one client at the moment whose partner is actually giving up (using drugs) and going into rehab. and I would actually look, despite the fact that he's not going to be in the home and she's not a drug user, I would actually look at supporting her while his is away". (Pat)**

This willingness to work with partners is an important aspect of the service. Not only does it indicate a willingness to embrace relational aspects of a clients life and address the impact of their drug use on those closest to them, it also results in opening up the services support to women, as partners and as mothers. It is important to consider the

nature of this support however, since if women's access to the service merely operates to further their commitments and energies as carers, this could not be seen as the service operating in their interests. There is some evidence to suggest that women are responded to in their own right, rather than as adjuncts of the male client. The question of how far women were or were not confirmed in their subordinate roles as wives and mother will be discussed more fully below, in relation to the principle of feminist practice concerned with 'sex-role stereotyping'.

5. Child-care and Child Protection

Again this issue will be discussed more fully in relation to '*sex-role stereotyping*'. It warrants some attention here however, as an oft-repeated concern in relation to women's access to services for illegal drug users is that, as mothers, they are reluctant to come forward because the assumption is made that drug abuse leads to child abuse. That the issue of child protection can be a barrier to women's use of the service is recognised by the team:

> **"The one 'biggie' that always comes up (in relation to women's access to the service) is childcare. If they've got kids, do they feel that the service will be confidential? Do they feel that they're going to be reported to Social services because they are a drug user?" (Jackie)**

The team tackled the problem in a number of ways. First, where child protection issues arose they acted as advocates on behalf of the parents and involved Social Services to look to the child's interests. Secondly, they openly acknowledged their responsibilities in relation to child protection with their clients while at the same time adopting a non-judgemental approach to child-care practices. Thirdly, they relied on the building up of trust amongst the drug-using community in relation to the issue of child protection. This strategy depends on women being plugged into drug using networks in order for the word to get around that the CDT can be trusted on such matters. This may not be the case for all, or even the majority of women users. Finally, the team acts in an advisory capacity to Social Services in relation to drug use in families. Their involvement here is designed to raise awareness of the issues and to challenge the too easy equation between child and drug abuse.

The team, then, used a number of strategies to encourage access by women who are mothers. They attempted to engender their client's trust, they relied on networks among drug-users to confirm that they can be trusted and they challenged other professional groups in their attitudes and practices in this area.

Conclusion

The above discussion has focused on the question of women's access to the service, an important issue which has been given some attention in the literature. I have pointed up the ways in which the work of the team is seriously skewed towards servicing men but have also drawn attention to ways in which the involvement of women is encouraged. Ultimately, the team relies on an 'equal opportunities' approach to

women's use of the service rather than on attempts to re-design the service to meet the needs of women:

> **"The same services for women are on offer as for men...it's whether women feel able to access the service which is important. Is the service user-friendly to women?" (Pat)**

There is little evidence to suggest an awareness that a different concept of servicing substance users might be necessary if women's needs, as well as men's, are to be met.

CLIENT/W0RKER RELATIONSHIP

The issues under consideration here are:

- client access to the decision-making process;
- client control of the treatment process and counselling agenda;
- client/worker interaction and boundary setting;
- the impact of prescribing policies on the client/worker relationships
- the team's ability to encourage increased self esteem in the client group.

The discussion will rely on material gleaned both through observation and through interview and will consider the principles of feminist practice which relate to *'equalising relationships'*, *'challenging the power of the professional'* and *'increasing self- esteem'*. The principle of *'re-defining social problems'* which relates to the need to *'de-individualise'* social problems will also be given some (further) attention.

1. Access to the Decision-making Process

Some of the very mechanisms which encouraged team cohesion and allowed staff to feel safe and supported in making decisions about individual clients, worked against two important principles of feminist practice, - *'establishing equal relationships'* (between client and worker) and *'challenging the power of the professional'*.

Client access to the team meetings which were important in equalising relationships between the staff, was not routine. This meant that clients had to rely on individual workers to put their case to the team although on three occasions in the past a client had been allowed to attend a team meeting in order to put his case forward for an increase in his prescription. This had established the possibility for clients to be involved in decisions which effected them as individuals. It was deemed to be appropriate in some cases but not widely used.

> **"There is a mechanisms but we don't let it be widely known." (Jackie)**

It was suggested, however, in relation to the client who had been told that either he gave up his job as a coach driver or his prescription for methadone and benzodiazapam. Jackie pressed, at her client's request, for an opportunity for him to discuss the matter with the team. Jackie felt it an appropriate way forward, as one of her client's key personal issues was a feeling **"that others were pulling the strings."**

Jackie's observation is a pertinent one but it begs the question as to how far other clients, particularly perhaps women, experience these feelings, i.e. that others are "pulling the strings", and whether wider access to the team's decision-making process would be a useful empowering strategy more generally.

However, in discussing the question of client involvement in decision-making with Dave during my interview with him, it became apparent that the purpose of giving clients access to the team meeting was not entirely to do with empowering them. Dave suggested that the reason for agreeing to client access to the team meeting was "*to*

present a united front" and that, in the three cases where clients had put their own case to the teams

> **"...the discussion had already gone one, the debate had ended when the client arrived...we had decided what our line was going to be. We felt that in order to prevent the client going round each individual member of the team and trying to split one against the other.. that it was important to present a united front." (Dave)**

This suggests that the main concern in giving clients access to the decision-making forum was to protect staff and to support individual workers in their negotiations with clients. Dave emphasised that each of the previous cases had been male clients wanting an increase in the size of their 'scripts'. He recognised that a client's attendance at team meetings was "intimidating" for them and expressed his admiration for the way in which they conducted themselves.

Dave's acknowledgement that the inclusion of clients in the team's decision-making forum was something of a charade, raises some interesting issues. That the team felt the need to protect its individual members in this way is indicative of the pressure that some male drug users can bring to bear when they are denied access to prescribed drugs. This is neatly illustrated by Sue's description of Jackie bringing a client's request for an increase in his script to the meeting and it being rejected. Sue says of Jackie;

> **..and I can see her thinking 'oh god, I've got to tell him' because I feel exactly the same way when that happens to me". (Sue)**

"Presenting a united front" is a mechanism devised by the team to cope with these pressures. This, I think is a good example of the way in which services are devised to deal with the assertive male drug user. This is not to suggest that the team are necessarily acting inappropriately in these cases, the problem is that in devising defensive strategies to deal with demanding male clients, whom the team feel the need to control (by intimidation) rather than empower, other client's needs for greater involvement in the decision-making process go unaddressed. Exclusion of clients and the protection of staff becomes the dominant concern rather than inclusion and empowerment.

If client access to team decisions which effect them as individuals is severely constrained, access to decisions about the service as a whole hardly "**enters the arena of discussion**" (Dave). So when the team were under tight financial constraints and had to decide how they could reduce their prescribing budget they had an 'away day' to discuss the matter. In reflecting on this Dave says:

> **"And obviously, we couldn't invite loads of punters to that awayday...I suppose we've had the chance since but never actually taken in on board".**

He concluded that "**..(clients) don't have any control in how the service as a whole is run".**

Dave continued to ruminate on the matter, however, and began to use the interview to critically reflect on the team's policy and practice. He began to see the potential for greater client participation in deciding how the service should be run and

remembered that there was an attempt to consult service users about opening times for the Needle Exchange. In thinking about a funding crises the service had experienced he says:

> "We could have got the thirty-odd people together (clients being prescribed methadone). We could have got them together and said, 'look, this is the score, what do you want?' But we didn't....it's only just occurred to me now. It would have been top of my list once. 'Come on, you're the users of the service, what are we going to do?'.. ..but that's all changed now." (Dave)

Why this participatory model has been 'lost', or more accurately perhaps, never been attempted, is a pertinent issue and one which will be taken up and developed more fully when drawing together the implications of my research finding.

2. Controlling the Treatment Process and Counselling Agenda

Clients, then, have extremely limited input into the formal decision-making structures at the Garage. Nevertheless, the commitment to client control of the counselling agenda and treatment process is strong. In trying to identify the extent of client control in the service Dave concluded that;

> "...it extends to the individual relationship that the client has with their worker. It doesn't extend to a client collective....a client collective doesn't exist" (Dave)

In exploring the question of client control in the client/worker encounter, Jackie's interview is also revealing. Her immediate response to the question of who is in control of the relationship was;

> "Well we are ultimately, aren't we....we say 'I will see you for an hour' and we control that session. But as far as the emotional stuff that is brought is concerned, the agenda is hers (clients). I never push anything because if they want it on the agenda, if it's an issue for them, they will make sure it gets on won't they?".

When pressed on this, in relation to abuse for example -."you know it's going on and they're not putting it on the agenda" (me), Jackie insisted that;

> "If it's an issue for them they will put it on the agenda but not necessarily in a way that you will pick up straight away." (Jackie)

Pat too saw clients as setting the agenda but also spoke of an agreed agenda. Respect for the client's agenda also came out strongly in Harry's response to one of the vignettes I used:

> "I suppose my gut feeling about this would be to see how she feels she should proceed, not how I think she

should do it - her expectations may be very different to mine.. ..I'd get her to look at how she wants things, what does she want and how can she get it?" (Harry)

The commitment to client control is confirmed through field work observations. Jackie and Sue's difficulty in filling in the review form (required under the Children Act 1989) in respect of a client's child who was being fostered was brought about because of the lack of contact either Sue or Jackie had had with the foster parents. The lack of contact was quite deliberate as Jackie was in touch with her client who was letting her know that the arrangements were working well. Jackie felt she wanted to encourage the relationship between the foster parents and her client rather than get involved herself. She expressed a keenness to leave the 'respite care' arrangements to the two women to control; she was reluctant to intrude as she trusted her client to contact her if anything went wrong.

Linked to the notion of client control was the idea of the worker as facilitator and enabler. In response to one of the vignettes, Sue suggested that;

"...it was a matter of enabling 'Jane' to feel confident enough to sort it (child care) out with her boyfriend". (Sue)

One of Jackie's observations about an ex-client who rang one day while I was at the Garage makes a similar point. In describing her work with Diane, Jackie said she used the team as a 'sounding board'. Diane would work things out, what she thought she should do etc. and then come back to check it out with her or one of the other members of the team.

Several of the team spoke of having to sit on their impulses to 'take over'as Pat put it. Sue, in response to a vignette concerning a woman with multiple problems says;

"My initial reaction is to want to go round and sort all her problems out! But she needs to take control of the situation". (Sue)

The emphasis on client control and on seeing the role of the worker as facilitator is underpinned by client/worker relationships characterised by partnership. There were a number of observed examples of a participatory style of working which treated the client as an equal partner. One such example was Dave's encounter with a client at Newhall prison:

> "Dave had arranged to see Christine as she was worried about her children and frustrated by her inability to sort out her housing needs for when she was released. Dave allowed Christine to explain and explore her frustrations and only gently reminded her that the reason she was back in Newhall, with parole affected, was because she was charged with smoking cannabis while at Askham Grange (a more liberal prison regime than Newhall). There was no attempt to hector her and in discussing the visit on the return journey Dave remarked that Christine didn't need reminding, she knew where her choices had led."
>
> (July 1993)

In observing and participating in the encounter I felt Christine was allowed to take charge. She saw the need to jointly tackle the problems - **"We've to get the ball**

moving" - i.e. her and the CDT, and Dave came away with a list of things to do. One of the strategies he unselfconsciously used to establish a rapport characterised by partnership, was the sharing of some news about what was going on the local drug scene, what sentences were being handed out etc. (but not, of course, identifying the people involved).

Other strategies used to establish a partnership between worker and client were observed in relation to record keeping and assessment. Two young women returned to the service for the second time in a week and were seen by Richard who has seen them previously. It was only on this second occasion that Richard asked if he could take some details. Before completing the assessment form he explained to them why and where it was kept.

In relation to record keeping more generally, all members of the team said that clients could have easy access to their files, but that they rarely requested this. Open case-files were clearly not used as a formal strategy to promote partnership and were not seen as particularly useful in this respect, but the principle of client access to their files was readily accepted.

Client choice was also stressed by all members of the team. There was a clear policy commitment to give clients a choice of key worker. This was seen as particularly important for their women clients. Recognising the client as an active subject, choosing to engage in drug use or in prostitution was a strong theme in the team's approach to their clients. Sue related how she had to work hard to accept drug use as a positive choice rather than an illness or personal weakness. Jackie stated quite clearly that;

> **"...if someone wants to stay on methadone with their head in the clouds and not deal with their problems, then that's their choice". (Jackie)**

Respect for clients was apparent in the interviews and born out by observations. Some examples of distrust of clients by workers were observed but these were few and far between and resulted largely from reports of 'lost' methadone and requests for it to be replaced, a notorious and recurrent event which maintenance prescribing seems to invite. Apart from these particular incidents, which were usually given the benefit of the doubt, clients were trusted and taken seriously. In contrast to their lack of access to the formal team decision making process, clients were given a good deal of power to control their own contact with the service, the terms of the treatment and what they brought to their counselling sessions with staff. There was evidence to suggest that clients found this approach empowering, giving them the confidence and ability to take more control over their own individual lives.

The limitations of the approach are also apparent however, since the focus remains with the individual - on personal strengths and weaknesses - not with the wider structures which shape and constrain individual action. The notion of partnership did not extend to a commitment to groupwork and self-help networks which can also result in the de-individualising of social problems. At least three members of the team had considerable experience of groupwork and were aware of its potential. Harry, in response to an interview question pointed out that he had served his "**apprenticeship with groupwork**" and felt that "**it's probably one of the most powerful forms of work**". Jackie, too, had extensive experience of groupwork;

"Well I was always a groupworker sort of person prior to coming here because I think peer group pressure works very well". (Jackie)

That several members of staff had considerable group work skills, was born out by my observations of groupwork with parents and of training sessions run by the team. An HIV awareness day for the residents of a local hostel for people with mental health problems demonstrated Jackie's participatory style of facilitating, her ability to hand over control to the group and to share an awareness of gendered power relationships and of herself as a sexually active woman.

That these groupwork skills were not used in relation to the drug using clients of the service is interesting. An experimental women's group had been attempted in the past and will be discussed further in relation to the findings on work with women. The consensus of opinion amongst staff in relation to groupwork was that it was not effective where group members were at different stages in their drug using careers with differing levels of motivation for change;

"I don't think we've got enough people at any one stage at any one time to do much with it (groupwork)". (Harry)

Harry's comments indicate an assumption that individuals would come together in a group around their drug using identity. The notion of bringing clients together around, say, their gender identity, had been considered only fleetingly with the experiment of the women's group. But even here, the group had been deemed to fail precisely because the women were at different stages in their drug use.

Women in particular can gain a greater awareness of the oppressive structures in their lives by engaging in groupwork which uses the empowering potential of consciousness-raising. There was little evidence to suggest that this level of awareness was encouraged, either through groupwork or in one-to-one counselling with clients.

The sharing of experiences between women is seen as a powerful equalising strategy in the feminist literature on health and social care, and also a means by which women's awareness of the oppressive structures in their lives can be developed. There was some evidence that women staff shared aspects of their experience, as women, with clients, although the general feeling was that any sharing of personal experiences or feelings needed handling with caution. There was a general concern that counselling should focus on the client and that the worker was there for them. Jackie felt that, particularly where she was working in a structured way with a client, she would disclose very little about herself. Where the sharing of experiences and feelings did take place, it tended to be seen as a way of **"normalising the client's feelings"** and **"putting the client at ease"** (Jackie) rather than a deliberate attempt at consciousness-raising.

3. Setting and Blurring Professional Boundaries

The team's approach to the client/worker relationship is one in which they appear to successfully manage a balance between establishing and maintaining professional

boundaries and encouraging a relaxed, informal style of interaction. Pat sums it up well when she says:

> **"I think there is a professional distance but the relationship is quite relaxed... I'm very friendly but I'm not a friend." (Pat)**

There are clear boundaries marked out by the physical structure of the Garage. Harry pointed out that:

> **"The office is a very clear boundary. When people try and push that, they try to come in....that's very difficult. We have to say to people, we care about you but this is our space". (Harry)**

In fact, my observations confirmed that the office boundary was regularly infringed, particularly by long-standing clients and that this was, by and large, accepted. It was also interesting to note that where a client had given up her drug use, a decision had been made to allow her access through the 'staff' door into the office. This was an attempt to recognise the transition that the client in question had made but also served to distinguish the team's relationship with drug-free clients from their relationship with current drug users.

The team used a number of strategies to encourage an informal style of interaction with clients, including visits to their homes and meeting them on the 'neutral territory' of a city centre pub or cafe. This can be seen in Jackie's description of her relationship with one of her clients:

> **"I'll call in an see Helen and see how she's getting on and chat with her and drop her off in town if that's what she wants, or go for a cup of coffee with her, or whatever...." (Jackie)**

Letters were also an important way of establishing and keeping relationships with clients. I found the tone of Jackie's letter to Christine, the client in Newhall prison, indicative of the team's approach to its relationship with clients. Jackie felt the need to apologise for typing the letter. A conversation with Harry later confirmed that it was policy to hand write letters where possible, as this was seen as being more personal. Jackie was writing to Christine to let her know that her and Dave would be '**having a run out**' to see her. (In the event it was Dave and I who visited). Jackie used the opportunity presented by the letter to try and keep Christine in touch with what was going on with one of her sons:

> **"The last time I saw him he looked fit and well and was chattering on about a hamster he had". (Jackie's letter to Christine)**

Jackie acknowledged Christine's concerns about her son's welfare but tried to reassure her and gave practical information on who to speak to at Newhall.

There were other examples of the use of letter writing to keep in touch with clients where they had moved out of the area for one reason or another. The sending of a get-well card to a client undergoing a hospital detoxification programme was a further

example of the easy familiarity which characterised the team's approach to its clients and which had the effect of breaking down rigid professional barriers.

A significant and recurrent theme in the team's discussion of their role and relationships with clients was their view of themselves as the client's advocate. In describing her role, Pat saw herself as;

> **...acting as an advocate in a lot of ways, liaising with services because they (clients) find it difficult to access them themselves... You might be liaising with their G.P. because they get a raw deal when they go to their G.P....they get second class service." (Pat)**

The team's role as client advocate in relation to child protection issues was apparent. It was felt important that the team had begun to be invited to case conferences where they could bring a more balanced view to the proceedings. Dave explained how members of the team had;

> **"...attended case conferences which social workers had convened because they'd found `Sharps' boxes (for the disposal of used needles) in the house and we were able to put our tuppeneth in and say, look, you've found a Sharps box with a sealed lid and it was in a cupboard. ...And in that instance the kids weren't put on the (`at risk') register...we've been able to put our views forward and generally it's resulted in the kids not being placed on the register, unless there has been some clear indication that it was irresponsible drug use". (Dave)**

There were clear indications of the team's willingness to contest decisions made by other agencies about client's, or to encourage clients themselves to do so. The clearest example of this was Jackie's suggestion that one of her clients might, with her support, challenge social services over their refusal to make monies available to pay residential drug rehabilitation fees:

> **"I suggested to her, because he's quite a strong young woman, that she could always take Social Services to court...because it wasn't her problem that Social Services didn't have money... She'll need good solicitors. But what was really nice about it was that she turned round and said to me 'what about you? Wouldn't you get into trouble for doing that with me?'.... And I said 'I probably won't get promoted Sharon but my role is to do what's best for you and your kids and if that means showing you the means of getting money (for drug rehabilitation) then that's within my role, it's my job". (Jackie)**

In conclusion, it would seem that on the one hand there is a clear awareness of the need to construct and maintain professional boundaries. This might impede the sharing of experiences between worker and client, which is an important principle of feminist practice. On the other hand, the team strives to limit the power differentials between client and worker by adopting an informal approach to relationships. Its willingness to take the side of its clients to ensure appropriate treatment and access to

resources, reinforces the idea of a partnership rather than of a hierarchy and at the same time encourages client self-assertion and self-determination. In this respect the team's relationship with its clients would seem to reflect the feminist principles of '*equalising relationships*' and '*challenging the power of the professional*'. However, there is nothing to suggest that it is feminist politics which motivates the team's approach to its relationship with clients and one has to conclude therefore that there is nothing intrinsically feminist about these particular principles of practice. They are indicative of good, rather than specifically feminist practice, but at the same time provide the necessary basis upon which feminist practice can build.

4. Prescribing Policies

I have suggested that the client/worker relationship is characterised by an emphasis on client control and self-determination, both in relation to their drug use and its treatment. Limits to this control have been recognised but evidence has been presented to demonstrate that the notion of partnership between the team and its clients is strong. The aim of the following discussion is to examine how far the team's prescribing policies undermine the concept of partnership in the client/worker relationship. It will also consider how far the team has succeeded in de-medicalising the response to drug misuse and in removing the 'script' from determining the nature and parameters of the client/worker encounter.

That maintenance prescribing could introduce a tension into the clientworker relationship has already been recognised. Sue identified prescribing as a "big issue" and suggested that it often got in the way of the therapeutic relationship. In reflecting on some of the difficulties, Sue toyed with the idea that it might be better if two workers could be involved with maintained clients, one to negotiate and police the 'script', the other to deal with 'other issues'. This would avoid some of the difficulties she felt she experienced and which she described in her interview:

> **"If you're involved in prescribing and somebody says 'I want an increase' and I say 'you can't have an increase'. ..for whatever reasons, then that might be detrimental to the work - it will obviously put a halt to it to some extent and stop you from moving forward."**

Sue went on to describe a situation where this had been the case:

> **"Two clients went through a phase of 'they dropped it', 'the dog drank it', 'the police pinched it'...and I was the one who ended up having to say 'I'm sorry but you can't have any more' or 'I'll try'.. and then if it didn't work out it was always my fault and I think it was quite damaging to the relationship". (Sue)**

Sue then described how one of these two clients spent the next half dozen counselling sessions with his back to her, addressing his remarks to Sue's co-worker, Dave. This was a graphic illustration of the resentment caused by a worker's inability/unwillingness to accede to a client's demands. It demonstrated the contradictions which can arise when a worker, who has the power to withhold the substance on which a client is dependent, tries to establish a therapeutic partnership with that client. In this particular case two workers were involved, due to the fact that the

clients concerned were partners and were seen together by two staff who co-worked the sessions. Where only one worker is involved with a maintained client, the worker has to tread a fine line between care and control. The difficulty of maintaining the line led Sue to suggest the need for two workers - one to police the client and one to counsel him. Sue quickly abandoned her suggestion, however, since she felt it would be too intrusive for the client.

The need to separate a worker's controlling function from their counselling relationship was apparent from Jackie's description of her work with one of her clients;

> **....he doesn't give urine the day he comes in for his counselling session with me. He gives it at a different time and sees someone else." (Jackie)**

Pat acknowledged that wrangles over 'scripts' can take up a lot of worker's time but seemed reconciled to it, seeing it as **"part of the natural progression of the relationship"** and something that you **"work through"**. This was born out by Dave's description of working with the clients that are referred to in the discussion of Sue's interview above. Dave described how the team had to take a firm hold of the situation with these two particularly demanding clients;

> **"We got hold of it, said look, that's it, forget it, there is no discussion about your scripts....if the Martians beam up your valium it's tough, you're not getting any more. And they tried it on two occasions, failed both times, neither of them got any more Valium or Methadone and they've accepted that now and are coming in once a week and talking about the future". (Dave)**

The controlling aspects of maintenance prescribing were recognised by all members of the team and they expressed some discomfort with their policing role. The role conflict it produced for the social work-trained staff on the team was particularly acute;

> **..... getting them in to daily pick-up at the chemist, urine screening and policing them, I think is grim....it goes against the grain for me a lot...it's something I feel particularly uncomfortable with and I know Dave does as well." (Jackie)**

The power of maintenance prescribing to underline the controlling rather than caring aspects of the client/worker relationship was apparent in Harry's relationship with a long-standing client and older user who was being prescribed amphetamine in an attempt to limit his drug use and illegal activities. The power of the 'script' to dominate the client/worker encounter, and to encourage feelings of mutual distrust which the team were anxious to move away from, was evident. Harry described his client as his **"sparring partner"** which neatly encapsulated the conflictual nature of their relationship. My notes in relation to the events surrounding this client include the following:

> "Harry's attention today was focused on Bob's non-appearance at the Garage and non-response to a number of visits Harry had made to his home. Harry was concerned that Bob was avoiding him and surmised that the reason for this was Bob's continuing, even increasing, illegal drug use inspite of the fact that he was now

being 'scripted' for amphetamine. The impression was that something of a power battle was raging between Harry and Bob and that the 'script' was the focus of this battle". (July 1993)

Maintenance prescribing involved the team in a good deal of surveillance work which seemed to undermine its voluntaristic principles. In terms of feminist principles of practice, one has to ask how far it is possible to establish *'equal relationships'* and to *'challenge the power of the professional'* when maintenance prescribing is an important aspect of the work and a central feature of the client/worker relationship.

Despite the dissonance that maintenance prescribing brings to workers' views of their relationships with clients, it would seem that most are able to reconcile the need to control with their view of themselves as facilitators and their view of the client/worker relationship as a predominantly caring one. Jackie likened the relationship to that between parents and children, in which the child earns independence through maturity;

".....it means us being the parent for a while, which is maybe what they've never had in the first place anyway, but in a caring way, rather than in a negative way.. we positively work towards, for example, three times a week pick-up, twice a week pick-up and then once a week." (Jackie)

An important way in which the voluntaristic principle and the idea of client control is maintained, is by an insistence on the client's right to remain on Methadone if that's what they want to do:

"And if they want to stay on their Methadone script, then so be it, we no longer force people off Methadone." (Jackie)

Dave echoed this commitment to client choice in relation to maintenance prescribing;

".....we don't put any pressure on people to reduce, we leave that up to them. We'll try and move them, in the counselling sessions that accompany the prescription, towards at least looking where they want to be in the future, but there isn't a great deal of pressure and we would certainly never take the decision to reduce somebody on methadone without their....agreement or request even." (Dave)

To a large extent, the CDT was able to reconcile its policing role in relation to maintenance prescribing with its commitment to client autonomy. One of the ways in which the team achieved this was by acknowledging the controlling aspects of maintenance prescribing with clients:

"I think we're fairly careful about saying to people 'this is exactly what you're getting yourself into. And it is controlling...it will control you'".

This is seen as 'responsible' prescribing as against the 'irresponsible' prescribing of doctors:

"I think when people come on a Methadone programme with us they know exactly what they're letting themselves in for, it's an informed choice, if you like". (Jackie)

The team is thus able to inject even the most controlling aspects of their work, maintenance prescribing, with the notion of client choice.

Another way in which the notion of client control was accommodated in relation to maintenance prescribing was to see the worker as initially taking control but then giving it back gradually. Initially clients are required to pick up their medication on a daily basis and take it under the eye of the chemist. They are gradually trusted with more responsibility, moving to a weekly pick-up and even two-weekly where a client is going to be away.

The stabilising effects of maintenance prescribing were also stressed by workers, this in itself being seen as giving clients more control over their lives. Worker discomfort about the controlling mechanisms that they were involved in were dealt with to some extent by stressing that Methadone maintenance afforded clients much more control over their lives by limiting the chaotic effects of their illegal drug use. The idea of there being a trade-off between the control that the team had over maintenance prescriptions and the control wielded by drugs themselves, was apparent. The former was seen as being less pernicious and warranted by the latter.

An important aspect of this trade-off however, was the crime reductive potential of maintenance prescribing. That prescribing policies were not only aimed at stabilising the individual but at reducing crime was evident. Having completed the administration of the week's prescriptions, Harry remarked that he saw them as representing the amount of crime that might have been committed. Dave too, alluded to this aspect of maintenance prescribing;

".....if people are on a methadone prescription they don't have to go robbing to pay for their drugs . (Dave)

This raises the issue of how far maintenance prescribing is meeting the needs of the individual and how far it is being used as a crime reductive strategy. The team's answer to this would seem to be that the two aims are not necessarily in conflict. The value of maintenance prescribing in bringing stability and control to clients' lives is stressed, not so much as an end in itself, but as a means of establishing a base from which to move forward. This in turn benefits the whole community as the threat from marginalised individuals, engaging in criminal activity, is reduced.

While individual team members experienced some difficulties in integrating their responsibilities for ensuring that clients did not abuse their maintenance prescriptions with their caring and therapeutic role, all stressed the value of methadone prescribing in bring stability to their clients' lives. Strategies were devised to cope with the conflicting demands of care and control and the principles of client choice and control were accommodated. It was this accommodation perhaps that allowed the team to see itself as establishing a very different model of treatment to that offered by the 'old' drug clinics.

Observations of the work of the team suggested that they were alert to the dangers of the 'over-prescribing' encouraged by out-patient drug clinics and keen to avoid their work and relationships with clients being dominated by a 'script culture'. Richard's suggestion, for instance, that a young woman who he had recently seen be given an amphetamine script was met with some resistance by the team-meeting that week. None of the team were keen to 'throw a script' at the problem and Harry insisted that a 'script' must be the last resort. Martin, the Consultant Psychiatrist, was seen by some members of the team as too ready to prescribe: "**You have to sit on his writing hand**" was a remark made by more than one member of the team.

A resistance to allowing the discussion of drugs to dominate the client/worker encounter was also apparent. As has been discussed elsewhere, the 'real work' that clients were engaged in was deemed to be that of exploring their emotional lives, and in understanding their drug use rather than in rehearsing their various exploits and experiences.

I remained unconvinced, however, that this rhetoric of resistance was born out in reality. As well as resistance to "**throwing a script at the problem**" I also observed a willingness to prescribe, both Methadone and Amphetamine, in situations where clients were not specifically requesting maintenance. I also regularly observed wrangles about 'lost' supplies of methadone and repeated requests for an increase in supply.

I was also struck by what seemed to be a heavy reliance on drugs administered as part of a client's detoxification programme. The cautious approach to maintenance prescribing which the team subscribed to, did not appear to extend to the use of drugs in relation to programmes of detoxification. My observations of a young client's 'fast-track detox.' seemed to contradict the team's 'de-medicalising' impulses. It relied on medication to send the client into withdrawal, medication to ease the cramps which accompanied withdrawal, a major tranquilliser to render the client oblivious to his withdrawal symptoms and a bottle of minor tranquillisers to help him sleep on discharge from hospital.

Harry's visit to the client after the hospital had discharged him, resulted in the prescribing of further medication to ease the side-effects (acute stiffness of the jaw) of the major tranquilliser. It seemed that while the use of maintenance prescribing as a substitute for illegal drug use was kept under close scrutiny by the team in a serious attempt to de-medicalise the problem, the use of drugs in the context of the psychiatric ward's detoxification programme was not only condoned but encouraged. This suggests that the commitment to de-medicalise the response to drug misuse is a limited one. The concern extends only to the use of those drugs, which, like methadone, are a substitute for the substance of misuse. Other drugs, administered and legitimated in the context of a hospital ward and a medically supervised programme of detoxification are used liberally.

The issue in relation to a feminist analysis of the service are perhaps less about whether prescribing policies are effective in helping women, and men, deal with their drug use, and more about whether they can be implemented in ways which preserve the principle of user-control. The controls surrounding the use of some drugs necessarily means that access to them is severely constrained. These constraints can be mitigated but not removed by the working practices of gate-keepers like the CDT. The team work

hard to reconcile the principle of client control with their responsibilities for administering controlled drugs. This is an inherently contradictory position which most workers are aware of. They see their task as managing this contradiction while preserving the principles which underpin their practice. The propensity to medicalise and thus mystify aspects of treatment undermines their efforts here to some extent.

Moreover, some older, predominantly male clients, stretch the team's ability to establish a partnership with their clients to the limit and there is some evidence to suggest that the controlling mechanisms adopted to deal with such clients has an impact on the service as a whole. Nevertheless, there is also evidence of the team's willingness to work flexibly with clients, to accede to their demands, to 'work through' apparent impasses in the client/worker relationship and to keep the principle of client control clearly insight.

5. Increasing Self-esteem

The final aspect of the client/worker relationship to be considered is the question of how far it encourages increased self-esteem in the client group.

> **"When people walk in the door they're seen straight away and they're taken seriously right from the start....not.....like a lump of rubbish...which I think is what you get when you go to places like Casualty and GP's surgeries. And I think that has an impact on people straight away...in terms of self-esteem....." (Jackie)**

This comment of Jackie's underlines the concerns of the team to treat their clients with respect and to encourage the development of self-esteem. The concern is echoed by others in the team:

> **"I don't really believe in giving people new skills. I don't believe people need new skills. I think most people know what to do, they just don't have the confidence to do it, or they never had a chance to do it. I suppose I believe that if people look in their own store cupboard they'll find what they need..... Helping people build up their own confidence...that's what the (client/worker) relationship's all about." (Harry)**

Sue also indicated a concern with building client self-confidence in her response to one of the vignettes. She felt it important that 'Mary', faced with multiple problems, be helped to tackle the most obvious and pressing first

> **"I think it's important that she ('Mary') gains some control as quickly as she can because if she feels she's floundering and she's at her wits end and she hasn't got control in her life, it's harder for people to pick themselves up. If you've got an area where you can think 'oh I did that', that helps people, it gives them a boost." (Sue)**

I have already demonstrated that the team operates in such a way as to encourage team members to feel valued. This ability to value others extends to the team's work with their clients. Given a model of professional practice which stresses respect for the client's agenda, the team's ability to enable their clients to feel valued, and thus encourage increased self-esteem, is not perhaps surprising. Nevertheless, the fact that they are consistent in reinforcing their client's strengths is worthy of note. The following extract from my fieldnotes, describing Richard's encounter with two young women clients of the service, illustrates very well this concern to increase client self-esteem:

> "Marie came back this morning with Danielle. Both were 'speeding' but coherent. I was interested to note that Marie came back so quickly, she obviously felt the Garage had something to offer. She said 'I feel much more at home here today'. Danielle proceeded to give an account of her circumstances and her drug use. I noted Richard's responses. At no time did he suggest that she had failed in any way, he just emphasised her achievements and her obvious strengths in getting through some very bad times."
>
> (some days later)..... Marie and Danielle kept their appointment, bang on time in fact. Richard saw Danielle first and once again adopted a positive stance towards her achievements since last week. She looked a little better, less strung out and said she had been 'digging' (injecting) less but only because she hadn't the money to buy the 'speed'. Richard insisted that, whatever the reason, the fact that she'd cut down was a very positive achievement.
>
> Richard then saw Marie who was very down. She said she'd tried cutting down but didn't sound very convinced or convincing. She expressed her guilt about the fact that she'd spent some of her young son's birthday money on 'speed' and that she hadn't picked him up from her mother's on Saturday evening when she said she would. Richard didn't pass judgement on these actions, he again looked for some indication of Marie's strengths and as the interview progressed she relaxed and became more open." (July 1993)

It is true that from time to time members of the team express exasperation with their clients. But unlike the relentless attention to what clients have failed to achieve which, as we shall see later, is a feature of the staff/client relationship on my other research site, client criticism at the Garage is expressed through a general, often amusing, store of 'outrageous acts' perpetrated by clients. It is an expression of general frustration with - and some admiration for - the audacities of some clients.

Overall I was impressed with the team's commitment to their clients. They consistently confirmed and reinforced their positive achievements and they were far more likely to 'boast' about what their clients had achieved than carp about them. This ability to value clients would suggest that the feminist principle of 'increasing self esteem' was firmly in place.

Conclusions

The discussion of client/worker relationships has revealed that clients have little input into the agency's formal decision making process and that the team is protective of its professional boundaries. The reasons for this constraint on client participation is related, in my view, to the issues raised in the discussion of maintenance prescribing. The controlling strategies which accompany prescribing in particular, and work with drug users more generally, make it difficult for the service to embrace the notion of a partnership with its clients. I consider the controlling aspects of the client/worker relationship further in Chapter 10 when I ask how far services are responding to all

clients in emphasising the need for control and constraint, and how far they are responding to a predominantly male client group which has traditionally made heavy demands on services.

The concept of control has been a shifting one in the context of this discussion. I have suggested that the team has control over its clients, through maintenance prescribing and the monitoring of illegal drug use, and I have considered how this might conflict with a concern to hand over control of the counselling agenda to the client. Control as constraint and control as empowerment sit uncomfortably side by side in a social care agency dealing with clients who use illicit substances. One of the ways of accommodating this unease is to emphasise the *giving* of control, through handing over the counselling agenda to the client, and by stabilising 'out of control' lives through maintenance prescribing.

REJECTING SEX-ROLE STEREOTYPING

The principle of feminist practice which emphasises the importance of challenging rather than confirming oppressive roles and structures in women's lives has been a useful lens through which to view some of the data. It has become apparent, however, that the lens needs to include a concern with the ways in which men, as well as women, are responded to by the service. The principle of 'rejecting sex-role stereotyping' in relation to social care practice will therefore be used to examine the data in an attempt to discover how far practices and assumptions underwrite stereotypical male and female roles and how far they challenge them.

The legitimacy of including a focus on men in a feminist analysis of a service needs defending perhaps, although it has long been recognised that the construction and maintenance of oppressive masculinity is an important arena of concern for feminist and pro-feminist scholarship. To overlook the role played by social and health care practice in perpetuating - or challenging - men's oppressive behaviours and attitudes on the grounds that this shifts the focus away from women, would be to miss a valuable opportunity to gain further insight into the ways in which women's oppression is structured and maintained. Services to drug users, unlike many health and social care services, are used predominantly by men and are thus fertile territory for research into the ways in which men are responded to by health and social care professionals.

The following discussion is in two parts. The first looks at the ways in which the CDT responds to its women clients. In particular, it considers how far women are confirmed in their stereotypical roles as wives and mothers and how far their needs as individuals in their own right are recognised and responded to. The second part of the discussion scrutinises the team's response to its male clients and asks how far the service challenges men's sexism, how men's violent and abusive behaviour towards women is dealt with and whether traditional patterns of masculinity are challenged or reinforced.

1. Servicing Women and Challenging Stereotypes

In examining the data in relation to the team's work, it is possible to find evidence which both refutes and supports the team's willingness to challenge stereotypical assumptions regarding women's roles. As in the case of the other feminist principles of practice being used as a critical yardstick, the aim is to point up where it operates and where it does not, rather than attempt a definitive assessment of the extent to which the team's work is underpinned by a commitment to challenging sex-role stereotyping. The discussion revolves around the identification of some key assumptions and stereotypes which continue to define the way in which women are seen and responded to.

Ideologies of motherhood

Clear evidence of the team's ability to separate women's needs from those of their children, and its refusal to collapse the two together, is to be found in Jackie and Pat's account of the women's group which formed part of the team's work with women clients over a period of three or four months. Their account of the group's activities and

their reasons for setting it up, stressed the importance of the women "taking space for themselves". In order to assist this, funding was made available for child-care expenses and the emphasis of the group was on **"getting out and having fun"**. In reflecting on the value of the group for the women concerned, Jackie commented:

> **"I think they got the fun element out of it.. .and being away from the kids, which I mean, is brilliant...but in terms of personal development and change.. ..we didn't feel we'd achieved that". (Jackie)**

Pat's independent comments on the group also emphasised the "**fun element**":

> **"I think the reasons behind it were to get the women out of their usual life for a start, and to do fun things, enjoyable things".**

And later in the conversation:

> **"It was more about a form of enjoyment than it was about 'let's get together and talk about issues'". (Pat)**

Clear evidence, then, of a commitment to relieving women of their responsibilities as mothers, wives and partners rather than confirming and reinforcing them. However, while there is evidence to suggest a firm commitment to freeing women from their role constraints, there is little to suggest a conscious attempt at encouraging the sharing of experiences and identifying the sources of such constraints. There is no evidence to suggest that the group aimed to raise women's awareness of themselves as women.

The group was deemed only very partially successful since it failed to capitalise on its potential to bring about change. It was clear that the change sought was quite specific and related to the women's drug use rather than to broader changes in consciousness which a group underpinned by feminist values would aim for. The recognition of the constraining effects of motherhood on women's live was evident, but did not appear to have been pursued as an issue with the women themselves.

A similar commitment to upholding women's rights to be free from constraints imposed upon them by ideologies of motherhood was apparent in Harry's response to one of the vignettes. He expressed a resistance to "**shoe-horning**" a single mother into "**family therapy**" and said that he would support the woman in this hypothetical case, by emphasising her need for 'space' in the face of pressure to get involved in the Family Centre. In response to the same vignette, Sue similarly emphasised 'Mary's' need to "**have time for herself**". She expressed her concern that;

> **"everybody's looking after the kids and nobody's looking after her and she might feel that she needs just some time for her". (Sue)**

The importance of addressing women's needs in relation to child-care issues was stressed by Jackie who was critical of the way in which women's needs were seen to be lost in the concern about children's safety:

...one of my hobby horses at the moment is that social workers go in and do the child protection work but leave the parents, usually female, because it's usually a woman with partners here and there...they leave the mother somewhere up here, going wappy, with all her own needs being left unmet. And when we're involved we actually pick that woman up". (Jackie)

A clear recognition of women's needs as separate from and different to the needs of her children is apparent here. It is not surprising then, that in relation to child protection, the team's commitment to its role as advocate on the part of the parent, is strong. In discussing a recent child protection case where the team was involved, Jackie commented:

"Sue went and made her role very clear to the case conference. She wasn't there as a drugs worker, she was there as a defender of Jean". (Jackie)

The issue of the team's resistance to equating drug abuse with child abuse has already been explored in the context of the discussion on access. It is important that the team's work with women is underpinned by this resistance as it supports the idea that women can be both mothers and drug users. One aspect in particular, of Jackie's work with one of her clients, demonstrates this willingness to reject the idea that 'the hand that rocks the cradle must be a steady one'. Jackie's client is a single parent and her daughter, now twelve was wanting to know about drugs. The child's mother was expressing some anxiety about how she should tell her daughter of her own drug use and Jackie had agreed to help her with this:

"I said we'd look at it over the next few weeks. And I...I think honesty's the best policy. You just tell her, I mean she obviously knows and fantasy's worse than reality. So that's what we'll work on". (Jackie)

Women's dependency

The team's willingness to recognise the needs of women as individuals in their own right was paralleled by the way in which young women were responded to, as autonomous rather than dependent individuals. In explaining the case of the self-abusing young woman referred to in the above discussion of access (*Expanding the Boundaries*) Jackie explained how Claire had initially been brought to the Garage by her father who had been **"livid"** when Jackie asked his daughter if she would prefer to be interviewed on her own. It had not occurred to Jackie to do anything other than offer a young woman the opportunity to be seen alone, an opportunity which had not been available to her throughout her history of contact with health care professionals. It was an opportunity to which Claire readily responded and which had the effect of challenging the view of this young woman as the invalid daughter of Mr. and Mrs. W., a view which the medical profession had colluded with.

Further evidence of the team's willingness to respond to young women without insisting on parental involvement or undue emphasis on their adolescent and dependent status was gleaned through observing and participating in encounters with young people seeking advice and support either in relation to contraception or their drug use. I was interested to note that the team's ability to engage young women and men in the service

resulted in an over-reliance on the Garage to supply contraceptives and advice on sexual health that other services were specifically set up to provide. Unlike the Garage, these dedicated services were not engaging the confidence of young people. To this extent, the CDT was a victim of its success in respecting young people's autonomy and independence.

Women's sex work

An interesting aspect of the team's work with women were Sue's visits to the massage parlour. This aspect of the work has already been discussed in relation to access but a further examination is now warranted since this aspect of the work exposes the team's attitude towards a group of women who transgress the boundaries of conventional femininity. The only member of the team to discuss the work in any depth was Sue herself and it was clear that her attitude towards the women who worked in the massage parlour was characterised by ambivalence. She clearly struggled to understand and accept that sex work could be a rational and legitimate choice for a woman to make:

> **"And they choose to do it...that was something that came out when we were talking. One girl said 'well I wouldn't do anything else, I couldn't possibly fill shelves at Tescos, I wouldn't get as much money and I wouldn't get as much respect'. And I thought how on earth can you get respect doing a job like this....I was under the impression that women did that kind of job because they couldn't get another job but the fact that she actually chooses to do that.. .she chooses it because she likes it...I mean, that was very hard for me to deal with".**

Sue also found women's involvement in sex-work difficult to reconcile with their roles as wives and mothers:

> **"A couple of the girls have young kids and they're on their own. So that's always a talking point, they're with child minders or relatives who know what they do, which surprises me really. I think, I wonder if my husband would let me do that!"**

This indicates that Sue has a view about what constitutes an appropriate femininity, a view which her work at the massage parlour clearly challenges:

> **"I had a bit of a traumatic time I think to start off with and I couldn't sleep. I talked to Jackie about it. I found it very difficult, I wrestled with that quite a lot".**

And while Sue has clearly managed to establish a working relationship with the women, there are indications that she still finds their involvement in sex-work difficult to square with her view of what is and what is not, an appropriate femininity. Although Sue works hard to understand and accept the women's sex work as role appropriate, her ambivalence is far from being resolved:

> **"I wonder about, you know, is it a good use of my time really?... when they are actually coming down (to the Garage) now...although only as a last resort. Part of**

me thinks they should be bloody buying them (condoms) you know, they're making the money and it's a business, but I'm not in a position to say that". (Sue)

Sue's difficulty in rejecting sex-role stereotyping in relation to women's sex work is significant since she does most of the team's work with this particular client group. Her difficulties are not shared by all members of the team however. Jackie appeared to readily accept that women's traditional responsibilities can, and do, go hand in hand with their work as prostitutes.

"They're not prostituting themselves for their drugs as the press would have you believe, they're prostituting themselves for other reasons really, like to hold a home together and feed the kids." (Jackie)

There were other examples of Jackie's ability to accept prostitution as a legitimate choice for women. A long-standing client of hers called into the Garage one day, a young woman who, despite her non-conformist life-style is clearly considered by Jackie to be one of her 'successes'. The young woman is by no means drug-free, she lives in Manchester where she is involved with a large-scale drug dealer and she works in a massage parlour. But Jackie is clearly proud of her and stresses Sally's self-reliance, self-confidence and ability to control her life. The ambivalence which characterised Sue's response to women's sex work was not apparent in Jackie's assessment of her client or of prostitution more generally.

There is some fairly clear evidence, then, of the team's willingness to respond to its women clients as individuals in their own right, and to support their right to be both drug dependent and competent mothers. Women's involvement in sex work was more problematic and a key member of the team had difficulty in reconciling it with her views of what constitutes an appropriate female sexuality.

'Natural Victims' and 'Rejecting Mothers'

While role stereotypes were not routinely reinforced in the team's direct work with its clients, some stereotypes operated in relation to the team's attitudes towards the mothers and partners of clients. In discussing the female partner of one of his male clients, Dave suggested that;

"... she was a natural born victim...she was a born victim and born helper". (Dave)

A willingness to see some women as inherently passive suggests an acceptance of the idea that, in relation to male abuse, women can be held responsible because they **"look round for limping dogs and try to help them out of the gutter"(Dave).** There is thus a willingness to accept rather than reject the stereotype of the 'natural victim' of male abuse which has been developed in an attempt to account for why it is that women stay in violent and abusive relationships. A feminist analysis of woman abuse resists this explanation and challenges the stereotype of the 'natural victim' seeking out men who will confirm her in her role of victim (Dobash and Dobash, 1993). Dave's comments suggest a ready acceptance of the type of explanation for women's involvement in abusive relationships which has been attacked by feminists. It is important to note the complexity of Dave's response, however, since he subsequently recommended her inclusion in the Women's Group which was then

operating. She was not merely 'written off' as a 'born victim', she was seen as having the potential to become more assertive in the face of oppressive male attitudes and behaviour.

A willingness to hold mothers responsible for the difficulties and distress of both male and female clients was also apparent. Jackie saw both Claire's mother and Sally's mothers as colluding in their husband's abuse of their daughters by denying it. The mother of a male client also regularly came under attack for creating many of the problems her son was encountering. Jackie's apparent willingness to accept the idea of the 'rejecting' or 'collusive' mother seemed to contrast with the strong feminist principles of practice which characterised her work with women clients. Her feminist practice did not appear to extend to a critical appraisal of the psychoanalytic framework which informed her work, a framework which sees the relationship between mother and child as being central to the healthy development of the psyche and which can too easily slide into 'mother blaming' The rejection of sex-role stereotyping which informed much of the work of the team, did not always extend to the mothers and female partners of clients.

2. Service Provision and Masculine Identity

Having explored some of the ways in which the team does and does not reject sex-role stereotyping in its work with women, the discussion now moves to a consideration of the team's work with male clients. In examining the data three areas emerge for consideration, all of which are broadly related to the issue of sex-role stereotyping.

Challenging men's sexism

An early insight into the way in which the team dealt with men's racist and sexist remarks was offered when an angry, agitated and 'stoned' male client called at the Garage. I sat in with Sue while she dealt with him.

> " Will was angry because his partner - 'the bitch' - had gone off after a lunch-time drinking session 'with a black fella' and 'a lesbian', taking all Will's money. While he was not openly challenged on his abusive remarks as, presumably, this would have merely fuelled his anger, Sue, steadfastly refused to get drawn into colluding with his attempts to portray himself as the victim and his partner as his abuser. Sue managed to calm Will down, let him know he was being heard but was not tempted into colluding with his complaints about his partner in an attempt to placate him.
> (July 1993)

The scenario is a fairly standard one and as an ex-practitioner I recognised the temptation to be drawn into and thus collude with men's sexist behaviours and attitudes. The temptation to do so derives either from the need to avoid antagonising clients or from the perceived need to encourage their confidences.

The temptation to collude was not always resisted as strenuously. Other observations confirmed that more collusive encounters operated. An example of this was a male member of staff's encounter with a client wanting condoms to take away on holiday. The worker clearly saw the rather large supply of condoms as a confirmation of his client's sexual virility and managed to communicate this through a joking remark.

This contrasted with another member of staff's handing out of condoms which was accompanied by remarks which associated condom use with safe sex and sexual health rather than with male virility and sexual accomplishments. The fact that the first encounter was between men and the other not is indicative, perhaps, of the particular pressures on male staff to forge links with their male clients and to rely on collusive strategies which bolster traditional masculine identity, to achieve them.

Other ways in which male workers colluded with rather than confronted men's sexism were observed.

> "Harry and I's visit to his young client who is about to go into the local hospital for detoxification revealed that there was some dispute between himself and his partner about where she should stay while he was in hospital. Craig wanted her to stay with his family, Lisa wanted to remain at home. Harry's solution was to use humour to break into the dispute and to suggest that Lisa could go home with him. The intention, as Harry later explained, was to challenge the way in which Lisa was being devalued, but the effect was to further undermine her independence by setting up a situation, albeit not a serious one, in which the two men, Harry and his client, were competing for Lisa as some kind of prize."
>
> (July 1993)

This encounter with Lisa and Craig also offered an insight into the ways in which men control women's drug use. Craig was the chaotic user of the partnership and was amused by Lisa's 'dabbling' in cannabis and LSD. It was clear however that he would condemn any further drug use on her part.

A further insight into this double-standard operated by male users was offered by a young woman's account of how her husband, a heavy drinker and drug dealer, had evicted her from their home because of her increasing drug use. Men's control over women in the private sphere extends, not surprisingly, to a control over women's use of drugs. This is not to suggest that this control is either complete or universal, Will's experience testified to that! Nevertheless, such controlling tactics are apparent and are not something which workers find easy to address. Evidence from the encounter with Craig and Lisa suggests that worker's attempts to challenge male control can backfire where they are not underpinned by a rigorous rejection of the concept of female dependency.

It is not the case that the CDT demonstrated a complete lack of insight into the operation of men's power over women in the family. Worker's awareness in this respect was apparent. In discussing a long-standing male client's relationship with his wife, Harry remarked that Bob's wife was someone who made him feel strong and powerful and that she was always there to feed her husband's ego in this way. There was little evidence that this misuse of male power was a focus of the client/worker encounter, however. The client's continuing chaotic drug use, despite the team's agreement to provide him with Amphetamine on prescription, dominated the treatment agenda. While worker's insight into what Harry described as men's "power games" was evident, there was a lack of rigour in applying this awareness and in translating it into coherent strategies aimed at bringing about changes in male client's attitudes and behaviours.

Where members of the team raised the issue of male client's sexism in their interviews I tried to discover what strategies were operating to deal with it. The answer seemed to be that on the whole worker's challenges to men's sexism were weak and tentative:

"Well I try to...you've got to suss the situation out. I sometimes deal with it with a bit of a laugh and a joke..' if you were married to me, the boot would be on the other foot...' that kind of thing...just to see what the reaction would be....I think that helps me decide which way I'm going to work with people". (Sue)

The concern not to "frighten men off" by challenging their sexism was apparent. It was suggested that it was something that a worker would have to have on the "back-burner" (Sue) to be brought into view if and when an opportunity occurred.

Challenging male clients, for whatever reasons, clearly poses a threat to workers and it is not surprising that they back off from it. An illustration of the way in which the risk of precipitating aggression deters workers from confronting their male clients is offered by the example of the client referred to in the discussion of client/worker relationships (p. 131). Counselling sessions were made difficult by Will's refusal to look at Sue who he held responsible for the team's refusal to increase the size of his 'script'. She recognised the need to confront him about this but in reflecting on why she had not done so, she says:

...but I never picked it up and said 'well look, you must feel that I've penalised you'...that was my fault but I didn't think I felt comfortable enough to do that..."

(Me) You didn't feel able to do that?"

"No...I don't think I wanted the wrath really, because I would have got a barrage of verbal abuse and I really couldn't have done with it...and that's a bit of a cop-out".(Sue)

This example of Sue's reluctance to challenge her male client is an indication of his ability to intimidate and therefore control the encounter. Despite the presence of a (male) co-worker in these sessions, the client was able to resist a challenge to his behaviour since neither of the workers were willing to provoke his 'wrath'. It is interesting that Sue criticises her behaviour, seeing it as a "cop-out", rather than as a coping mechanism in the face of male aggression. It is also interesting to speculate about the extent to which men's behaviour and attitudes towards women go unchallenged in the social work encounter precisely because of men's abilities to control the agenda through threat of aggression.

I was particularly interested in the way in which the encounter between male client and female worker had the potential for replicating and thus reinforcing patterns of male dominance. Sue's account of her counselling sessions with a male client in prison, who she described as "a hard, macho type", prompted a concern on my part that she was being seen as a 'captive audience' for her client, providing him with an opportunity to display his past exploits. Her account of the counselling sessions - and it was an account rather than firsthand observation - suggested that the client spent a good deal of time recounting his various exploits to her. My interpretation of these sessions was that Sue was being used to relieve the boredom of imprisonment and to provide a foil to her client's ego, by allowing him to reflect an image of himself as a successful, if temporarily

incarcerated, criminal. The fact that she expressed some concern that she was being **"tested out"** and that she had to work hard to suppress her moral outrage at some of the criminal activities that her client had been involved in, prompted me to question the client's motives for requesting and continuing with the sessions:

> **"...he tests me I think `what will you do if I tell you this...how will you react?'" (Sue)**

Sue's interpretation of her client's motives did not accord with mine. She felt that her client was engaged in a genuine attempt at a moral and ethical review of his life to date. My (more cynical) view, deriving from my own past experience with similar clients and the feminist lens through which I was now viewing events, focused on the male client's potential for subverting the sessions in order to provide a confirmation of, rather than challenge to the machismo which Sue identifies.

Over and above the particular issues raised by this encounter, Sue's discussion of her work with this client gives insight into more general issues. As with her work at the massage parlour, Sue struggled to rid herself of the judgmental attitudes which she sees as characterising her work on the Ward and inappropriate to her work on the team. In exploring her struggle to adopt the client-centred values of the team Sue threw them into sharp relief:

> **"I work very hard...I work hard at not letting my morals come out because I don't want to let that influence him wanting to tell me what he thinks I want to hear". (Sue)**

This raises the question of how far a challenge to men's sexism can be generated in the context of a relationship which stresses a non-judgemental approach and which relies on the client to control the agenda. If the aim is to be non-judgemental, does this necessarily preclude the worker from challenging the machismo embedded in a man's view of himself and which oppresses the women he comes into contact with? If the client is relied upon to set the agenda, and if he does not regard his masculine identity and behaviour as problematic, does this effectively mean it is left unaddressed? These are important questions which may go some way to accounting for the difficulty that practitioners appear to have in translating their awareness of the problem of gendered power relationships into strategies for change. The tools of the trade, i.e. client-centred counselling, and an emphasis on a non-judgemental style of work, might make it difficult to launch the challenge to men's oppressive behaviours which a feminist approach to social care practice must include.

Men's groups

If the one-to-one counselling session is a difficult arena in which to challenge men's sexism, group-work with men seemed to be an impossible one. Women worker's accounts of their attempts to work with male colleagues running group sessions for male prisoners on the issue of drugs and drug use, testify to the difficulties of challenging men's sexism in an all-male environment. Women staff said that they had been **"sitting targets"** for male abuse and harassment and by the time I arrived at the Garage only Dave was involved in this type of work, at the local Young Offender Institute.

It was with some trepidation, having had the benefit of the women worker's experiences of these groups, that I accompanied Dave on one of his visits to observe the work that he did. In the event, Dave's command of the group and his tight hold on their attentions meant that my presence was hardly noticed and therefore did not attract sexist comments. Dave's handling of the group was impressive.

Dave met the young men largely on their own terms, using the language of the street-user and demonstrating his extensive knowledge of drugs and drug use. But he also managed to subtly undermine the young men's macho image of themselves as street-wise users when he described all the ways in which drugs were tampered with and users duped and cheated. This had the effect of subverting the image of the drug user as street-wise hero while at the same time alerting the young men to the dangers of using.

He used a video with one of the groups to help focus their attention on issues of health and safety in relation to drug use. In making the video, women as well as men had been used to demonstrate the dangers of injecting. Dave had earlier suggested that the predominance of women in the video was designed to challenge the idea that injecting drug use was a male preserve. But rather than challenge the sexist assumptions of the young men in the group, the images of women users merely confirmed them. Remarks of "dirty bitch" were made on a number of occasions. Dave heard but did not pick up on the remarks.

In reviewing the session on the journey back, Dave raised his non-response to the remarks, as an issue. His explanation for not challenging them was lack of time. He was right to suppose that a response to the young men's remarks would have opened up many issues and would have demanded much more time than he had. He would also have been entering upon territory which was relatively unknown compared to his well planned session on drugs and drug use. The fact was, however, that men's sexism remained unaddressed while the subject of drug use had had a good airing. While on the one hand Dave had neatly challenged the notion of the street-wise drug user as the embodiment of aggressive masculinity by substituting the image of drug user-as-hero with that of drug user-as-dupe, on the other, derogatory views of women had been left unchallenged and reinforced by the silence with which they were met.

In relation to the young men's behaviour, the question of the researcher's responsibility to challenge and my own silence cannot escape attention. I was able to abrogate my responsibilities, on the grounds that I was an observer. I was nevertheless, left with a feeling that I had been complicit in the silence, and that I was as reluctant as Dave to open up a challenge to the young men's view of women.

Challenging Male Violence

An important way in which male abuse of women featured in the work of the Garage, was via its work with women, many of whom had been victims of male abuse. Violence and abuse was also a significant feature of the way in which male clients of the service related to their female partners and other female relatives. The team often found itself working with either the victims or the perpetrators of male violence towards women.

That many of the team's current clients were involved in the violent or sexual abuse of women was evident. Some particularly disturbing accounts of male client's

violent abuse were recounted by the team. One of Harry's long-term clients had a history of abuse towards his wife which had been known to have included other men. Another long-term client of the service was known to have inflicted serious sexual violence on a girlfriend who had been unfaithful to him. Dave was working with a client who was regularly inflicted violent assaults on his mother and other cases where mothers were the victims of male violence were apparent.

I was struck by the way in which male violence was an integral feature of the lives of the people the service came into contact with but it was not a focus for intervention. I discussed the issue with the team on a number of occasions and evidence suggests that these discussions prompted them to think about the issue of male violence in a way in which they had not previously done. Jackie, for instance, when asked in her interview whether she felt that men on the team worked effectively with their male clients around the issue of male violence remarked:

> **"I don't know, because we've never particularly talked about it till you popped up on the scene". (Jackie)**

This was some confirmation that my presence and my shared observations, had prompted the team to reflect on how it worked with violent men. Further evidence of my role in prompting discussion on the issue was gleaned.

> "I arrived at the lunch-time meeting today a little late and was met by Sue saying; "We've just been talking about you". It transpired that the team had been discussing my observations on the issue of how they worked with men who were violent towards women. The discussion that followed revealed a concern on the part of the staff to examine their work with violent men and they were keen to discover what strategies I thought they might adopt. I had to confess that I had no blueprint for action but that I thought the issue was too important to go unaddressed."
>
> (July 1993)

An early conversation with Harry on the subject of male violence among drug-using clients demonstrated that he had a very particular perspective on the problem.

> "Harry maintains that he is now working with the male partners of many of the women he came into contact with when he worked as a Community Psychiatric Nurse in the locality. He said he now realises how many of the women's problems he had previously dealt with were not psychiatric disorders but understandable trauma arising as a direct result of the violence inflicted upon them by their partners."
>
> (July 1993)

Despite such insights and a general awareness of the extent to which violence towards women was a significant feature of their client's lives, the team admitted to having no coherent strategy to deal with the problem.

It was clear that a good deal of work had always been done with women who were the victims of male violence. This ranged from assisting them to contact Women's Aid and move out of violent relationships, to helping them, via role-play, to assert themselves against their violent aggressors. In contrast, however, there was little evidence of the team's ability or willingness to tackle the issue with male perpetrators of the abuse. That the team felt they lacked the skills to do so was evident from Jackie's interview. In reply to a question of how she might work with a client who was involved in the violent abuse of a woman she replied:

> "I have to say that while I've worked here that's only happened once...and I ignored it. And I've felt awful ever since because I didn't know what to do about it...I didn't know what to do. And he was the perpetrator of the abuse against his girlfriend and I just didn't know how to handle it."

And a little later in the conversation, in answer to my question as to how she thought she might tackle a similar situation now, since she maintained that she learned from that experience, Jackie replied:

> ... I don't know. I think it's different...you have to challenge but I think it's a different set of skills isn't it, I guess... .working with perpetrators of abuse, as opposed to survivors of abuse...a different set of skills. And I haven't got them, I don't think".(Jackie)

Other evidence confirms the team's lack of confidence to tackle the issue of male violence with its male clients.

> " My observations today included an encounter between the consultant psychiatrist, Harry and his client (Bob) who is known to indulge in abusive violence against his wife. I was struck by the way in which the interview opened with Bob putting the issue of domestic violence firmly on the agenda by complaining that his head hurt because his wife had thrown a cup at him. He returned to the subject of the domestic dispute and the thrown cup more than once, but only a few minutes at the start of the interview were spent on the issue of his relationship with his wife. During the course of this brief discussion he was asked what had provoked his wife's violence. His reply was somewhat defensive and non-committal but instead of pursuing the issue further, the agenda was moved on to focus on the client's drug use.
>
> Bob had been asked to come in to the Garage because Harry was expressing concern about his continued chaotic use of Amphetamine despite his regular prescription. It was clear that it was this issue - his 'script' and his drug use - which was provoking the team's and the consultant's concern and the remainder of the interview, some forty-five minutes, was devoted to negotiations with the client and to laying down the ground rules for a continuation of prescribed Amphetamine. Rather than follow the client's agenda and pursue the issue of the domestic violence further, the session swiftly moved on to consider drugs and drug use. This, despite the client's history of woman abuse and despite the team having some insight into the impact of this on his wife and daughter." (July 1993)

This observation was a particularly good example of the way in which men's abusive behaviour towards women is sidelined in the client/worker encounter by a concern to tackle men's drug abusing behaviour. It is also contradicts somewhat, the team's suggestion that they work to the client's agenda, which was often given as a reason for not thrusting men's abusive and sexist behaviour onto the counselling agenda. There was a consensus of opinion amongst the team that such issues had to be handled "gently" and "with care". A discussion with Dave suggested that if a client identified violence towards women was an issue, it would be looked at. Similarly, Harry remarked that "you work with what you get".

Where there are serious concerns about the impact of violence on women's mental health, one option the team has, is to involve other services. This was Harry's solution in the case of Bob and his wife but it appeared to be fraught with problems:

> "The social worker who is involved in trying to give Jane, Bob's wife, some assistance does not seem to be providing the support that was hoped for. Bob has relegated her to the role of 'snooper', checking up on the child of the family, a relegation with which Harry seems to concur."
> (July 1993)

That the social worker was seen in this way was apparent both from remarks made by the couple when I accompanied Harry on a visit and from a telephone conversation between Bob and Harry in which Bob apologised for not keeping his appointment at the Garage because the social worker had been "sniffing around again". This seemed to indicate a reluctance on Bob's part to allow his partner free access to the social worker brought in on her behalf.

While the separating out of responsibilities and the harnessing of additional support in complex cases such as this would seem an intelligent approach, a high degree of co-operation is clearly necessary in order to prevent a male client policing a partner's involvement with support services and setting services off against each other. A high degree of co-operation is also necessary in order to ensure that any work with the victims of male violence is complimented by a focus on the perpetrator's abusive behaviour, a focus which, as we have seen, is not a central feature of the team's work with its male clients.

The concern not to alienate male clients by confronting them about their sexist and abusive behaviour too readily or too firmly, contrasted with the firm and immediate response to the client, referred to in my discussion of the client/worker relationship who had taken a job as a coach driver while being prescribed high doses of methadone and barbiturate. Little reluctance had been expressed as to the necessity to present this client with a stark choice, either he gave up his job or his 'script'. While it is clear that such an approach could not be adopted in relation to male clients' abuse of women where the issue are far more complex, it does indicate a willingness to act firmly, and to force the agenda in some circumstances. That wife abuse does not warrant such a firm approach is revealing. By juxtaposing the two issues, driving while under the influence, and wife abuse, we can see that the first warrants decisive and punitive action, the other a much vaguer, ambivalent and tentative response.

I have suggested, following Jackie's lead, that the issue of male violence and sexual abuse of women is one which the team feels singularly ill equipped and lacking in the skills to deal with. While the same is probably true for most workers in the health and social are field, drugs workers, like probation officers, are dealing with a predominantly male client group. This throws the issue, and the team's inability to grasp it firmly, into sharp relief.

We need to question however, how far the problem is one of lack of skills, as Jackie suggests, and how far it is a problem of analysis. I have suggested that male violence does not command the attention that a client's chaotic drug use or potential dangerous driving does. It has little priority as a problem which needs to be tackled. This may result from an analysis of gender relationships which takes too little account of men's power over women in the family. Returning to Jackie's interview and discussion

of male violence towards women, I was struck by the way in which she moved between discussing male violence towards women, and women's abuse of children. The result was an elision between woman abuse and child abuse, an elision which depended on a refusal to recognise the gendered power relationships which underpin the former but not the latter. In reflecting on her discussion of her lack of experience in dealing with the perpetrators rather than the victims of abuse, Jackie goes on to consider that she does indeed have the experience of working with perpetrators, through her work with women who physically abuse their children.

The failure to develop clear and coherent strategies to deal with men's abuse of women may derive from an analysis which fails to see male abuse of power in the family as different from and separate to women's abuse of children. It may also relate to the way in which men themselves are seen as victims. In speaking of her experience of working with one particular male client who, again, was known to abuse his wife, Jackie said:

> **"And when I was working with him I was like...acknowledging his needs as a person because of, like, his upbringing and that's made him how he is, but also putting back to him that he couldn't go around walloping J..(his wife) like he was doing". (Jackie)**

Not surprisingly, perhaps, workers find it difficult to see and respond to clients as both victims and perpetrators. A professional ideology which emphasises a client's internal trauma brought upon by abusive and unsatisfactory relationships in childhood, makes it difficult to focus on their abusive behaviour to others. Unlike women, who are condemned as abusers of children but who risk having their own needs left unmet, (see Jackie's comments in relation to *Ideologies of Motherhood*) men's abusive behaviour slips out of the frame in an anxiety to respond to their needs as victims. Male clients have reason to present themselves as victims, particularly where they are caught up in the Criminal Justice System. But in trying to respond sympathetically to their client's status as victim, workers may loose sight of a male client's propensity to victimise women.

Where male violence is recognised as a problem by the team, issues are further clouded by the fact that it is seen to result from the effects of drugs and drug misuse rather than to emanate from men's power over women. The decision to prescribe maintenance doses of methadone or amphetamine, may be influenced by the perceived need to tackle a man's violence towards his female partner. In this way, male violence is seen as being tackled indirectly, by the use of maintenance prescribing. Examples of maintenance prescribing being used in this way, in relation to both male and female clients, were observed. In relation to male clients, maintenance prescribing was seen as a stabilising mechanism and as mitigating the worst excesses of violence. In the case of a woman client, prescription was advised in order to avert the danger of her partner becoming violent towards her because of the amount of money she was spending on drugs. Other observations confirmed this view of male violence as a side-effect or direct result of drug use.

> "Harry's account of his encounter with a male client, made it clear that the issue of his violence towards his wife had been on the agenda. Harry indicated that he had helped his client deal with the anxieties he was experiencing about his violence towards his wife by reassuring him it was part of the "swinging pendulum" which goes with drug use and withdrawal from it."
>
> (July 1993)

An account of male violence which identifies the drug as the agent responsible absolves the client from his responsibilities. It illustrates the way in which male violence is constructed as an integral part of the recovery process and as a by-product of a client's attempt to deal with an amphetamine habit. The violence-provoking properties of amphetamine, were recognised by most of the team:

> **"And often, say with a drug like amphetamine, it can lead to the partner becoming fairly aggressive and that means the kids take the aggression and the (aggressive) behaviour gets directed to the wife and partner and the kids". (Pat)**

The issue of male violence towards women was introduced into all the interviews with the team. As a conclusion to this section I include my reflections on one interview where the discussion of male violence was not captured on tape since it happened after the tape had finished. As a result, I made comprehensive notes as soon as possible after the interview had ended and a mental note to always put in a new tape, however near the end of the interview one might appear to be! I include the comments in full since they reinforce much of the analysis so far and take me into the final section of the discussion which deals with the team's willingness to challenge traditional and oppressive masculinity. It also takes the discussion of the team's response to male violence a little further by examining the way in which male violence is seen as an inherent feature of working class male identity. This poses something of a problem for workers concerned not to impose the values of the professional middle-classes on its clients.

> "In discussing the team's strategies for challenging male violence, Dave assumed that, where a woman was the subject of violence, the intervention would be one which encouraged her to leave her partner. Until I prompted him, he did not consider the possibility of challenging men on the subject of their violence. The assumption was that male violence was a problem for women and that any help which could be offered in situations characterised by male violence, was help which enabled women to leave. Dave was reluctant to counsel this option, however, since it would have the effect of marginalising the woman concerned by dividing her from her family, friends and community. Clearly this is a risk, and is presumably why some women stay in violent relationships. Nevertheless, it seemed to suggest that for Dave the possibility of fracturing working class family and community ties was at least as big a problem as men's violent abuse of women. When I suggested that another way of tackling male violence might be to challenge men's perception of themselves as having the right to maintain and reinforce their dominance of women through violence, he suggested that a) this would be very difficult to do given the entrenched nature of violence in the communities in which his clients lived and b) that such a challenge might be very uncomfortable for a male client since any heightened critical awareness of traditional masculinity would result in his marginalisation and alienation from his peer group, family and local community. He also seemed to feel that tackling such deeply entrenched attitudes and behaviour was beyond his sphere of influence when he remarked: **"It's a job, not a crusade.**
>
> It was clear to me that where violence is the community 'norm' Dave, as a social worker, felt limited in the degree to which he could challenge it without imposing his 'middle-class' professional values on his working-class clients. It was noticeable that by this time, Dave had begun to discuss violence per se, rather than male violence towards women. So the example of 'Mum's boxing of 'Wayne's' ears sat alongside 'Dad's' violence to 'Mum' after a night in the boozer." (Notes from Interview with Dave)

This analysis is not unlike Jackie's. It subsumes male violence within a broader framework of violent relationships in families and only superficially acknowledges patterns of male dominance which structure relationships between men and women.

Drug use and Masculine Identity

I have suggested that challenging men's sexism and male violence presents a real and as yet unmet challenge for the CDT. It is perhaps a challenge which can only be met where the work of a service is underpinned by a critical analysis of a dominant masculinity which supports and is supported by oppressive attitudes and behaviour towards women. Some recognition of the need to challenge oppressive male attitudes was apparent and some strategies were in place to meet this challenge. Male members of the team stressed the importance of providing a different model of masculinity in their encounters with clients, a model characterised by a willingness to listen and an ability to empathise with emotional distress.

Similarly, women staff emphasised the importance of challenging male clients' attitudes towards women by presenting them with an alternative model of femininity in which women were strong, assertive and in control. These strategies were piece-meal and limited in their impact. They were also undermined by the reluctance to problematise a masculine identity seen to be rooted in a class identity which workers felt they should respect rather than confront or try to change.

The drugs field would seem to offer a wealth of opportunities for working with men on the issue of masculine identity since, as we have seen, the majority of its clients are men. However, dedicated services to drug users make it difficult to look beyond the problem of drug misuse and highlight the problem of men. The treatment task is conceived of in terms of controlling drug use and the spread of HIV infection rather than as encouraging an awareness of the ways in which men's behaviour is constrained by a dominant masculinity which is oppressive to women.

A closer scrutiny of the meaning of drug use in men's lives, reveals the way in which men have appropriated the image of the addict to buttress and reinforce an oppressive masculinity. Drug use and the paraphernalia associated with it become symbols of a masculinity which may be hostile and suspicious of 'straight' society but which nevertheless reflects similar oppressive attitudes towards women. Men's drug use is thus inextricably bound up with their image of themselves and is often a powerful symbol of their masculinity.

One of the risks that services run is being annexed by the male addict as further confirmation of their identity as drug users. Services become just another building block in the construction of an identity which supports an oppressive masculinity. This happens in two ways. First, the service itself, as a dedicated service, confers the 'master status' of drug user on its clients. Even though the CDT has succeeded in jettisoning some of the more stigmatising practices of the traditional drug clinic, the Garage is still a service for illegal drug users and confirms a client's status as such when they become involved. Secondly, the service offers opportunities to discuss drugs, drug use, negotiate over prescribed drugs etc. and thus enhances the user's image of himself as someone who knows about drugs and how to get them.

The team were not unaware of the dangers of being used to bolster the image of the drug user. Towards the end of his session with the young offenders, Dave invited them to request individual visits from him should they wish to discuss their drug use further. He added that he was not interested in hearing how 'big' they were on the outside, but would respond to genuine requests for support. The fact remained, however, that drugs and drug use still dominated the team's agenda with many of its clients who were thus offered opportunities to bolster their image of themselves as committed drug users.

Moreover, there were times when I felt the team encouraged the view of the male drug user as anti-hero. A recognisable theme in their entertaining anecdotes about clients was the portrayal of the antics of past and present clients in heroic terms. The legendary excesses of some clients was part of the team's folk-lore. While the sharing of such legends with me was appreciated as a way of encouraging my involvement and inclusion on the team, it also served to bolster the idea of the male drug user as charismatic folk hero.

Conclusion

The work of the CDT offers some important insights into the way in which health and social care services work with their male clients. By using the feminist principle of rejecting sex-role stereotyping as a way into observational and interview data, the fact that some oppressive male practices and behaviours remain largely unchallenged by the service has been revealed. That this should be the case in a service where workers demonstrate high levels of awareness and a willingness to reflect upon their work, indicates a more general lack of attention to the development of social work strategies which effectively address the issue of male violence with male clients.

Summary

This chapter has examined the work of the CDT using the principles of feminist practice to assist the analysis. It has been concerned to understand the assumptions which underpin professional practice and the dynamics which drive the organisation. The discussion has considered the extent to which client access to the service is facilitated and the nature of the client/worker relationship. The feminist principle of *'rejecting sex-role stereotyping'* has enabled the development of a number of insights into how far the service operates in women's interest. A consideration of the way in which the service works with its male clients has revealed the extent to which men's abuse of women is left unaddressed and unchallenged.

CHAPTER 9

PHOENIX HOUSE

An initial outline of Phoenix House was given as an introduction to the chapters reflecting on the research process. Since it is a large, multi-site project, a more detailed description, together with some indication of 'who's who' is probably necessary in order to assist an understanding of the ensuing analysis of the research data.

Phoenix House consists of a **Main House** where some thirty residents, both male and female, spend the first eight to nine months of their treatment programme. **The Family Unit** occupies the same grounds as the **Main House** but has a separate set of buildings. Residents here are mainly women and children and they undertake a separate, shorter treatment programme to that offered in the **Main House**.

Once residents in the **Main House** have completed their eight to nine month programme, they move to the **Re-entry House** on a separate site, where they spend approximately four to six months preparing to live independently. Once residents have moved out into their own accommodation they can expect to receive ongoing support from a newly appointed **Outreach Worker** (soon to be an Outreach Team).

Each site has its own separate staff group, although **Re-entry House** staff share the weekend and overnight cover rota for the **Main House** and individual team members may have experience of working in one or more of the teams during their time in the organisation. The manager of the **Family Unit**, for example, was previously the manager of the team of staff responsible for the day-to-day running of the **Main House**.

Data was collected on each of the sites and interviews were conducted with as many staff as possible in each of the teams. I indicate below the location of staff and residents at the time the field work was in progress. For clarity, only those staff and residents mentioned in the discussion of findings which follows, have been listed. Pseudonyms have been used to assist confidentiality.

Staff Members : Main House

- John: Team Leader
- Jane: Team Member
- Craig: Team Member
- Roger: Team Member
- Vicky Team Member
- Annette Team Member
- Carole Team Member
- Ian Temporary team member

Staff Members: Re-entry House

- Fiona: Team Leader
- Rachael: Team Member
- Dean: Team Member
- Bev: Team Member

Staff Members: Family Unit

- Tony: Unit Manager
- Robin: Team Member (Child-care)
- Helen: Team Member (Child-care)
- Cathy: Team Member
- Lesley: Former Unit Manager

Staff Members: Outreach

- Annie: Outreach Worker

Staff Members: Relief Team

- Jenny

Residents: Main House

- Jean: Woman in early '30s, two children being looked after elsewhere
- Tessa Young woman, early '20s
- Linda Young woman, late teens
- Kim Young woman, mid-20s
- Jackie Young woman, early 20s
- Frank Man in early '30s
- Sam Young man, early '20s
- Jay Young man, late teens
- Chris Man, late '20s
- Ray Man, mid-30s

Residents: Re-entry House

- Tina: Young woman, early '20s, two children looked after by parents
- Fran: Woman, early '30s, two children looked after by family
- Alli: Woman, mid-'30s, four children looked after elsewhere
- Steve: Man in mid '20s
- Mark Man in early '30s

Residents: Family House

- Sally and son Tom
- Pat and daughter Kelly
- Elli and son Jo
- Kate and daughter Suzie
- Mo and daughter Dee
- Geoff) partners
- Carrie)
- Sue and baby son
- Hazel
- Emma (prospective resident)

Ex-residents:

- Pete (Main Programme)
- Louise (Family Unit)

PROFESSIONAL IDEOLOGY AND PRACTICE

The following discussion is in two parts. Part one identifies some key assumptions which underpin the treatment programme at Phoenix House. Part two considers them critically. The critique pays particular attention to the feminist principle of '*re-defining social problems*' and considers how far the programme's design and operation is informed by a perspective which recognises both the social and gender dimensions of drug use and its treatment. The analysis relies on data gleaned through interviews with staff, and through participant observation. Interview material proved particularly useful in making explicit the assumptions which are implicit in the programme's operation.

1. Key Principles and Assumptions

Four key principles and assumptions can be identified:

I. An overriding principle which drives the treatment programme is that abstinence from illegal drug use is possible, desirable and an ultimate goal of treatment. Linked to this, is the assumption that abstinence will be resisted and residents will seek opportunities to continue their dependency. A significant aspect of the programme is devoted to controlling and thwarting these undermining impulses and to ensuring that the momentum of change, from addiction to abstinence, is maintained.

II. A second assumption which underpins the treatment programme is that illegal drug use is a contaminating influence and brings chaos to the lives of drug users. The programme aims to bring order into this chaos.

III. A further assumption is that individuals can only benefit from treatment if they enter the programme voluntarily; the concept of readiness is evoked and any attempt to work with drug users who have not yet reached a state of readiness is deemed likely to fail. Closely related to the notion of voluntarism is the assumption that the individual can and must assume responsibility if change is to take place. A primary aim of the programme is to help residents exercise their responsibility for change and determine its pace and direction.

IV. This concept of self-responsibility is reflected in the commitment to self-help principles and model of treatment, a key feature of the programme. Residents are expected to progressively take more responsibility for themselves and others as they move through the programme. They are also expected to make increasing levels of investment in the effective operation of the therapeutic community.

I intend to explore these assumptions more fully before embarking on an analysis which aims to reveal the problems and possibilities they pose for feminist principles of health and social care practice.

The Goal of Abstinence

The raison d'être of the therapeutic community as conceived in relation to drug use, is to bring about abstinence from illegal substances. This requires a commitment to change and a willingness to exchange dependency on drugs for a drug-free life

characterised by independence and self-respect. A recurrent theme in the group work at Phoenix House is the encouragement to change and leave the past behind. One of the groups I observed was centred around this theme:

> "Craig (staff member) explained the group's theme as being concerned with reflecting on the past and the importance of leaving it behind. He sent each resident up their room to bring down something that was a remnant of their past. After giving group members an opportunity to talk about their chosen remnants, he took the group out into the garden where they lit a small bonfire. He then invited the group to burn their remnants if they so wished. Later the group buried the ashes of the fire in a box labelled 'Ashes of Our Past - Phoenix House 1994'".
>
> (July 1994)

This theme of burning and renewal, is of-course symbolised by the Phoenix, a metaphor central to the Community's philosophy.

The expansion of therapeutic programmes run by Phoenix House in the mid-1980s coincided with, and to some extent resulted from, a growing disillusionment, from within Psychiatry and the medical profession, with maintenance prescribing as a way of treating drug use. The Phoenix House programme was seen as an alternative to maintenance prescribing and a way out of the cul de sac of dependency.

To a large extent this continues to be the case although the rigid requirements for residents to be drug-free on arrival and to undergo urine tests to confirm their drug-free status has recently been relaxed a little. It is now possible for residents to enter the Community and to undergo a rapid programme of detoxification under the supervision of a local GP, the aim of which is to ensure drug-free status within a two-week period. In addition, and through its recently established Outreach programme, the organisation now demonstrates a greater willingness to work with clients who are still using. Nevertheless, the goal of abstinence remains firmly in place and the value that the therapeutic community places on its drug-free status is high. The Community is seen as a refuge from the pressures of drug use and drug using culture and as such places a premium on ensuring that it remains uncontaminated by both.

The need to maintain a drug-free environment and the assumption that abstinence will be resisted, legitimates the high levels of control and the constraints on personal freedoms which obtain. Comings and goings are carefully regulated and any individual deemed to be placing the Community at risk of being infiltrated by illegal substances is reprimanded.

On arrival, new residents are routinely searched either by staff or senior residents and any subsequent arrival of belongings are similarly subject to scrutiny. Private cash is carefully controlled and receipts have to be produced to account for all expenditure. Freedom of movement outside the Community is restricted, only those having gained the privilege of a 'local' or 'full' pass can leave the premises unaccompanied by a more senior resident. Residents with passes are required to seek permission for any outing and are required to sign in and out.

Urine testing is routinely used, either for general surveillance purposes, in which case an unannounced urine screening of the whole Community will be undertaken, or for checking on the status of particular individuals. This might be done routinely after, say,

a first weekend visit home, or because a resident has come under suspicion for other reasons.

The intrusive nature of such practices is recognised by some of the staff, but they are deemed a necessary part of ensuring a drug-free community. One member of staff commented in her interview with me:

> **One thing I'm quite uncomfortable with is urine samples - that we take urine samples and that we go in the toilet with people and that we think we've got the right to do that. I mean, I'm not sure I think I've got the right to do that..(Team Member)**

Visits and telephone calls are restricted in the early stages of the programme and when restrictions are lifted residents require permission for all visits and telephone calls. Visits from family are encouraged but visits from friends (and sometimes spouses/partners) are scrutinised and vetted. Proof that they are non-drug users will be sought.

Contact with residents who have left the programme prematurely (splittees), or contact with those who have completed but who are suspected as having returned to their former habits, pose a particular set of problems. The rules of the Re-entry House state what is expected of residents and include:

> 4) That you do not fraternise with drug users or splittees

While I was observing the work of the Re-entry team, concern was expressed about the company some residents were keeping. I noted that:

> "Contact with 'splittees' known to be using is very much discouraged and sanctions are in place to try to ensure that contact isn't sought. This results in an on-going concern with the lives of past residents, in particular, whether they are drug-free or not."
>
> (September 1993)

Contact with 'splittees' is prohibited unless and until they have been vetted by staff and are deemed to be conforming to the goal of abstinence. Evidence of this vetting procedure was gleaned when Craig (Re-entry staff member) went off to see an ex-resident who had left before he was due to do so.

> " Craig seemed keen to meet M. at his flat in order to get a better insight into his life-style - were there empty beer cans around, signs of cannabis smoking? Here was an example of a check on an ex-resident to ascertain his drug-using status."
>
> (July 1994)

Residents who have contact with 'splittees' and ex-residents against the advice of staff, are seen as putting themselves at risk and undermining their recovery process.

A fairly elaborate set of procedures are in place to ensure that comings and going are scrutinised and monitored. The boundaries between the Community and the outside world are carefully policed in an attempt to maintain the Community's drug-free status. The need to be vigilante at all times is impressed upon staff and residents, a vigilance

born out of a distrust of the recovering drug user and an emphasis on the power of dependency.

Ensuring that the goal of abstinence is kept firmly in sight involves not only the need to ensure that the Community is free from illegal substances but is also free from what is seen as the cultural norms associated with i.e., dress, language, music, images. This results in a form of censorship with regard to dress and behaviour as residents are expected to give up their 'street image' as part of their commitment to change. Where residents continue to wear clothes, sport hairstyles, jewellery or hang posters which are deemed to 'belong' to their former life-style, they are likely to be seen to be transgressing the Community's norms. In some circumstances residents will be told to remove posters, or change their clothing in order to present a more acceptable appearance. Residents are continually scrutinised for what are taken as signs of a continued adherence to a deviant subculture associated with drug use.

The goal of abstinence is an important principle of the treatment programme, and one which is vigorously protected from undermining influences both inside and outside the Therapeutic Community. It is a goal which is attractive in its clarity but it does in fact harbour some contradictions and unresolved tensions. The first is in relation to the use of alcohol, the second surrounds the issue of cannabis.

In the Main House and the Family Unit the consumption of alcohol by residents (and visitors and staff on duty) is prohibited either on or off the premises. In the Re-entry House residents can apply for 'drinking privileges' and embark on a programme of controlled, social drinking. However, the problem of Re-entry residents engaging in heavy drinking and the concern that they are merely substituting alcohol for drugs is an issue. Observations of a Re-entry team meeting confirmed that the drink diaries which residents are required to keep as a way of monitoring their drinking and which they are supposed to discuss at the weekly group run by staff, can often be a cause of some tension. Staff questioned how truthful the diaries were and observed that none were actually brought to the group meeting in the week under review. Fiona (team leader) suspected that more drinking was going on than was being admitted to.

In an attempt to address the problem a second, 'dry', Re-entry House was created for the 'newest' Re-entry residents, i.e. those just moving down from the Main House. The more radical solution of making the whole programme, i.e. both the Main House and the Re-entry House, drug and alcohol free has been mooted on more than one occasion and is an indication of the intransigent nature of the problem for staff at the Re-entry House. To date, this course has not been adopted. Residents are allowed to engage in a programme of controlled drinking backed up by educational workshops, individual monitoring programmes and group discussion. The concern remains, however, that alcohol merely becomes a substitute for the former drug of choice.

The dividing line between drugs and alcohol, while both potentially leading to problems of dependency, is clear for the Phoenix House programme. Heroin, cocaine, amphetamine etc., are illegal substances and are seen to be closely linked to a deviant subculture whereas alcohol is not. In theory the goal of abstinence can accommodate the use of alcohol, in practice, both staff and residents wrestle with what often appears to be an inherent contradiction in a programme which permits alcohol use but sees drug use as totally unacceptable.

A further tension that arises in achieving the goal of abstinence is that between 'hard' and 'soft' drug use. Cannabis, like heroin is a classified substance and must be included in the abstinence model. In private many of the staff would admit that it is unrealistic to expect abstinence to extend to cannabis but in public they are committed to warning residents of the dangers of becoming embroiled in drug-using circles, at any level. They feel compelled to alert residents to the fact that the supplier of cannabis might well be the supplier of other drugs and that they are embarking on a risky enterprise in buying cannabis. In her taped interview with me Cathy admitted to some difficulties with the issue:

> **"Sometimes, in a review or evening meeting they (residents) gang together and...it gets a bit difficult because it goes something like...'Oh, come on, there's no harm in smoking dope, I know loads of people who smoke dope and it doesn't give them any problems'. And I say 'No, but your drug use has given you problems..' But privately I'm thinking, well, they're right really." (Staff Member, Family Unit)**

As the lobby to legalise cannabis grows in strength, its inclusion in the goal of abstinence becomes harder to defend.

Managing the Chaos

The association of drug use with chaos and the need to bring structure into unstructured lives, is a dominant motif of the therapeutic community. Visitors are immediately struck by the spruce appearance and well-ordered running of the house. Each resident is assigned to a specific work team or Department on entering the community and these teams are displayed on a meticulously aligned and printed board in the central hallway. The 'Structure Board' is both a symbol and a manifestation of the ordered Community. If names are omitted or misspelled, the resident responsible can expect to be reprimanded.

The Departments have a hierarchical structure, with senior residents occupying the positions of Department Head and Assistant Department Head. Their task is to ensure that the team functions effectively and that personal and emotional needs are met. The Departmental structure serves a number of interrelated functions. It is fundamental to the maintenance of order in the community and is seen as an important therapeutic tool. It ensures that all residents have a clearly defined role which carries its own set of privileges and responsibilities, it brings structure into unstructured lives and instils the respect for authority on which order depends.

> **"The Departments are a way of creating an order among a lot of people and it's something to do with them in the day. I don't honestly know how brilliantly the jobs that they're supposed to be doing are getting done. But I do see the value of the varying amounts of responsibility and being able to gradually increase that" (Rachael - Staff Member, Re-entry House)**

> **"It brings residents into touch with issues of authority..... They may have quite a strong deep antiauthoritarian attitude to the system...lots of layers of antagonism really. In coming into the hierarchical situation of taking on a position of**

> **responsibility, Assistant Department Head, Department Head, or Co-ordinator, they are learning and experiencing how to be respectful to self and others." (Dean - Staff Member, Re-entry House)**
>
> **"I think it (Departmental structure) teaches people self discipline." (Craig - Staff Member, Main House)**
>
> **"It's a good idea to have a manager and an under-manager on a Department because that's realistically what any job's going to be like when people leave here". (Craig - Staff Member, Main House)**

The Departmental structure is also a central plank of the self-help model which operates and which is explored more fully below.

Time is carefully structured in the Therapeutic Community. Residents are woken up at 7.00 a.m. and from then on the day is punctuated by Community meetings, work activities, group therapy sessions, counselling and organised recreational activities. At 9.00p.m. most residents are officially 'off structure' but their whereabouts continues to be monitored by residents still 'on duty'. There are set mealtimes, eaten communally and cooked by residents assigned to the Kitchen Department. If meals are not well-cooked and ready on time, or if standards of hygiene and cleanliness are not met, those responsible will have their shortcomings brought formally to their attention, and to the attention of the Community as a whole.

Sanctions are an important aspect of managing the chaos. They range from 'pull-ups' in which senior members of the Community reprimand residents responsible for, e.g. late meals, poorly cooked meals, dirty cups left lying around, to 'contracts' for more serious misdemeanours. A 'pull-up' is recorded in a book and announced to the Community at its evening meeting. A 'contract' results in the removal of the resident from their work-team and the allocating of tasks for them to work on alone. These tasks range from menial work, e.g. scrubbing floors, to written work. Contact with the Community as a whole for a resident 'on contract' is restricted and carefully regulated. The aim of the 'contract' is to bring about greater self awareness by allowing the resident time for self-reflection. S/he is given opportunities to articulate these reflections in regular counselling sessions with peers and other residents. Efforts are made to ensure that 'contracts' are not regarded as punishment but they are prone to distortion. As a result, their nature - punitive sanction or therapeutic opportunity - remains ambiguous.

I had an early insight into the use of contracts on my first day of participant observation at Phoenix House. On approaching the front door I encountered a lone resident sweeping the drive-way. Previous experience told me that she was 'on contract' and I was not to acknowledge her. Later in the week she left the programme. I had no way of knowing how far this particular resident experienced the 'contract' as punishment and how far the experience of it was related to her decision to leave. In discussion with another resident, however, I was able to gain some insight into how a 'contract' is experienced.

> "Tina told me she was on a contract in order to help her be more open and more in touch with and expressive of her emotions. The contract consisted of various written tasks set by her key worker. I asked if she experienced the contract as punishment. She said she did at first but was now really into it and felt it was helping her." (September 1993)

Although most staff stressed the value of 'contracts' as therapeutic strategies, helping residents to focus their energies, set and achieve goals, the way in which they were presented suggested that they contained a punitive element. During my first visit to the Family Unit I noticed a memo on the office wall notifying a resident that she was 'on contract'. In setting out the reasons for the 'contract' it stated:

> "You will not learn to organise everyday events which could result in triggers to relapsing".

The sanction of the 'contract' bears the weight of a history in which strategies for belittling residents for their failure to conform to the rules and expectations of the Community were regularly used. While concerted attempts have been made to extricate it from these associations in order to use it as a constructive therapeutic tool, the ghosts of the past regularly return to haunt it. Craig, in his taped interview with me, articulated the difficulties of making this conceptual change in the use of the 'contract'.

> **Craig: "A few years ago I would have said a contract was a way of putting someone in their place. Contracts have started to change a lot now and they're more based around what the person needs and it's a contract that's worked out between the keyworker and the resident. But in the past I would have said it was a punishment."**
>
> **Denise: "Does the past still hang on, or has the transition been made?**
>
> **Craig: "I think at times it does hang on. And I think it will be something that will take a lot of changing, I mean it's a very old form of Phoenix therapy really, I think it will take a lot of changing. But I think it's getting there. The contracts are nowhere near as...gruesome...as they used to be."**

A further set of sanctions derive from the privilege system which operates. When residents first enter the Community their freedom of movement is constrained and they have to earn the privilege to move in and out of the Community, make telephone calls, receive guests etc. Non-conformity to house rules, or misuse of privileges can result in their loss.

Sanctions such as the 'contract' the 'pull-up' and loss of privileges earned, hold the structured day and structured work teams in place. The whole is legitimated in terms of the need to bring order into the chaotic life of the drug user by engendering a respect for authority and conformity to a pattern of activity which approximates to the normal working day.

Phoenix House offers a controlled and controlling treatment environment. Permission for the high levels of constraint which operate derives from two sources, the need to protect the Community from the contaminating effects of illegal drugs and the need to bring order into the chaotic life of the drug user.

The Concept of Voluntarism - a Contract of Adherence?

The treatment programme is underpinned by the notion of voluntarism. Residents will only be accepted for the programme if they are motivated to succeed. Self-referral is considered to indicate a higher level of motivation than referral by another agency. In my taped interview with Robin he commented:

> **"People ring in...and then the social services bit follows on as part of the process of getting funding.... And they're often the most successful referrals, the ones where people ring themselves. The process works best when it's driven by the client and not by the worker." (Team Member, Family Unit)**

In discussing the process of referral and assessment with Carol (team leader, Main House) she made it clear that the expectation is that prospective residents will self-refer, and that agencies such as Community Drug Teams understand this and will encourage their clients to approach Phoenix House direct. A referral from a third party is not acted upon.

Responses to a vignette aimed at eliciting worker's responses to requests to return to the programme after an initial failure to complete, confirmed the centrality of the principle of self-referral:

> **....I'd tell her that if 'John' wants to come back into the programme then 'John's' got to get in touch. I'd explain that that's about his commitment and wanting to stop using drugs." (Craig - Team Member, Main House)**

The concept of 'readiness' is evoked in order to try and assess an individual's motivation to succeed. It is assumed that individuals will reach the stage when they perceive the need to make fundamental changes in their life-style and drug-using habits. Dean, discussing the issue as much from personal experience as from his position of team member, comments:

> **"My belief is that the person really needs to be at a point in their life where they have had enough. And only then will some headway be made by that individual. If they return to abusing drugs or drink, having decided to give them up, then for me, it's an indication that they're not yet ready". (Team Member, Re-entry House)**

From the outset, the emphasis is placed on the importance of the drug user themselves making a rational choice to enter into treatment. Requests from women and men on remand and facing the possibility of a custodial sentence, pose particular problems of assessment. How far is the pursuit of treatment generated by a concern to escape a prison sentence and how far is it a genuine desire for change? Staff visit prospective residents in prison to carry out assessment interviews in an attempt to assess what is driving the request for treatment. The aim is to find out more about the nature and circumstances surrounding the offence and to consider how 'genuine' the request for treatment is.

To some extent, the move to Community Care and the need to ensure that funding is available for residents before they can be accepted into the programme, means that some of these concerns to assess motivation have given way to the more pragmatic consideration as to whether funding is available. Where it is, there are strong pressures to admit individuals for treatment and staff fear that clinical decisions are increasingly being driven by funding decisions. Staff concern about and resistance to these pressures indicates the importance of the concept of 'readiness' and the principle of self-determination.

Efforts are made at interview and assessment stage to ensure that those seeking treatment know what they are 'letting themselves in for'. House rules are made explicit and the abstinence policy emphasised. Once accepted into the programme it is deemed the responsibility of the individual to ensure that they get the most out of it. Rachael in her taped interview, commented on what she felt the Phoenix programme had to offer:

> **"I actually think what we have to offer is quite limited. I think an awful lot of it relies on the individual's approach to what we have to offer. I think we offer a package of stuff and if they take it and use it then it can be of use...." (Team Member, Re-entry House)**

This emphasis on freedom of choice - to enter the programme, to make use of what is on offer and to stay the course - sits alongside the heavy constraints on individual freedom outlined above. This suggests that a contract of adherence is operating which relies on the individual willingly giving themselves up to the programme. A deal is struck in which the individual voluntarily gives up certain rights in exchange for a refuge from the pressures of a drug-using life-style. In return they are offered the opportunity to embark on a process of self-discovery and establish themselves as non-drug-using members of the wider community.

Self-help Model of Treatment

An important aspect of the process of legitimation is the fact that controls are exercised to a large extent by the Community itself. Seniority in the Community carries with it the responsibility for imposing and protecting both the house rules and the feedback mechanism which monitors resident behaviour and attitude. The model is one of self-help rather than professional intervention. The controls and sanctions are operated through a hierarchy of responsibility among the residents themselves with staff at the pinnacle of this hierarchy to ensure that it is held in place[1]. The resident group are expected to take ownership of the rules and constraints.

The Community is structured in a way which ensures that taken for granted rules and constraints are quickly and effectively transmitted to new residents. The normalising influence of the Departmental structure outlined above, together with the Peer Group structure outlined below, ensures that rules and constraints which might appear bizarre or illegitimate to outsiders, become accepted as the norm. The normalising thrust of life in the Therapeutic Community was commented upon by Rachael who outlined how it operated in relation to staff. She commented:

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[1] The original Concept Houses were staffed entirely by ex-users who themselves had undergone a programme of treatment in a Therapeutic Community. This 'pure' self-help model has now given way to a hybrid version as qualified non-using members of staff have been engaged.

> "When I describe the job to other people they....think it's very bizarre - and it is. The amount of control that is exercised over how much they (residents) can use the telephone...and the fact that they have to have all their personal comings and going vetted by us.....w hen I came into working in these sorts of Communities I was initially really quite shocked at how interventionist you were and just how many rights we thought we had. But very quickly I just accepted it as normal." (Team Member, Re-entry House)

The resident hierarchy is reinforced by the notion of the Peer group, i.e. residents at a similar stage in their therapeutic programme. Peer group members are expected to form close bonds of friendship and establish a strong group identity. Peer groups are fundamental to the operation of the self-help principle. They have a strong therapeutic role in that they provide the support, the empathy and understanding deemed necessary for the individual's recovery. If the Departments are the fulcrum around which the day to day running of the Community is ordered, the Peer groups provide the focus for the emotional and therapeutic work that residents are expected to undertake. Emphasis is placed on the importance of peer group bonding and regular groups, counselling sessions and activities are arranged to facilitate the bonding process.

A clear set of expectations is attached to each peer group stage. The 'Induction' group is expected to concentrate on settling into the Community while individual members of the 'Tribe' are expected to involve themselves in a rigorous process of self-analysis. The 'Interphase' group contains the most senior members of the Main House and is expected to undertake voluntary work outside the Community while providing strong role models to newer residents within it. Once residents move out of the Main House into the 'Re-entry' stage of the programme it is expected that strong bonds of friendship will have been established which will help the resident through the final stage of their recovery, a stage seen as a particularly testing one since the controls and constraints of the Main House are lifted, leaving the resident vulnerable to temptation and relapse.

Progression from one peer group to the next is undertaken by individuals as they feel, and are deemed ready, to progress. Readiness depends to some extent on the length of the time the resident has been in the programme but also includes their ability/williness to 'open up' emotionally to others and demonstrate a commitment to the House, its rules and therapeutic programme. Progression from one peer group 'phase' to another involves a process of negotiation with staff and members of the peer group to which the resident is seeking entry. It culminates in a celebration meal, a 'rite de passage' in which the resident is formally received into their new peer group to embark on the next stage of their programme.

A resident's progression from the 'Induction' to the 'Interphase' Peer group is accompanied by an increase in privileges which in turn is accompanied by an increase in responsibilities for the running of the house and the welfare of newer residents. The Peer group structure dovetails with the Departmental structure to ensure that senior residents in the house take the major responsibility for running Departments. This ensures that both the physical and emotional work of the Community conforms to the principles of self-help. The model, as Rachael's remarks illustrate, allows staff considerable leeway

for what she terms 'intervention'. If one remembers that traditionally, staff in the Therapeutic Community would be recovered addicts, their role as the most senior and most privileged members of the community is logical. The wisdom of a logic which confers a good deal of power to individuals as a result of their seniority will be explored more fully below.

Having explored what I have identified as the principles and assumptions which underpin the Phoenix House treatment programme, the discussion now moves on to examine them more critically. My analysis will be informed by the principles of feminist practice, in particular - *'Redefining Social Problems'*, *'Challenging the Power of the Professional'* and *'Increasing Self-esteem'*.

2. The Goal of Abstinence

The abstinence model of treatment has many critics which span a broad spectrum of opinion and political positions and the concerns from a feminist perspective will necessarily take in some of these more general concerns. My analysis recognises that the problems with the abstinence model which I identify are not necessarily confined to a feminist perspective but they do logically follow from it. It is possible to identify four main areas of concern about the goal of abstinence from a feminist perspective:

I. It gives permission for high levels of control and constraint which are disempowering and which undermine self-determination.

II. It is a very hard task-master, difficult to achieve, and deemed impossible for those with low self-esteem.

III. The price of failure is very high, both in terms of self-esteem and in terms of women being able to continue to care for their children which is sometimes made dependent on their success in the treatment programme.

IV. It individualises and pathologises the problem of drug use. The emphasis is on change in individual behaviour and attitude, little or no attention is paid to the structural dimensions of drug use and the need for change at that level.

Control and constraint

I have set out in Part 1 of this discussion, the range of controlling mechanisms adopted by the Phoenix programme in order to ensure that the Community remains drug-free. Such high levels of control are, I would argue, deeply problematic from a feminist perspective. They are imposed on the client with little negotiation, as are the penalties which attach when the constraints are transgressed. They reinforce rather than challenge the power of an external authority, which in the self-help model is not intended to be 'the professional' but which, as I shall argue later, merely inverts rather than subverts the professional power structure.

But to take issue with the question of control and constraint, which a feminist perspective must do, is to leave unaddressed the very real problem of providing the refuge from illegal substances and the drug-using community which many residents genuinely seek. Perhaps there is an inevitable conflict between principles of practice

which seek to give individuals more power and more control over the treatment process in situations where illegal drug use is the issue. This conflict was illustrated very clearly in the following case.

Elli had been in the Family Unit with her son on my first visit for fieldwork purposes. I was struck by her resistance to staff and the impatience she expressed with being under scrutiny. In a 'Budgeting' meeting where residents were required to account for the past week's expenditure and plan for next, her impatience manifested itself in successful attempts to confuse and subvert the whole process.

By the time I returned to Phoenix to complete my fieldwork, Elli had completed the programme and was being supported by Annie, the newly appointed Outreach Worker. I accompanied Annie on one of her weekly visits and was struck by the way in which Elli referred to Phoenix as 'a prison'. But I was also struck by the quality of Elli's relationship with Annie and by the fact that she clearly felt indebted to Phoenix House. The visit confirmed Elli's resentment at the constraints placed on her when she was undergoing treatment, but also indicated that inspite of this resentment, she valued the programme.

I had yet a further encounter with Elli, when she subsequently visited the Family Unit (having left some 6 months previously) and was invited to join the current group of residents who were going on holiday later in the summer. This time I was struck by her immediate accession to Tony's (Unit Manager) request that she agree to undertake a urine test, to confirm her drug-free status, before accompanying the group on holiday. She readily agreed that it was only right that she should be asked to undergo the test and that it would be unfair to current residents if she was not scrutinised in this way. Time, it seems, had wrought changes in how Elli viewed the controlling aspects of the Phoenix programme. As a resident she resisted and resented them, as an ex-resident, well on the way to recovery, she felt able to readily agree to the request for a urine sample.

Elli's ambivalence towards the programme at Phoenix is interesting. On the one hand she experienced it as overcontrolling and 'prison-like', on the other she clearly valued the ongoing support it offered. Perhaps what Elli struggled with was the feeling that some of the controls she encountered were legitimate and reasonable, hence her ready accession to the urine test, but the overall burden of constraint was too heavy to bear. The problem perhaps lies in the fact that the controls in place to ensure the Community remains drug-free are overlaid by controls designed to bring order into the chaotic life of the drug user. This adds up to a heavy burden of control. Furthermore, it is a burden which has some relevance to those who define themselves primarily in terms of their drug use, who see themselves as chaotic and in need of control. It has less relevance for those who, like women with children, have multi-dimensional identities of which drug user is only one.

Elli's ambivalence also has to be understood in the context of a situation where women in her position have few options for treatment. As the primary carers of their children with little family support, they need to be able to take their children into treatment with them and Phoenix House has one of the few Units which offer this facility.

The goal of abstinence, the emphasis on leaving the past behind which this entails and the controls deemed necessary to bring it about, are a response to individuals defined

in terms of their drug-using behaviour. Women, particularly those with children, may have difficulty in relating to this 'master status' as drug user. It is a status which sits more easily, even to some extent enhances, a traditional masculine identity. It sits much less easily with ideas of conventional femininity. Drug use is seen and portrayed as an 'unfeminine dependency' (Perry, 1979) and thus threatens rather than enhances a woman's identity. For this reason women may resist the 'master status' of drug user. Or, they may simply be more inclined to define themselves in relation to others i.e. as wives/partners and as mothers rather than first and foremost as addicts. Constraints designed to control the chaotic addict by ensuring that the Community remains ordered and drug-free, may have less relevance to those who, while recognising their dependency, do not identify themselves solely or even primarily in terms of their drug use.

Self-esteem

From a position of dependency, the goal of abstinence is difficult to achieve. It requires a degree of self confidence and a belief in ones ability. Given that women's levels of self-confidence and self-esteem are generally lower than those of men, it is probable that the goal of abstinence, for women, appears more difficult to achieve. It may be that they will more readily resist the setting of such a goal, and be reluctant to enter treatment programmes where abstinence is the aim, because they do not believe they can achieve it.

Where a treatment programme which demands the goal of abstinence *is* embarked upon, the risk of failure is high. The risk is perhaps greater for women since failure is less easily accommodated where levels of self-esteem are already low. The goal of abstinence may deter women from embarking on a long-term treatment programme such as is offered at Phoenix House or it might exacerbate their feelings of low self-esteem where a programme is undertaken and the goal is not met. The way in which 'splittees' are regarded (see above) only serves to enhance feelings of failure and low self-esteem

Increasing self esteem is an important principle of feminist practice and one which the goal of abstinence appears to actively work against. The establishment of the Outreach programme has been important in mitigating a sense of failure and in providing a 'safety-net' for those vulnerable to relapse having left the safety of the Community behind. In the hands of a skilled worker, damage to self-confidence caused by failure to complete the programme or remain drug-free on completion can be limited, as was demonstrated to me by Annie's work with Elli. However, much depends on the individual making contact with the Outreach Worker which itself requires a degree of self-worth and a willingness to make demands.

The price of failure

For women who have children and who enter a treatment programme which aims for abstinence, the risk of failure can involve not only loss of self-esteem but loss of the care of their children. This was illustrated to me clearly by one particular set of circumstances which were played out during my fieldwork.

Pat had come into the Family Unit with her youngest daughter, after many years of using drugs and several failed attempts to overcome her dependency. Both her children had been placed with foster parents but when Pat decided to embark on a treatment programme she was allowed to move into the Unit with her youngest child. Some weeks after Pat's arrival, Sally moved into the Unit with her son, and the two women struck up a friendship. After one of their outings together they failed to return at the stated time and when they did return, much later in the evening, it transpired that they had made contact with drug users in the City, had bought drugs and used them.

After a good deal of discussion between the staff of the Unit, and the Social Services Departments involved in the care of the children before they came to the Unit, it was decided that both children would be taken back to into care, that Pat would be told she must leave the programme altogether and that Sally would be given the option of moving into the Main House with a view to being reunited with her son once her programme there was well underway. In the event, and after the intervention of the Project Director, it was agreed that both women would be given the option of moving into the Main Programme while their children were returned to their foster parents.

Neither of the women were involved in this decision-making process, an issue which I shall look at separately in my discussion of staff /client relationships, and were informed that their children were being taken back into care only when Pat's Social Worker had actually arrived. This was done to protect the children from staff fears that one or both of the women would take off with their children if they got wind of the decision that staff had taken about their futures.

Both women were devastated at the realisation of where their transgression of the abstinence policy had led. I too struggled to understand the reason and felt that to some extent these two women were paying the price for a number of other transgressions which had occurred in recent months and the feeling among Unit staff that **'we can't go on like this'** (Tony, Unit Manager). The feeling that the Unit's reputation as a drug-free refuge was under threat was clearly a important consideration in the staff reaching their decision. This was confirmed in Robin's taped interview with me:

> **"....it's important to keep the place empty of drugs. And I think that there's actually a marketing aspect in this as well, I think funders expect it at this moment in time." (Staff Member, Family Unit)**

This particular set of events demonstrated to me that the stakes can be very high for women with children who enter programmes of treatment which operate with a model of abstinence. Both the women, and particularly Pat, who was given no indication of when she might be expected to be reunited with her baby daughter, paid a high price for their failure to meet the goal of abstinence.

Pursuing this issue of the price of failure for some women coming into the programme in my taped interviews with staff, Robin confirmed that many came into the Family Unit on the 'last chance' basis.

> **Me: "Do women ever come into the Unit with their children on a sort of last chance basis?"**

> **Robin: "Oh yes. I mean...yes."..... "Yes, certainly. I think that it's not always explicit but I can think of one..two families in the last month that have come here more or less on that basis." (Staff Member, Family Unit)**

Similarly, in answer to my question about whether many of the women came into the Family Unit under threat of having their children removed if they did not do something about their drug use, both Tony (Unit Manager) and Cathy (team member) readily agreed that that was the case. Tony added that ultimately he would like to see the Unit "**as a Social Services referral centre**".

In setting a treatment agenda in which abstinence is a central plank, residents are under pressure to succeed. Failure to achieve the goal means something different for women because the custody of their children can be made dependent on their success. If the goal of abstinence is problematic in itself, it is doubly problematic when it is tied to women's ability to continue to care for their children. The closer relationship with Social Services, envisaged by Tony, would seem both to formalise and to increase the making of women's continued care for their children conditional on their success in the treatment programme.

I have tried to indicate some of the problems that the goal of abstinence poses for a feminist analysis of the treatment process. In addition to the problem of the way it legitimates a highly controlling treatment environment in terms of autonomy and freedom of movement, are the problems it poses for women with children who fail to achieve the goal. A further problem for a feminist analysis is the way in which the goal of abstinence confirms and reinforces the idea that drug use is a problem for the individual and one which the individual themselves must overcome.

Individualising Social Problems

There is ample evidence in the data to support the view that an underlying assumption on which the programme operates, is the notion of the psychologically damaged individual. A significant part of the programme is devoted to exorcising and resolving the personal trauma which is seen to be an underlying reason of an individual's retreat into chaotic drug use.

Dean (Team Member, Re-entry) saw the treatment programme as offering the opportunity for residents to undertake "**a personal odyssey**" which would result in personal growth and a greater level of self-awareness. He saw it as a journey which many, understandably, feared, as it was extremely painful and difficult.

Just as treatment was seen in individualistic terms, so the origins of addiction were seen as being firmly rooted in early childhood experiences:

> **"I would suggest, I wouldn't have figures at all, but I would very strongly suggest that the majority, if not all, persons needing to come to a residential long term rehab., have had, not just abuses of varying kinds, but...deep and perhaps long term, abuses - repetitive abuse and abuses." (Dean - Team Member, Re-entry House)**

This theme of abusive experiences, usually in childhood, as lying at the roots of addiction, was a dominant one. Most staff saw events in the early family life of residents as being implicated in their subsequent dependency on drugs.

In trying to account for why it is that some people become dependent on drugs, Rachael said she was thought problem drug use was associated with

> **"deprived childhoods, you know, emotionally or physically or both. You don't have to be in poverty to be deprived, it's more the emotional aspect of life that's important".**

She went on to say how she was struck by the high proportion of women in the programme who had been abused as a child:

> **I remember being very struck, it felt like almost a hundred percent of women to come through (the programme) had been sexually abused as a child. And it seems like they get into a whole set of patterns that is to do with having low self esteem and a lot of anxiety and not feeling trusting of people." (Team Member, Re-entry House)**

Craig also emphasised past life events as being an important reason why people use drugs, although he did allude to external pressures also:

> **"I think half the people use to escape...escape something in the past that they don't want to think about...and half because they're bored and they've nothing to do, there's no facilities for them."**

Craig raised the possibility of abuse being at the root of men's drug use, not just women's:

> **"I think that for some men, perhaps men who have been involved in some sort of sexual abuse, using drugs will be a way of getting involved in the male scene"[2]. (Team Member, Main House)**

Robin too, emphasised early traumatic life events in trying to account for the reasons why people became involved in problematic drug use:

> **"My experience so far is that everybody that we've worked with in this Unit has had really significant traumatic painful experiences of some sort or another...from their childhood. There's a high level of people having been physically abused, sexually abused, neglected...lots of people have lost really important relatives. They've been the dumping ground of their family's dynamic, so they've got damaged as part of their family process, growing up. And I think it's stuff like that that leads to very low self esteem and that leaves people with insufficient emotional**

[2] Craig also confirms here my earlier point, that drug use is part of the 'male scene': "..a lot of men use because its seen as macho to be able to use drugs."

resources to actually fight their way out of the corner they get into when they start to dabble." (Team Member, Family Unit)

The emphasis of the programme is on strengthening and increasing these emotional resources, repairing the damage sufficiently to enable individuals to manage their lives without drugs as a 'prop'. Drug use is constructed as a personal problem, a weakness which can be overcome by identifying appropriate coping strategies and developing greater levels of self-awareness. There is little attempt to look critically at the construction of drug use as a problem. Indeed, discussion of prescribing and maintenance policies and/or the illegal status of classified drugs, is actively discouraged among the resident group. Such discussion is seen as subverting the focus on abstinence as it is seen to indicate a continued need to participate vicariously in the world of the drug user, under the guise of political debate.

Some staff felt that the opening up of the issues surrounding drug use would be desirable, but recognised that this would be difficult to accomplish. Smoking cannabis is a particularly 'grey' area for some staff:

"We know that certain people have every intention of smoking dope when they leave here....." (And can they talk to you openly about that?). "They feel that they can't, unless it's in a group...and I don't mean a structured group, I mean in an evening review, for instance. That's safe because they can gang together, and it gets a bit difficult because it goes something like...'Oh, come on, there's no harm in smoking dope, I know loads of people who smoke dope and it doesn't give them any problems'. 'No', I say, but <u>your</u> drug use <u>has</u> given you problems. .. (Cathy - Team Member, Family Unit)

While Cathy recognises that in reality many residents will return to smoking cannabis on completion of their programme, her way of dealing with discussion of the subject is to warn of the dangers that might be encountered:

".. have you thought about how you're going to afford it...have you thought about the dangers of turning up stoned at school and being reported to Social Services....have you thought how you're going to get up in a morning when you're bleary-eyed from the night before, to get the kids to school...have you thought about who it's going to bring you into contact with?" (Team Member, Family Unit)

Craig felt that people should be able to continue using drugs recreationally, if that was what they wanted to do, but admitted that it was difficult to raise the issue in the context of the current Phoenix programme:

"If someone said they wanted to use drugs recreationally, the first thing that would happen is that they'd probably be put on a 'contract' to give them two weeks out to think about why they wanted to use recreationally, when they probably already know!". (Team Member, Main House)

Craig and Cathy's comments indicate the difficulties of engaging in a critical discussion of the issues and of challenging the concept of drug use as a problem. If discussion of recreational use and cannabis use is stifled, as the evidence suggests, broader questions which focus on the construction and portrayal of drug use as a social problem cannot be raised. This being so, the concept of drug use as a problem, which the individual must resolve, remains firmly in place.

The individualising of social problems which the goal of abstinence and the Phoenix programme more generally supports, is inimical to a feminist approach to treatment which seeks a redefinition of social problems. From a feminist perspective intervention should aim at raising awareness of the broader and gendered power structures which constrain individual action and subjectivity. It requires the focus for change to shift, away from the notion of personal adjustment towards a concern with identifying and transforming oppressive social circumstances and relationships.

3. Managing the Chaos

I have suggested that the Departmental structure has an important function in bringing order into the Community and simultaneously, into the lives of its individual members. It is certainly useful in ensuring that all residents, even the very newest, have a recognisable and clearly defined role. The daunting task of entering and establishing oneself in a large Community is probably eased considerably by being allocated a position in a Department.

The Departmental structure also has a very real practical purpose - it ensures the smooth running of a large Community - and it firmly establishes the 'self-help' principle. It also holds out the possibility of encouraging new interests and the development of new skills, in gardening, catering etc. which might provide a springboard for further training and job opportunities. But while there are obvious advantages to organising the Community into work-groups, the fact that they operate hierarchically, with a Department Head, Assistant Department Head, 'top' crew and 'bottom' crew, is problematic from a feminist perspective. Some of these problems were highlighted by one member of staff in her interview with me. While she recognising "**the value of varying amounts of responsibility which are gradually increased**", she expressed some concern about who the Departmental structure favoured and what kinds of values were being encouraged:

> **"The Phoenix programme...talks about increasing amounts of responsibility that are rewarded and I don't know what sort of merits we actually do reward. It can be the ability to be quite regimented and quite..I don't know...aggressively assertive perhaps? .....I think it's quite 'male'...I think it's a very male part (of the programme)....you know, to have little hierarchies with people at the top. And it (getting to the top) doesn't necessarily have to have anything to do with how well you do something. And I think the women that get to, say, Department Head position often have quite a hard time of it.(Rachael - Staff Member, Re-entry)**

Rachael did not express her concerns from a wholeheartedly feminist position.

> **"I would fluctuate between saying it's a gender problem and just saying it's a type of personality problem".**

Nevertheless, her comments reveal the concerns about what feminists would see as the gendered nature of the Departmental structure and its reliance on relationships of dominance and subordination. The same staff member makes the interesting point that the men in the Community are far more likely to have spent time in prison than the women. She sees this as pertinent in relation to which residents feel the most comfortable with the Departmental structure:

> **" People that are less able to be aggressively assertive will have problems (with the Departmental structure). I think that on the whole women will probably struggle with it more than some men. I mean, getting back to how much time you've spent in prison, in some ways the structure of Phoenix is very much like prison, a prison structure. And the men have had a lot of experience of it and are in Phoenix with the people that they were in prison with - or at least similar characters..... And they very quickly re-establish that hierarchy. Very quickly." (Rachael - Staff member, Re-entry)**

While to some extent the Departmental structure undermines the power of the professional since it is residents, not staff, who head up the work teams, it does nothing to challenge traditional power structures based on relationships of dominance and subordination. Departments, like sanctions, are seen as important in controlling the chaotic impulses of the drug user. Both are problematic from a feminist perspective.

The Department structure which is such an important aspect of the programme in the Main House, does not operate in the Family Unit. This is because the Unit is seen as being quite separate from the Main House and as having a different set of aims and objectives. This separation results in the Unit being far too small to make a Departmental structure viable.

To explain the lack of Departmental structure in the Family Unit purely in terms of its size, however, is to miss the opportunity for further questioning and analysis. The decision to separate out the two projects is not self evident. The Main House and the Family Unit both occupy the same site and there is no reason why Unit residents could not simply be part of a Departmental structure which covers work tasks in both houses. The reason for the separation lies in the fact that the therapeutic task is defined somewhat differently for Family Unit residents who come into the project with their children. The emphasis for them is on their private responsibilities as parents, rather than their responsibilities to their peers and the Therapeutic Community. As a consequence, their work tasks are defined in terms of the needs of the family rather than the Community, and it is this, at least as much as the Unit's size, which renders the Departmental structure redundant.

While the Department structure does not operate in the Family Unit, the concern with the chaos of the drug user's life is nevertheless strong. Indeed, the chaos is assumed to extend to the way in which children are nurtured and cared for and the day in

the Family Unit is ordered around private child-care and associated domestic tasks rather than the communal tasks to which work groups are assigned in the Main House.

These and other differences between the Main House and the Family Unit are central to my analysis and will be given further sustained attention below. For the moment it is sufficient to draw attention to the fact that the Departments which are a central component of the treatment regime in a setting where men predominate - the Main House - cease to be seen as either necessary or appropriate in a setting made up almost entirely of women and children.

The Concept of Voluntarism

The emphasis on personal and individual change, from drug user to drug-free member of the wider community, is a strong theme which underpins the treatment process at Phoenix House. As outlined above, the responsibility for bringing about this change is seen to lay with the individual. Staff and other members of the Therapeutic Community are there to support the resident, but finding the initial motivation and maintaining a forward momentum is seen as the individual's responsibility.

The notion of residents entering the programme and progressing through it under their own volition, sits alongside the concept of a controlled therapeutic environment. There are some clear and inherent contradictions here and, as one might expect, the controls have an undermining impact on individual initiative and voluntary action. A recurrent theme in staff meetings was a concern about the unwillingness of residents to take initiatives:

> "Today's 'clinical' was dominated by John's concern about the lack of requests from Community members for positions in the structure. Department Heads were seen to be failing in their duty to encourage members of their teams to put in memos to staff requesting changes in their departmental positions."
>
> (July 1994)

The same concern was expressed by Craig in his taped interview discussing resident input into the decision-making process at Phoenix:

> **"(Residents) get a say into the clinical. Every Department Head can hand in a memo of what they recommend for changes. But I can guarantee out of the five Department Heads and the Co-ordinator, you'll probably get the Co-ordinator and one Department Head bothering to put recommendations in.....the Crew are supposed to have an input through their Department Head. They should tell their Dept. Head what sort of changes should happen and the Dept. Head should then make sure that goes to the Clinical. (So that's how it should work?).. .Should do, but it doesn't". (Staff Member, Main House)**

A similar concern was regularly expressed in relation to resident's unwillingness to suggest ideas for activities at the weekends and in the evenings when most of them were "off structure".

"Arrived to do Cathy's interview to find that she had arranged for the women and children in the Unit to go to a museum of local interest. John was taking them in the mini-bus. Cathy spoke of the trip as very much her idea, she was "getting the women out of the house" lest they should decide to "doss in the house all day".

(July 1994)

During the interview Cathy expressed her frustration at the lack of initiative taken by residents in organising their free time:

> "Take this afternoon, for example, they'd be dosing down in front of the tele if I hadn't kicked them out. And it's....you feel like you're banging your head against a brick wall sometimes. Why don't they come to us and say 'can we do this, can we do that, can we go there, would you pay half ?'....It never happens, although they've been told that it's all right."(Staff Member, Family Unit)

This perceived lack of willingness on the part of residents to initiate work opportunities and leisure activities for themselves suggests that the controlled therapeutic environment makes it difficult for residents to take the kind of responsibility on which the success of their programme depends. In fact, the degree of control that residents have over the treatment process is heavily circumscribed and can only operate in the few spaces left by the highly structured programme. The rhetoric of self-help obscures the fact that this structure is largely imposed, and as such, undermines the will to self-determination.

Even where the constraints on residents are much looser, in the Re-entry stage of the programme, staff there worry about the lack of participation in the few group meetings which residents are obliged to attend:

> "I think they just think 'oh well, there's no point in saying anything'. Unless they really have some huge reservations or they feel that they would be personally affected by something going ahead, they just don't say anything. I mean, I often get a bit cheesed off with the amount of participation because we do, I think, provide quite a lot of opportunity for people to get involved and it just feels like they don't use it". (Rachael, Team Member, Re-entry).

Explanations for this lack of involvement are presented largely in terms of resident lethargy:

> ....they don't always have their say because they can't be bothered or they forget...or...I mean I suppose that it reflects how they used to live....." (Craig, Team Member, Main House)

Occasionally it is recognised as resulting from the 'institutionalisation' process but the concept is used broadly and vaguely. Little awareness of the way in which the programme makes conflicting demands on residents is apparent.

In general, then, there are strong currents in the therapeutic programme which undermine the process of self-determination upon which recovery is seen to depend. For

women who come into the programme with their children the notion of self-responsibility is further undermined by the responsibilities they have to their children. I have suggested above that it is not unusual for women to come into the programme under threat of 'losing' their children into the care of the local authority. This threat not only undermines the voluntary nature of their entry into the programme but also their willingness to stay and make progress. Louise's case throws these issues into sharp relief.

Louise had been implicated in another resident bringing drugs into the Unit and had been warned that if she broke any more house rules her licence agreement would be terminated. Cathy's account of the subsequent case-review with her statutory Social Worker indicated that it was made clear to Louise that either she "**stopped messing around and got on with her programme**" or they would take action with regard to her two children.

In maintaining that women in Louise's position choose to stay in the programme and are responsible for their own progress within it, the very real pressures that they are under are overlooked. These pressures come from a number of directions; from Unit staff, from statutory social work agencies and from women's own desires to be responsible mothers.

The voluntaristic principle which is a central feature of treatment is heavily compromised, both by the controlling aspects of the programme and by the pressures on women to enter, stay and succeed. Neither the constraints on its operation nor its gendered nature are sufficiently recognised in the Phoenix programme. The idea of self-determination is used too readily to absolve staff from grappling with some of the programme's inherent contradictions and with the gender issues which surround the treatment of women.

Self-determination is also undermined in less direct ways. The group therapy programme and counselling style at Phoenix House encourages confrontation and relies on residents being prompted by others to 'look at' personal issues. So rather than leaving individual members to bring their own issues to the group in their own time, other, often more senior members of the Community, will confront individuals with, for example, their attitude, their behaviour, or their silence. Many of the groups and counselling sessions I observed relied heavily on group leaders and group members giving unsolicited advise on what various members of the group 'needed to work on'.

> "Carol's feedback in this morning's handover gave me some insight into the nature of last night's group session. Much of it seemed to centre on the women 'getting on Kate's case' with regard to her relationship with one of the men in the Main House."
>
> (July 1994)

> "In today's Interphase group one member was confronted by staff for being willing to take on things put to him by staff but not things put to him by peers."
>
> (August 1994)

> "One of the reasons put forward for moving Sally into the Main House from the Family Unit was that she would get more confrontation about her behaviour, since there are many more residents there."
>
> (July 1994)

The issue of advice-giving masquerading as counselling was recognised by staff as a problem and in my fourth week of fieldwork I participated in a training session run by two members of staff for the Community. The aim of the session was to encourage a more self-directed style of counselling between Community members to emerge. My comments on the afternoon sessions included the following:

> "Craig and Roger's training workshop to try and tackle the problem of counselling being seen as advice-giving was a rather hurriedly put together session, but it had some useful points. I could see the value of this kind of training since peer group and resident-to-resident counselling is a cornerstone of the therapeutic programme. It was a pity it hadn't been approached more thoroughly and as part of an ongoing programme of training in counselling techniques."
>
> (August 1994)

A willingness to define the therapeutic agenda for others is seen most clearly, perhaps, in the use of 'contracts'. These are used when it is felt that residents are resisting treatment either by transgressing the rules of the Community or by 'blocking' feelings and obstructed the therapeutic process. I had an insight into why one particular resident had been given a 'contract' when she showed me the book in which she kept a record of events, thoughts and feelings associated with it. A member of staff had written:

> "The purpose of this contract is to help you build some self-esteem, have your emotional needs met in a way that is helpful to you and your peers, develop trusting relationships with your peers and free yourself of your 'guilty secret'."
>
> (July 1994)

Even where the aims of the 'contract' are drawn up with the resident concerned, which is increasingly the case, the need for the 'contract' itself is determined largely by others, usually by staff.

The therapeutic process then, is not entirely, or even largely self-directed. There are clear expectations that residents will bring personal and emotional issues forward and penalties if these expectations are not met. The ability to 'confront' is a valued commodity but while the importance of confrontation as a 'ground clearing' mechanism in a situation characterised by group living must be recognised, its value as a therapeutic tool is limited. Where it permits an individual's therapeutic needs to be defined by others, it distorts the therapeutic process and undermines the claim that the treatment programme is self-directed and self-determined.

Moreover, not only does a confrontative therapeutic style have the effect of undermining individual control over the pace and direction of treatment, it is also a style which is heavily gendered:

> **....the whole ethos of encounter groups where people scream and shout for an hour and a half and then walk out.....is all well and good for people with big voices that can scream and shout...but for those who can't, all it does is terrify them and they think 'this place is no good for me'." (Craig - Team Member, Main House)**

While 'big voices' are not the prerogative of men, it can be argued that men feel more comfortable in the type of situation outlined by Craig. Certainly, some of the women

members of staff felt that this was the case. In referring to the staff team in the Main House, Lesley, the Family Unit manager, described it as a "**macho team with a macho, confrontative style**" and Rachael, in her interview with me commented:

> **..these Communities seem to have sprung up around small groups of men and they've evolved by men taking the leading roles.... It doesn't feel very conducive to a lot of women... .we don't get a lot of women coming and there's not a lot of women stay." (Rachael - Team Member, Re-entry House)**

The willingness to encounter others requires a degree of self confidence and personal presence which women are less likely to acquire, given their subordinate status in the wider gender order.

4. Self-help

The self-help principle in the Therapeutic Community is held in place partly by the Departmental structure and partly through the Peer Group structure. The Departments, as has been suggested, establish the principle in relation to the practical work of the Community while Peer Groups establish it in relation to the emotional health of the individual and the group.

The aim of the Peer Groups, as we have seen, is to establish strong bonds of friendship and to encourage supportive links between residents at a similar stage in their treatment programme. It bolsters the Departmental structure, in as much as it is further insurance that all Community members will have a clearly defined friendship group with which to identify. The progression from one Peer Group to the next also enables residents to gain a sense of forward momentum through their programme.

Peer Groups can and do act as an empowering dynamic for residents since they emphasise the power of the group rather than of professional intervention, as a prime motor in the treatment process. An illustration of this process of empowerment at work was the Tribe peer group getting together and presenting a list of suggestions for changes in the programme, to staff.

> **"They've (the Tribe) put in a written memo and a list of things they think should change and they've asked for a meeting with staff to discuss it all. Which is good, because that's how things should work." (Craig - Team Member, Main House)**

From a feminist perspective, the concept of the Peer Group structure which operates at Phoenix has much to recommend it. It provides a strong counterweight to the power of the professional, it encourages resident co-counselling and it recognises the contribution of peers to the therapeutic process. A closer look at its operation and effect, however, reveals some serious flaws.

The first is that, while staff encourage the development of Peer Group friendships, they are also alert to the dangers of it providing a basis for subversion rather than enhancement of the treatment process. The risk of a negative (pro-drug use) rather than a positive (anti-drug use) Peer Group dynamic developing is most acute in the Re-

entry House where residents have much greater freedom of movement. This means that staff distrust of the resident group and unease about the 'health' of Peer Group relationships is never far below the surface.

The second is the risk of ghettoising the former drug user who establishes close links with his or her immediate Peer Group but who then finds it difficult to break out of the confines of an ex-drug user identity and status. The process is exacerbated by the programme's continued reliance on ex-users returning to the Therapeutic Community as paid members of staff. Since this practice is in many ways a hallmark of the Therapeutic Community, it is difficult to see how the problem of ghettoisation can be avoided. From a feminist perspective the problem is particularly acute since the numbers of women completing the programme are few and the opportunities for them to make links and form relationships with other women are that much more important.

The third problem, more specifically feminist in its concerns, relates to the impact that the Peer Group structure has on women's experience of the treatment programme. Women are always in the minority in the Main House and in the Re-entry House. During my period of observation women never made up more than a quarter of the Community and in the Re-entry Houses it was considerably less. Only one woman was resident in each of the two Re-entry houses at the time of my observations. When I enquired about the criteria used for dividing Re-entry residents between the two house it was clear that it varied. Sometimes it was deemed necessary to ensure some senior residents in each house, at others, the need to place Peer Groups together was paramount. At no time did the allocation of residents between the two houses seem to take account of the need to ensure that women were not isolated in a group of men.

The Peer Group structure has the effect of exacerbating women's invisibility in the Community by dividing them up between the groups. It was not unusual to find only one or two women in each of the groups and this can be further depleted where women are 'on contract' and excluded from day-to-day interaction with peers (though not from formal therapy groups). The Peer Group structure means that women are often isolated in a group of male peers and are forced to look to men for their main source of emotional and therapeutic support. Gender groups have been established in an attempt to address the issue of women's isolation and to recognise the different needs of men and women in the Community. These groups meet very infrequently, however, and have far less status or significance than the Peer Group.

The fact that the Community is structured into Peer Groups and Departments means that women's prime source of support will inevitably have to come from men rather than from other women. So while on the one hand the Peer Group structure would seem to conform to feminist principles of practice in as much as it challenges the power of the of professional, on the other it undermines feminist practice in a number of important ways. Peer Groups not only create a wedge between the women in the Community who are already in a minority, they also encourage Community members to relate to each other first and foremost as former drug users. This results in a gender blind approach which privileges the sharing of experiences as ex-drug users over experiences as women, mothers and partners. The Peer Group structure thus offers little opportunity for women to work together to develop their awareness of gendered power relationships and must therefore be considered problematic from a feminist perspective.

5. The Family Unit

My discussion of the principles which underpin the design and operation of the therapeutic programme at Phoenix has focused on the Main House and its Re-entry stage. Some indication has been given as to the ways in which the treatment programme in the Family Unit differs in its organisation, structure and focus. Since many of these differences are revealing in terms of the extent to which gender biased assumptions are operating, they warrant further and more sustained attention which the following discussion aims to provide.

Some differences between the Family Unit and the Main Programme are given, inasmuch as they are determined by funding and by buildings. (These 'givens' will be looked at more critically when I consider the issue of gender bias in relation to access to the rehabilitation programme offered by Phoenix House, but for the purposes of this discussion they will be accepted, uncritically, as 'givens').

The Unit is a recent addition to the Phoenix House portfolio. It was built in the grounds of the Main House and occupies a much smaller building which can accommodate four or five adults and their children. The Main House, in contrast, accommodates approximately thirty residents and the Re-entry House twenty. At any one time therefore there may be fifty residents in the Main Programme as opposed to the four or five in the Family Unit.

In addition to this disparity in size, the length of the residential programme in the Family Unit differs from that in the Main Programme. Family Unit residents spend approximately half as long - six months as opposed to twelve - at Phoenix House and their programme is not divided into stages. Hence, the opportunity to move into a Re-entry House prior to re-settlement in the wider community is not available. The shorter programme in the Family Unit is necessitated to a large extent, by the inclusion of children and the extra costs they generate. The lack of a Re-entry stage to the programme is similarly related to cost but also to the undesirability of moving children around too frequently.

These given differences - of size, length of residence and the inclusion of children in the Family Unit - provide the basis for the construction of rehabilitation programmes which differ markedly in their focus and organisation. A recurrent theme in my observation and interviews with staff was the marking out of the distinction and separation between the Family Unit and the Main House. There is a good deal of evidence in the data to suggest that staff were keen to establish a separate identity for the Unit and had to a large extent succeeded:

> Roger (Staff Member, Main House) was explaining the relationship between the Unit and the Main House to one of the male residents who had struck up a relationship with one of the women in the Family Unit. Roger stressed that the two were 'separate Units in the same grounds' and reiterated the point "The Family House is there, the Main House is here, they are two separate entities".
>
> (August 1994)

> Jane (Staff Member, Main House) was about to embark on the 'morning handover' when another member of staff asked her whether they would want to hear it, i.e. was it 'bad' news or 'good'. Jane replied that it was bad news for the Family Unit (referring to one woman's illness and to another's state of mind over her relationship with one of the men in the Main House) but not for the Main House. In setting out

the problems and then remarking "that's them, not us", she was making the distinction between the Unit and the Main House clear.

(July 1994)

A consistent theme in discussion with Unit staff and observations of their work, was their concern to have the Unit's separate identity both confirmed and respected. Staff felt that the Unit was seen to lack structure - and therefore control over its residents - and that there was little understanding of their role and responsibilities from staff and residents in the Main House. I was struck by the way in which staff felt that the Unit existed in the shadow of the Main House and expressed a concern to establish it as different to and separate from its 'big brother'.

> "We're getting to the point where we need, for the sake of the service, to be seen as a separate service, not just an addendum to Phoenix House."
>
> (Family Unit Manager)

Staff felt under pressure to adopt the principles and practices of the Main House but recognised many of them as being inappropriate to an environment which involved children in the process of rehabilitation. The "Therapeutic Community model of treatment" was singled out for criticism:

> "It isn't really appropriate for the client group, so that's what I've worked on for the last year, steering it in it's own direction because it has got a unique identity." (Tony - Family Unit manager)

There was pressure for the Unit to be re-established elsewhere, in order to confirm its separate identity:

> I think we've got a consensus throughout the Management group, certainly among the staff that I work with, that really the Unit would be best placed elsewhere, and an entire separation took place". (Tony - Family Unit Manager)

And as a move to separate premises began to look like a distinct possibility, it was greeted positively by staff:

> "I can't wait to move, I can't wait to move away from the monolith next door (i.e. the Main House)... because that's what it feels like." (Cathy - Staff Member, Family Unit)

While it is important to recognise the need to challenge established principles of practice in order to make the Unit operable and amenable to the needs of a very different client group, i.e. women and their children as opposed to single men and women, the outcome of the challenge was a somewhat different but, from a feminist perspective, equally problematic set of principles and practice. An exploration of the nature and extent of the Family Unit's challenge to established practice reveals that a significant change of emphasis emerged but that some underlying concerns remained firmly in place.

A challenge to established practice?

I have already pointed up the lack of Departmental structure in the Family Unit and have suggested that resident's time is structured around meeting the needs of their children rather than those of the Community. This means that a large part of a resident's day is devoted to taking children to and from school or nursery, cooking meals for their themselves and their children and doing related domestic chores. Group meetings take place each morning, after children have been taken to school, and each evening, once the children are in bed. In reality, children are often present at these times either because they are too young to attend school/nursery or because they are reluctant to go to bed and stay there.

More formal, staff led groups operate two or three times a week (depending on staff availability). At such times children are looked after by one of two Child Development workers on the team. The groups, like those run in the Main House, focus on the treatment needs of the individual and emphasise the importance of the group process in meeting them. In addition to these groups, which encourage a concern with women's emotional experiences and processes, Family Unit residents participate in group work with a more practical focus. Staff run a weekly budgeting meeting and an organised shopping trip which are designed to help the women manage their finances so that the family's needs can be met. Staff also run regular planning meetings with residents in order to ensure that the Unit is kept clean and tidy and that weekend activities are planned and organised.

There are some clear parallels between the way in which the Unit and the Main House operate. Both offer regular opportunities for involvement in staff led therapy groups, both offer regular opportunities for less formal group counselling sessions and both offer opportunities for involvement in practical activities designed to assist planning and organisational skills. The difference lies in the balance of activities and in their focus. Residents in the Family Unit devote a large part of their day and their week to meeting their children's needs. There is an emphasis on the need to learn how to parent, as an entry in the Unit's 'day-book' kept by staff, reveals:

> "I feel she's (Unit resident) learned she needs the Unit as a place to learn to cope with the children drug-free"

Improving parenting skills and recovering from problematic drug use are collapsed together so that the two become synonymous.

Residents are expected to be responsible for the care of their own children and opportunities for participation in activities and events which do not include children are strictly limited.

> "Nursery places have been obtained for the two 3 yr. olds in the Unit. They go two full days and three half days. But the days are quite short - 9.30 to 3.30.- and it takes Elli and Sally an hour to get them there and an hour to collect them. This leaves them little time to do much else. Sue's babe is entirely her responsibility, except when she attends staff -run groups two or three times a week. Even then, if numbers of children warrant it, a resident will need to stay out of the group in order to help staff look after the children. It seems that the priority is in reinforcing women's responsibility for children rather than on releasing them so they can work on their own issues."
>
> (August 1994)

Staff are alert to the dangers of residents seeing them as baby-sitters and child-minders. They are very clear that children are the responsibility of their mothers and are vigilant in their attempts to maintain and reinforce this responsibility.

> "Rather than leaving me to look after the children, Tony (Unit Manager) called Robin (Unit Staff) out of the review which was taking place with Mo (Unit Resident) and her social worker in order to look after Pat and Kate's toddlers. Robin's immediate response was to ask me what Pat was doing. I said she was helping Kate with a housing application and this seemed acceptable. Robin then played with both children for some time. When they wandered into the office, Helen (Unit Staff) responded by taking them next door to Pat and Kate clearly feeling that the women had had long enough on their own. I noticed that Helen collected Mo's two children from school and when I asked whether this was usual I was told that the children's mother would usually do it but as she was in an important meeting, Helen had taken on the task. It seems that the women need to have legitimate and approved reasons to be relieved of their child-care responsibilities." (August 1994)

> "Once the older children arrive home from school, the Unit's play facilitates are under siege. This afternoon a tussle over bikes developed and I jokingly suggested that more bikes, or some training in negotiation skills was needed. Tony's response was to ask 'where are the mothers?'....'it would be useful if mum could get involved'. Robin is reply to this was **'If she can stir her stirrups'**. The exchange indicated both the emphasis that is placed on the women themselves taking on the tasks of child-care and staff's concern that they will shirk this responsibility where opportunities arise.
>
> (August 1994)

As my observations progressed it became increasingly apparent that staff saw their role as encouraging rather than relieving women in their child-care responsibilities.

> "Robin and Helen are very skilled child-care workers but it is clear that child-care input is fairly strictly confined to that which is deemed necessary by staff. Today's activity - a visit to Chatsworth - was planned by staff who participated fully in the care of the children. For example, Helen took charge of Suzie in the van when she got fractious, Robin pushed Kelly's pram up a long hill and Helen took her to play with the ducks while Pat sat in the shade. But child-care seems strictly rationed and attached to activities which staff identify as needing childcare support."
>
> (August 1994)

Confirmation of the importance placed on women retaining responsibility for their children was gleaned from interviews with staff:

> **.. ...other than in maybe, individual counselling or groupwork where the adults are directly with the workers, away from the children, the whole emphasis is to keep the parent fully responsible at all times for their children." (Tony - Unit Manager)**

In observing the work of the Unit I was struck by the way in which childcare dominated the residents' daily activity and treatment agenda. In contrast, the day in the Main House was dominated by group and Community activities, with a clear emphasis on self-reflection and self-responsibility.

The rhythm of the day in the Unit had a different tenor to that in the Main House. It was less dominated by an established pattern of events and the structure that was brought to bear on the day in the morning meeting (itself a rather hit and miss affair) was

likely to be blown off course by unforeseen events. While the Main House tried to mirror the structure of a working day, the Family Unit was characterised by an ebb and flow of events which were difficult to foresee, regulate or control. This led to a view of the Unit as rather chaotic.

Given the fact that the bringing of order into chaos is fundamental to the effective operation of the Therapeutic Community, the Unit sits uncomfortably alongside the more ordered Main House. It is this discomfort perhaps, which generates a concern for separate identities and a concern on the part of staff in the Main House (see Roger and Jane's comments above) to distance themselves from their disordered sister.

Unit staff's response to the chaos, and the anxiety it provoked was more ambiguous. To some extent, the chaos was regarded as a healthy sign, an indication that life in the Unit was more akin to 'real life' and of staff's abilities to work flexibly and creatively. But this was overlaid by a struggle to bring order into chaotic habits, particularly in relation to childcare and associated tasks. The chaos of the Unit was deemed by staff to be symptomatic not so much of family life per se, but of drug use and its undermining impact on women's ability to function efficiently as mothers.

> **... there will be deficits in...there will be areas of parenting which the parent needs to address and change, and that's another set of problems. Plus, on top of that there's always chaos because the sort of...the using life is a chaotic one, so there's establishing, actually, your child needs organisation, your child needs structure." (Robin - Unit Staff Member)**

Other interviews with Family Unit staff offered further confirmation of the concern about a "parenting deficit" and of the emphasis placed on re-establishing family relationships. In answer to a question designed to get staff to identify the aim and purpose of the Unit, Tony replied:

> **"It offers the opportunity for people to really look at their situation within the family without the pressures and interferences of other things. That is to say that people usually come from chaotic circumstances, usually because of drug use or even before drug use, but the situation has broken down and often grandparents have been involved in child-care quite significantly and there's usually partners, specifically male partners, who have their part to play in the pattern of things not really being as right as they could be". (Unit Manager)**

Later in the interview, Tony made an even clearer statement of the focus of the Unit's work when he spoke of "**parenting and child development**" being "**the primary issue**". He went on to say:

> **..what we ought to do is say, right, the drug using is a secondary issue to the primary concern of the family breaking down completely, or continued behaviour in the family being quite destructive. Our primary aim in working with the children is to help them address the issues that have come up for them within their little lives up to now with a view to actually giving them**

> some understanding of that to go forward with. So I think, if we had a mission, it would be to stop the cycle of abusive relationships within the families."

Other staff, similarly emphasised the centrality of the family as a focus for therapeutic intervention:

> "The most important thing we do is that we help the process of the families that come in, to happen.....people come in here with their family and we work with the process, we help them to understand it, we help them to change it, we help them to be more comfortable and secure with it.....I think that's the biggest thing we've got to offer".

and:

> "The work is with the women's family process". (Robin - Unit Staff Member)

Cathy felt that the Unit offered:

> "....a chance to be in a safe place, get the support they need, the chance to work on their addiction and the reasons for it but the effects that it has had on the children...on the child care, as well. To learn how to be a parent really. And to be a drug-free parent as well."

And in replying to a question about the focus of the work, she responded:

> "I think it changes from day to day according to what people's needs are. Some people will need a hell of a lot of input about just caring for children's emotional needs. I'm saying that because that came to the fore today really. Sometimes the focus has to be on basic things, like children's diets and hygiene and nappies and all those things." (Cathy - Unit Staff Member)

As well as some clear statements of focus in respect to the work of the Unit, some interesting uses of language, which reveal a lack of attention to women as individuals, can be discerned in the above extracts. First, there is an inclination to render women invisible by referring to 'family' responsibilities and 'family' relationships when what is being referred to primarily, is women's relationships with, and responsibilities for their children. Secondly, the use of the word 'people' is noticeable and disguises the fact that the Unit works largely with women. And thirdly, the temptation to refer to individual women as 'mum', as evidenced in my account of the incident regarding the sharing of bikes (see above) and further revealed in interviews, indicates that staff tend to loose sight of women's identities as individual in their anxieties about their responsibilities as mothers.

In addition to the Unit's focus on parenting and child-care responsibilities as opposed to that of self-reflection and self-responsibility in the Main House, further differences can be identified. Staffing levels, and the degree of surveillance and intervention are markedly higher in the Unit than they are in the Main House. A large resident population in a large house with a relatively small staff group, together with a deliberate attempt to generate self-help networks among the client group, means that

residents in the Main House are under less scrutiny from staff than residents in the Family Unit. A more overtly interventionist policy operates in the Unit, as was clear from my discussions with the Unit Manager:

> "Tony sees the Unit as a Community House but not as a self-help project. He feels that they are working with vulnerable people, many of whom are being given a last chance to retain care of their children. For these reasons, he feels, residents need a lot of staff involvement arid staff attention and the Unit can't rely on input from other residents in the same way that the Main House does."
>
> (July 1994)

Women in the Unit have readier access to staff and there is a marked difference in the level of staff involvement with residents in the Unit as opposed to that in the Main House. That this greater level of involvement is often appreciated by residents, was apparent. However, high levels of staff availability can undermine the very processes of self-reliance and supportive networks which is the hallmark of Phoenix' approach to treatment. In fact, the women in the Unit did seem to offer one another very high levels of support, despite the more interventionist stance of staff. Nevertheless, staffing levels and practice in the Unit indicates an assumption that the treatment needs of women and children are substantially different to those of the residents in the Main Programme. They are deemed to be more vulnerable and therefore more needy in terms of staff time and intervention. In my view, this jeopardises the values of independence and self-reliance which underpin the Main Programme and indicates the operation of gender bias.

Conclusion

I have outlined what I consider to be the main differences between the Family Unit and the Main House in terms of their professional ideology and practice. The concluding section of this discussion explores some of the consequences of fostering a sharp distinction and separation between the Unit and the Main House.

One of the most apparent consequences of the separation is the way in which it further divides the women who enter the Phoenix House Community. I have suggested that the problem of women's minority status in the Community is not helped by a Peer Group structure which divides up the small group of women between the three Main House Peer Groups. The separation of the Unit and the Main House serves as a further wedge between women. Given that the experiences and backgrounds of the women in the two programmes are often remarkably similar, the separation is a rather false one.

Many of the women in the Main Programme have children who, for a variety of reasons, including lack of Family Unit places, are being looked after elsewhere. Referring to the women in the Main House, Cathy remarked:

> **"Some of them were referred to us initially. Couldn't get the funding for the children, so they go in there (the Main House)." (Cathy - Staff Member, Family Unit)**

To a large extent the only difference between the two groups of women is that Unit residents have their children with them whereas Main House residents do not. Moreover, as a woman's programme in the Main House progresses, she will have her

children to stay regularly at weekends. Once this happens, the separation between the two groups of women seems increasingly arbitrary and lacking in logic.

However, while there is a formal emphasis on separation, a good deal of contact between Unit and Main House residents does, in fact, take place. This is particularly so at weekends when residents have fewer formal demands made upon them by the treatment programme. Staff levels are low and there is an emphasis on recreational activities. This enables a good deal of informal contact between women in the Unit and women in the Main House to take place. I observed, for example, that a Saturday visit to the local park involved both women and children from the Unit and women in the Main House who had children on a weekend visit. It is nevertheless significant that this contact took place in the spaces left by the more formal rehabilitation programme which, as we have seen, was keen to establish the principle of separate and distinct groups of residents following different programmes of rehabilitation.

The emphasis on separation results in women who share a good deal of common ground being offered markedly different programmes of treatment. It also means that there is a failure to capitalise on opportunities for building support networks amongst the women in a programme where the numbers of male residents are always much greater.

I had a number of insights into the extent to which women in the Main Programme and women in the Unit share experiences and concerns, as the following extracts from my fieldnotes indicate. The first extract is a record of a conversation with the only female resident in the Re-entry House at the time. I was interested to discover her views on this aspect of her Re-entry experience:

> "Tina said she hadn't appreciated or sought women's company until very recently but that she had realised last night how much she enjoyed talking to Sally (Family Unit resident). Tina said that she had talked to Sally about her weekend with her children who are currently being looked after by her parents. She explained that for the first time she had felt comfortable having them and sad when the time came for her parents to take them back. Previously she had felt only relief."
>
> (September 1993)

My conversation with Tina revealed that she was grappling with some important issues around her identity and responsibilities as a mother, issues common to both residents in the Main Programme and residents in the Family Unit. Her discussion with Sally, however, was the result of a chance encounter rather than a conscious attempt by the programme to identify and develop links between women as a therapeutic device.

The issue of shared concerns between women in the Main House and women in the Family Unit was further highlighted by a set of circumstances surrounding the death of a women who had left the Main programme prematurely.

> "Residents in the Main House were formally informed this morning of B's death, but the women in the Unit only received the news from a chance encounter with a Main House resident. Mo and Kate were angry and upset that they had found out about B's death in this way and our conversation this evening was dominated by their concerns. It became clear that Mo and Kate knew B and recognised her as someone with very similar problems to themselves; she had two children, was the same age as Mo, but was in the Main House not the Family Unit. Mo made it clear that she felt B was not receiving the support she needed, support that they in the Family Unit could

have offered: "We could have helped her - you know what I mean?" (Mo). "She needed help man, and she didn't get it" (Kate).

(July 1994)

My conversation with the women in the Family Unit revealed their awareness of the common ground that existed between them and the women in the Main House. It also illustrated the way in which the potential for establishing networks of support among the women in the Community is under-mobilised. Chance encounters brought Mo, Kate and B together, but there was little evidence of more formal encouragement to creating and sustaining links between women or of such links being seen as a core element in the therapeutic process. In fact, what links there had been - a weekly women's group which included women in the Unit and women in the Main House - had long since been severed. In explaining why the joint Women's Group had been abandoned, Cathy commented:

> "There was a trial scheme at one point where.....women from here would go over there to the Women's Group. Now on the surface that seems a really good idea until we start thinking about it a bit more, and then try and do it. People over there are doing a completely different programme, a lot more introspective and 'deep and meaningful' than over here, because basically, we haven't got the time to do all that and everything else that needs doing. We have to prioritise what we can do in the time that we've got. What's more, while on the one hand we were saying to people, look, you mustn't form relationships with men or women over there (on the other hand we were saying) but once a week at a certain time we'll take you over there and you can sit in a room with complete strangers and talk about your deep innermost feelings. And when I actually did it once, I was embarrassed. Our women thought they were on another planet, they didn't know what was happening, they didn't feel safe, they were in a strange environment with a load of strange people who were well versed in the therapeutic process." (Cathy - Staff Member, Family Unit)

Cathy's comments confirm the difference in focus between the work of the Family Unit and the programme in the Main House. They also reveal how this makes it difficult for women to identify common themes and common bonds upon which group processes can build. Cathy sees the experience of trying to run the joint group as confirmation of the lack of connection between the women in the Unit and the women in the Main Programme, a perception belied by Tina, Mo and Kate's comments. The lack of connection which Cathy identifies is manufactured by the way in which the programmes are organised and orientated. Her comments make some recognition of this, but there is no attempt to consider that it might be problematic and operate against women's interests. Rather, the experience is taken as confirming the necessity of separation.

The separation of the Unit and the Main House, then, is problematic from a feminist perspective since it places a wedge between the women in the programme. It indicates a failure to recognise the potential for change which is unlocked in the process of women developing an awareness of their common ground and shared oppression.

Further problems with the separation of the Family Unit and the Main House can be identified. In order to maintain the separation, the boundaries between the Unit and Main House have to be carefully constructed and policed. A good deal of staff time and energy is devoted to ensuring that male residents in the Main House keep the required distance from the Unit and do not enter the premises without permission. Similarly, Unit's staff concern about maintaining boundaries often manifests itself in a concern about women striking up relationships with men in the Main House.

> "Tony (Unit Manager) expressed concern about sexual relationships developing between men in the Main House and women in the Family Unit."
>
> (July 1994)

> "Jenny (weekend relief staff) reported on events over the weekend in the morning handover. Kate's (Unit resident) relationship with Frank (Main House resident) was raised. Hardly a handover passes without some mention of illicit contact between the residents of the Family Unit and residents of the Main House."
>
> (July 1993)

The result of these and similar concerns is that the women's sexuality is subject to surveillance and men are cast in the role of sexual predator.

> "At today's morning handover Carol (Manager, Main House) expressed concern about two male residents at the Family Unit gate at 11.00 p.m.. They were told that this wasn't to happen again and sent back to the House. Tony added his concerns about the fact that there were four vulnerable women in the Unit who would not benefit from the attentions of men in the House, particularly at the gate late at night. Tony took up the issue with John (Manager, Main House) after the meeting, who decided that an announcement to the Community was now appropriate, along the lines that women were to be left to get on with their programme and were not to be pursued."
>
> (July 1994)

There was little evidence to suggest that the issues raised by the incident (one of a number), provided the material for a series of Men's Groups and a basis for raising men's awareness of their role in sexual relationships and sexual encounters. Rather, they were defined in terms of issues of control and reinforcement of boundaries, a definition which confirms rather than challenge the gendered power relationships which characterise heterosexual relationships.

Anxiety about the development of sexual relationships between women in the Unit and men in the Main House is key to understanding the concern to keep the two groups of residents separate. The insistence on separation is closely connected to the need to control male residents' access to the Unit. In the concern to protect the women in the Unit from unwanted male attentions, the development of valuable links between the women in the two programmes is, as I have demonstrated, obstructed.

The final concern raised by the separation of the Family Unit and the Main House centres on the way in which the separation relieves the Main programme of the responsibility for reviewing its operation in the face of changing needs. By creating a separate Family Unit, the responsibility for re-orientating the treatment programme more generally and making it more responsive to women's needs, is side-stepped. Constructing the Unit as different to and separate from, the more established Main programme, deflects the challenge that bringing women and children into treatment presents. Rather than a radical reappraisal of the ability of the treatment programme to

meet the needs of all users, and a consideration of the gendered nature of treatment that this reappraisal would necessitate, an annex is created to contain the challenge. Moreover, the Unit is referred to as a Family Unit, rather than a Unit for women and children. This ensures that the gender bias which underpin the provision of treatment remains firmly in place and that women's needs are further annexed.

ACCESS

While much of the feminist literature on health and social care, as has been suggested elsewhere, is concerned with the way in which services are too ready to involve women and make them the focus of health care or social work intervention, the concern in relation to drug misuse services is quite different. The issue here is the under rather than over-representation of women as clients.

Women's under-use of services has been addressed in one of two ways. Services have either been set up specifically for women or existing services have tried to become more woman-friendly in order to encourage women's increased involvement (Doyle et. al., 1977; Mandel et. al., 1979). The former have either been inspired by feminist concerns to provide a woman-centred service (Henderson, 1990; Marsh, 1981), or have been modelled on the mother and baby units that were developed in the US in the mid-1970 (West et. al., 1981).

The following discussion examines the ways in which Phoenix House has responded to the current of concern about women's under-use of services. Like the CDT, Phoenix inclines towards a strategy characterised by concerns to encourage 'equal opportunities', and while recognising the limits of this approach, some assessment of how successful it has been in increasing women's access to the service is warranted. In making this assessment I demonstrate how an 'equal opportunities' initiative developed into something much more akin to the mother and baby units identified above.

Women's under-involvement in Phoenix House, and in Therapeutic Communities more generally, is an on-going concern. An early attempt to attract more women into the programme involved establishing a women's helpline and publicising the service through a variety of formal and informal networks. Twelve years on, a working-party from amongst the staff group, has been established to take a fresh look at the programme and revisit the problem of women's under-involvement. An invitation to participate in some of these working-party discussions gave me an insight into the organisation's commitment to designing a more woman-friendly environment and into the strategies being considered to bring this about. While a detailed concern with these proposals - still in embryonic form - is beyond the scope of this discussion, it is important to acknowledge a commitment to change in order to improve both women's access to, and ability to complete, the programme.

1. Access to what?

An important initiative aimed at increasing women's access was the setting up of the Family Unit. Prompted by a concern that women's responsibility for children made it difficult to access a residential programme of rehabilitation, ways of accommodating children were explored. The result was that a cottage and some outbuildings in the grounds of the Main House were extended into a Unit which could accommodate children. At an early stage in the development of the Unit, it was considered important to establish the principal that, while women would undoubtedly form the majority of the Unit's residents, it could be accessed by men who were parents. The need to increase women's access to rehabilitation was thus overshadowed by the perceived need to allow men access to the Family Unit. This policy decision was an important first stage in

substituting the relatively straightforward aim of increasing women's involvement in the existing programme (modified to take account of child-care responsibilities) to a much more ambitious attempt at establishing a very different programme of rehabilitation for women and men with children.

My observations of the work of the Unit suggested that for extensive periods women and children were its sole occupants and that where men were involved, they usually came as partners of women residents rather than as single parents in their own right. It could be argued that, in terms of access, the inclusion of partners may encourage individual women to participate. On the other hand, given that men are vastly over-represented in the Main Programme, a woman-only policy in the Unit could have been justified on the grounds of going some way to equalising access. A policy which insisted on men's right of access to the Unit indicates a weak commitment to prioritising women's access and opened the way to shifting the emphasis away from women's participation in the programme traditionally offered in the Therapeutic Community, to a concern with family relationships and family functioning. It would appear that women's increased involvement is only tolerated where men's right of access is retained and that the notion of men giving up rights of access in order to accommodate more women is resisted. This resistance is reflected in the Community Drugs Team's reluctance to curtail men's access to the service in order to establish women only sessions.

The effect of a policy decision to establish a Family Unit rather than an annex which could accommodate women and their children resulted, as I have demonstrated in my discussion of *Professional Ideology and Practice*, in women with children having access to a different service than men, single women, or women whose children are looked after by others. Thus, a development designed to give women greater access to Phoenix's established programme of treatment, resulted in them being offered an altogether different opportunity.

This need not, in itself, be problematic. It could be argued that the principle of equality could usefully give way to that of difference. However, the result is not the woman-centred service that the politics of difference aspire to, it is a service which, unlike the traditional Phoenix programme, adopts an interventionist social work model of practice; a model which uncritically incorporates patriarchal definitions of women's needs and how best to meet them. From the point of view of access the establishment of the Family Unit has done little to encourage women's involvement in the traditional Phoenix House programme. Nor has it provided a woman-centred service committed to feminist principles of social care.

Recent developments seem set to ensure that women with children continue to access a service very different to that offered by the TC. Not only have new, much larger, premises for the Family Unit been identified, well away from the Main House, but the overall responsibility for the Unit has shifted, away from the local Director of Phoenix House to the Regional Director of the national organisation. In assessing the significance of this shift, account needs to be taken of the Directors' backgrounds. The local Director is in many ways a testament to the organisation's self-help philosophy, since he has a background of involvement in drug use and in the traditional Phoenix House programme, whereas the regional Director has a professional background in social work and social work training. The fact that responsibilities for the Family Unit and the Main House have now been divided in the way that they have, lends support to my suggestion that women with children entering the Family Unit are being offered a social

work service rather than an opportunity to address their drug-use supported by the Therapeutic Community. Whatever the problems of the T.C., and there are undoubtedly many, it has, historically, posed a challenge both to paternalistic social work models of intervention and to hierarchical medical models of treatment. The hiving off of the Family Unit suggests that where women and children are concerned, a social work model is imposed.

It is important to recognise that the establishment of the Family Unit singularly fails to provide a challenge to the male-dominated T.C. In terms of anti-oppressive practice there is little to choose between the masculinist assumptions embedded in the design and operation of the TC and a social work model of intervention which uncritically incorporates a familial ideology. Had the initial challenge to the male dominated TC survived intact, the inclusion of women and children in the traditional programme may well have provided precisely the lever that was needed to bring about change. The establishment of the current working party is perhaps a recognition that, with the establishment of the Family Unit as a separate project, the original impetus for challenge has been lost and there is a need to try and regenerate it.

2. The Family Unit

Having suggested that a different service has been developed for women with children, it is important to explore some of the details of that difference in relation to access. I have noted elsewhere that the Unit offers far fewer places than the Main House and the programme is much shorter. The pressure on places is such that prospective residents have to be put on a waiting list, something that rarely happens in the Main House. The risk attached to waiting is high for the chaotic drug user, since an initial motivation to enter treatment is quickly lost. Phoenix House has traditionally operated a policy whereby a period of short detoxification is quickly followed by entry to the T.C. This lessens the risk of relapse and loss of motivation for change. The shortage of Unit place means that this policy cannot operate, as my observations confirmed:

> "The main issue at today's staff meeting was throughput of residents in the Unit. Concern was expressed that the waiting list of funded applicants stretched until April of next year (i.e. a period of nine months).
>
> (July 1994)

The move to the new Unit will undoubtedly address this pressure on places. It will also provide day-care places which will enable the programme to extend beyond the six-month residential period where appropriate. To this extent the new Unit will improve access to the service for women with children and provide support for a period of time closer to that enjoyed by residents in the Main Programme.

In addition to the restriction on the number of adults the Unit is currently able to accommodate, there is also a restriction placed on the ages and numbers of children who can be admitted. Children over ten are not considered, and it is unlikely that more than two children from any family will be taken, due to the restricted bed-spaces. This means that women with older children, or more than two children, still face the problem of having to make arrangements for them to be looked after elsewhere. During both my periods of observation in the Unit I noted that two of the women - i.e. approximately

half the resident population - had the youngest child with them but had other children being looked after by relatives or foster parents.

Further restrictions on access to the Unit derive from funding arrangements. The cost of an adult placement in the Family Unit is substantially higher than that in the Main House (£350 as opposed to £235 in 1994) and when this is added to the cost of a child's placement - £259-£308 depending on age - a place for a woman in the Family Unit is significantly more expensive than a place in the Main House. Under recent Community Care legislation somewhere between £90-£120 (1994) comes through the Department of Social Security, leaving the remainder to be found by the local authority, sometimes in conjunction with the Probation Service. The shortfall between DSS entitlements and actual costs is very substantial in the case of a Family Unit placement and funding seemed to be something of a lottery. Tony (Unit Manager) talked about having to 'hoike' round for funding, from the Health Authority, Probation, Social Services and in the case of one child, funding had been cobbled together from a variety of charities.

My observations of interviews for prospective Family Unit residents gave me further insight into this funding minefield:

> "Emma's interview revealed difficulties in gaining funding for children. Emma originally wanted to come into the Unit from Liverpool with her three daughters but this proved to be prohibitively expensive. Maggie, Emma's social worker who accompanied her to the interview, said that to fund the three children would have taken the whole of the child support budget for her area. She did manage to secure funding for Emma and her baby daughter but she remarked 'I've had to dance on my head to get it."
>
> (July 1994)

I also had an insight into the difficulties of funding for children from another perspective. My interview with Jackie at the Community Drug Team revealed the difficulties she experienced in getting funding for one of her clients who wanted to enter a programme of residential rehabilitation:

> **"Anybody wanting to go to rehab at the moment...there's no problem because there's money available for adults. And about three blokes have already gone. No problem. Done the assessments, they've been appropriate and they've gone. We've got it funded through Community Care monies. But I've got a young woman who's got three kids who wants to go to rehab. ....a predominantly female rehab that takes kids. It's got a very good reputation for working with women who've been abused etc..... Surprise, surprise, she can't go because she's got three children and money for the children comes out of the children's budgets, hers comes out of the adult budget. The adult's budget's got the money, the children's hasn't.... Absolutely classic stuff. And we put all the arguments forward...'she's been denied a resource because of her gender.' You know?**

But the interview also revealed Jackie's reservations about the need for the high levels of children's funding required by treatment services:

Jackie:" But I do have some sympathy with them (Social Services) saying 'you can't blame it all on us'....how can a rehab justify £210 (1993) per week per child? I must admit I just think that's iffy.....I think...somewhere or other rehabs have got to get real as well, to be honest."

D:" Mmmmm...Unless they're providing a very high level of childcare perhaps?"

Jackie: "Well that's what they say they do, but my argument is, as is Social Services, these kids aren't particularly disturbed. They don't need a high level. They will be (disturbed) if we leave them where they are much longer but at the moment they're just naughty kids that need to be with their mother, where their mother is able to look at her drug use and offer them some stability. And the kids will slot into that.....they don't need a high therapeutic input and key workers and child development...." (Jackie, Community Drug Team)

The latter part of Jackie's interview reflects a concern, which I have explored elsewhere, about the assumption that children of drug-using parents are damaged and in need high levels of expert care. Not only is the assumption problematic in itself, it also seems to justify high charges which preclude some women from accessing the service.

Financial pressures on the organisation, mean that bed-spaces in the Unit have to remain occupied and that places are offered to those whose funding is secure. Cathy's letter of an offer of a place to Sally not only made it clear that the place depended on funding being forthcoming, but that available places were allocated on a 'first funded' rather than needs basis. Her letter stated:

"...the first family to furnish us with funding will be allocated a place."

A further issue in relation to funding was revealed when I was given access to resident's files.

"A note on Sally's file revealed the funding implications in relation to the discharge of a care order on a child. Discharge of the care order on Tom and the removal of his name from the 'at risk register' was mooted by the social worker involved in the case, but although his name was taken off the register, the care order remained in order to make it easier to obtain funding for treatment at the Family Unit. "

(July 1994)

This suggests that the need for funding ensures that the children of drug-using parents are drawn into, or kept in the statutory welfare net. It is difficult to see how entry to the Unit can be achieved without the sponsorship of social workers, since they gatekeep the funding of placements. This has serious implications for women wishing to enter treatment with their children. It means that their problematic drug use effectively becomes redefined as a child-care issue.

3. Main House

Gender imbalance in the Main Programme is very marked. During my fieldwork observations I noted that the ratio of male to female resident was approximately 4 : 1. This imbalance may deter women from seeking access but it is perhaps more likely to have an impact on retention rates.

In comparison to the Family Unit, funding for residents in the Main House is more straightforward, but with the introduction of Community Care legislation, it is by no means guaranteed. As in the Family Unit, placements depend on the availability of funding. I noted that at the time of my observations, it was policy to waive the weekly 'top-fee' of £50 for women and for those from ethnic minority groups, in an attempt to increase their participation in the programme. But while it is easier for women to obtain funding in order to access the Main Programme, child-care responsibilities may prohibit their involvement.

Women with children wishing to enter the Main Programme are dependent on either local authority fostering or relatives. Contact with children, once women enter the programme, is, as I have demonstrated, restricted and often difficult. Even telephone access, particularly in the early stages of the programme, is monitored and restricted, and tends to be regarded as a privilege.

Like women's under-representation in the service, access to children, for both men and women, is an on-going source of concern. Historically, the therapeutic community was developed to meet the needs of a different generation of drug-user - predominantly male, single and living in the largest cities. Its structure makes the involvement of children or other family members difficult to manage successfully and as I suggest elsewhere, the hiving off of the Family Unit means that the management of child-care in the project has been side-stepped. However, the problem of accommodating child visits at weekends remains. With increasingly large numbers of both men and women in the programme demanding contact with children, the issue has become pressing and the staff training day described below, to consider the issue of child-care, has now developed into a working party. This indicates a commitment to addressing the issue, but how far it is resolvable within the context of the current structure, is not at all clear.

The problem is exacerbated by a policy which favours the participation in a programme of rehabilitation which is geographically removed from the user's home town.

> **"...people...who are living in the local area....seem to find quite some difficulty in staying and completing their programme. I think that's because of knowing people...for accommodation...or whatever....so a person needs to be looking a relocating." (Dean - Staff Member, Re-entry)**

It is a policy which prioritises the importance of the user becoming detached from fellow drug-users over the need to be within easy reach of relatives or foster parents who might be looking after children.

Women's access to the Main Programme is undoubtedly affected by their ability to make adequate child-care arrangements and their willingness to remain in the

programme may depend on how satisfactory these arrangements turn out to be. The service is largely dependent on women themselves and on other agency workers, making these arrangements before they enter the Community. Once in the programme, efforts are made to ensure ongoing contact with children and their carers but given the limits on how many children can be accommodated at any one time, women find themselves in competition with other residents for child visits at weekends and holiday times. Women have little priority in this respect since men wishing to have contact with their children are deemed to have equal rights to them.

4. Outreach

The development of an outreach service makes some important contributions to the service. It offers support to those who are in the early stages of considering a rehabilitation programme, support to those who leave prematurely, as well as ongoing support once a programme is completed. It eases access to the TC by offering counselling and support prior to a commitment to long-term treatment. It also offers the opportunity to sort out issues around housing, debt, childcare, etc. prior to admission.

The service was very much in its infancy during my period of participant observation but has since developed and expanded. At the time of my observations Annie was working with a caseload of eighteen clients. That half of her clients were women with children is an indication of the value of the service to this client group. Her case-load was made up of those who had left the programme as well as those considering entering, or re-entering treatment.

The work is centred on home visits and referrals are accepted from a range of agencies and from individuals themselves. While the service is not aimed specifically at women, and not substantially different from that being offered by a number of other agencies working with problem drug users, the initiative may encourage women to access the Phoenix House programme in larger numbers.

The outreach worker offers a more flexible service than the TC and works on the basis of taking the service to the client rather than the client having to present herself to the service. This is particularly valuable to women who lack confidence in approaching services and to women with responsibilities for children.

Conclusion

It is clear that the organisation is concerned to increase women's participation in the service. A number of initiatives are in place aimed at encouraging women's access to the programme and improving retention rates for women.

A two-pronged approach to the problem seems to be operating. On the one hand a Family Unit has been created in order to cater for women, and some men with children. This Unit operates on a different model of treatment to that offered in the Main House and from a feminist perspective, it fails to make a significant break with the masculinist ethos of the TC. Access to the Unit is constrained by the high cost of placements and the availability of funding. I have argued that the Family Unit developed out of an attempt to increase women's participation in the Main House, an attempt which had the

potential to provide the impetus for restructuring the programme in order to make it 'fit' women and children more easily. The hiving off of the Unit as a separate project has effectively neutered the challenge that women with responsibilities for children presented, and there is once again a concern to explore ways of making the TC into a more woman-friendly environment.

CLIENT/WORKER RELATIONSHIP

The following discussion of staff /client relationships is concerned to explore how far the feminist principles of '*challenging the power of the professional*' and '*equalising relationships*' are operating. It aims to discover the extent to which Phoenix House is committed to establishing an equal partnership between staff and clients, a partnership which challenges rather than confirms the power of the professional in the social care setting. The discussion here will relate closely to my exploration of the organisation's professional ideology and identity, since this determines, to a large extent, the nature and structure of staff/client relationships. The control and constraint, for example, identified as an important part of the organisation's professional ideology, is an important determinant of the parameters in which the client/worker relationship is forged.

1. Care and Control

> **"Some of the time we're counsellors, some of the time we're policemen." (Robin, Staff Member, Family Unit)**

Staff are charged with the responsibility for imposing and policing constraints, and for ensuring the running of an ordered community. While to some extent this responsibility is shared with the senior residents of the community, staff are seen as the final arbiters and upholders of house rules. This means that a good deal of power resides in the hands of individual staff members and in the staff group more generally. On the whole, it is a power which is embraced rather than resisted. Staff accept the responsibility, for instance, for being vigilant with regard to standards:

> "In this morning's staff handover, Tony reported that the state of the kitchen must constitute a health risk. He said he was still trying to get to the bottom of who was responsible. The state of the kitchen is a regular cause for staff concern and a repeated theme in handovers. I noted that I resisted the temptation to remark on the unsavoury smell in the dining room. That I was tempted to participate in the discussion in this way, is indicative of the pressures on staff (and those wishing to align themselves with the staff group) to be vigilant in relation to standards of cleanliness around the House. Individual staff member's credibility among their peers and in the Community as a whole, is heavily dependant on their abilities to enforce standards and ensure that the House remains 'tight'."
>
> (July 1994)

As has already been seen in relation to the Family Unit, staff also embrace the responsibility for ensuring that residents do not engage in too much television viewing:

> "Jean (resident) was on telephone duty in the office in the Main House today. Our intermittent conversations provided a window into the experience of being a resident. One of Jean's gripes was the strict limits imposed with regard to watching TV."
>
> (July 1994)

Other examples of staff accepting their role as rule enforcers can be seen in relation, for example, to administering urine tests, either to the whole Community as a random check or in relation to specific individuals who come under suspicion. Staff are charged with the responsibility for ensuring that tests are properly conducted, a

responsibility which requires a staff member to be present while the sample is being provided. Similarly, staff can be required to search newly arrived residents and their belongings, although this is usually done by senior residents under staff supervision.

The need to ensure a well ordered, drug-free Community places demands on staff which sit uneasily with a partnership approach to care. Pressure to enforce and maintain standards is strong. Staff credibility among their peers and the Community as a whole, is heavily dependent on their ability and willingness to ensure a tightly run House, characterised by high standards of cleanliness, prompt attention to maintenance tasks and meals produced on time. Staff are expected to identify the cause of any failure to maintain standards and to ensure that the appropriate reprimand is forthcoming. Order is a highly prized commodity in the Therapeutic Community and staff demonstrate a commitment to their responsibilities for ensuring resident's co-operation in this respect.

A recurrent theme in conversations with ex-residents and re-entry residents was their regret at the 'slack' state of the House, compared with when they were in the programme. Phoenix's commitment to employing ex-residents as staff members, ensures that the pressure to maintain a 'tight' Community where residents involve themselves in work activities **"whether they like it or not"** (Pete, ex-resident), is maintained.

My observations would suggest that the concern to bring order into the chaotic lives of former drug users and to ensure a drug-free Community, means that staff /resident relationships are constrained within a framework characterised by authoritarian impulses. This, coupled with a self-help ethos which is dependant for its success on the ability of residents to achieve staff member status, means that the possibilities for re-structuring and 'equalising' staff/resident relationships are limited.

One of the ways in which staff maintain a sense of themselves as "counsellors" rather than "policemen" is to emphasise the way in which control is only the flip-side of care, and has to be understood in these terms. An incident in the Family Unit illustrates this elision between care and control:

> "Mo was angry when she discovered that one of the staff from SHIFT (a video-making workshop she regularly attends) had rung Cathy this morning to tell her that Mo had not arrived. She said she felt controlled and watched. Tony insisted that this was because people cared about her and were concerned for her safety. In trying to get Mo to accept what had happened as an indication of care, Tony used the analogy of her, as a mother, expecting her kids home at a stated time and them not arriving until much later."
>
> (August 1994)

Mo clearly struggled to see the actions of Unit staff, who were responsible for making her involvement in the workshop contingent on close monitoring of her attendance, as caring rather than controlling. Tony's analogy of mother and child may well have been unhelpful, as it suggested that Mo was the child in the care of Unit staff. This tendency to see residents as children is explored further below.

Seeing control as care may well defuse a resident's anger, and enable staff to feel more comfortable with the constraints they impose, but it obscures the ways in which control operates. Resisting control is redefined as resisting care, which, in the therapeutic setting, means that residents are urged to look at the emotional and psychological roots of their resistance to being cared for. External constraint is thus re-written as internal

disturbance and the focus of attention and responsibility shifts, from the organisation to the individual.

2. Marking out the boundaries

In the Main House clear rules govern and mark the boundaries between staff and resident. Departmental Heads and senior residents act as gate-keepers and control resident contact with staff. A request for a resident to see staff is processed through recognised channels and any attempt to by-pass them are likely to be met with demands that residents "use the structure."

> "Sam came to the office to ask for his penicillin. Jane told him to 'go through the desk'."
>
> (July 1994)

The resident holding the position of 'Expediter'[3] has a key role to play in controlling staff /resident contact. Staff requests to see particular residents will be processed through 'the front desk', situated in the foyer, where the 'Expediter' sits. It is not unusual for a member of staff who requires assistance from the desk to simply shout 'Expediter' from the staff office door, although other staff will approach the desk and either make their request directly or ask for the Expediter to come to the office. I noted that a number of staff regularly shouted for the Expediter and requested tea/coffee to be brought into a room where staff were meeting.

Protocol requires residents to knock on the staff office door and wait to be invited in before entering. A clear protocol also surrounds the making of written requests to staff for a Departmental position change, for a resident to move to the next stage of the programme or for a visit home. Requests or 'memos' have to begin: "**I am making a formal request to staff....**" and end "**Yours respectfully.....**".

In the context of a programme which has traditionally stressed the therapeutic value of relationships between peers rather than between staff and residents, clearly establishing and controlling staff /resident boundaries is seen as appropriate and necessary. It is born of the need to prevent too heavy a reliance on staff which may undermine the development of the bonds between peers which are seen as fundamental to support recovery and a subsequent drug-free life-style. In marking out the boundaries between staff and residents, however, the Phoenix programme also renders clients subordinate to staff and thus creates the very dependency which it is aiming to challenge.

In contrast, the concept of equalising relationships between staff and clients challenges dependency relationships by ensuring that clients are not diminished or disempowered by feelings of subordination and lack of status. This emphasis on a client's equal status with staff, as in a feminist model, as opposed to their subordinate status, as in the model operating at Phoenix House, presents a more effective challenge to the establishing of dependency relationships.

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[3] The 'Expediter' is responsible for overseeing the smooth running of theHouse. S/he heads up a team whose job it is to ensure that all in-coming telephone calls are answered promptly, residents are in the appropriate places at the appropriate times and staff are kept in touch with events in the Community.

Unlike the Main House, residents in the Family Unit have more or less open access to the staff office. This indicates a somewhat different style of staff /resident relationship; one which relies more heavily on the establishment of a therapeutic relationship between staff and resident rather than between community members. But while the clear demarcation and control of the boundaries between staff and residents is much less apparent in the Family Unit, relationships are constrained by the need to be vigilant in maintaining the drug-free status of the community, in ensuring that house rules are not transgressed and in ensuring that parenting skills are closely monitored. In the Family Unit the strict hierarchy of the Main House gives way to a more benevolent tutelage but leaves residents in little doubt as to their subordinate status in the staff /resident relationship.

Staff are not unaware of the impact of power inequalities on clients. Observations of interviews of prospective Family Unit residents illustrated Tony's awareness of the issues:

> "Tony made strenuous efforts to make the women feel at ease. In Carol's interview he openly acknowledged that he was in a much more powerful position than her and that he didn't want to coerce her into a decision to enter the Unit. He nevertheless made it clear that he would be willing to admit her, urgently if necessary. In Sally's interview he said things like 'where do we go from here then, Sally...', making a clear attempt to involve her in the decision about how and when she might come into the Unit.....I felt that Tony worked hard to make the interview comfortable for Sally, he acknowledged her fears and tried to diminish the power he had in the situation."
>
> (July 1994)

The Re-entry House, too, operates a more or less open door policy in relation to resident's access to staff. This greater accessibility relates to the 'senior' status of residents who have completed the Main programme and have thus earned the privilege of greater accessibility to staff. The nature of the relationship between staff and client here is one more akin to the traditional client/worker relationship in the social work setting.

3. Behind Closed Doors

A significant feature of the Phoenix House programme is the extent to which staff engage in discussion *about* residents rather than in discussion *with* them. Regular staff handover meetings, made necessary by shift working, means that a significant part of the day is devoted to staff discussion of the client group. This dynamic, together with the authority rested in staff, results in an emphasis on making decisions *about* clients rather than in making them *with* them.

Events in the Family Unit surrounding the two residents, referred to above, who used drugs and alcohol while off the premises, gives an insight into the extent to which staff take control of the decision making process. Staff responded to the women's drug-taking by deciding that they would be expelled from the Unit and their children returned to Local Authority care. This decision was made by staff on the Friday following the incident on the Thursday but was not communicated to the residents concerned until Monday afternoon, shortly before the social worker arrived to remove one of the children.

"Monday 25 July. I went into the handover in the Main House before going over to the Unit to catch up on events there. The questions I wanted answering were 'did Sally and Pat know what decisions had been reached about their futures?' and 'how had the weekend been managed if nothing had been said to them?'

I went over to the Unit about 10.30 a.m., by which time Robin had described to Cathy, who had been on holiday last week, the events surrounding the drug-taking episode. This meant that staff were once again closeted in the office, much as they had been during the whole of Friday afternoon.

The Director subsequently arrived and was also put in the picture regarding the drug-using episode. This discussion, between Robin and the Director took place, in whispered tones, on the wall outside the office. By now the whole thing had taken on a conspiratorial tone as it was clear that the women had not been told of their fate, either on Friday or over the weekend and the social worker was due to arrive to remove one of the children. The upshot of the Director's intervention was that he felt he needed to see the social worker before the child was collected, as he was not entirely happy with the decisions that had been made. This added a further air of conspiracy since the social worker now had to be intercepted and sent up to the Director's office.

The morning in the Unit was dominated by staff handovers and meetings. By 1.00 p.m. still nothing had been said to any of the Family Unit residents about Kelley's (Pat's daughter) impending departure. It had been decided that Robin would keep watch for the arrival of the social worker, intercept her and take her up to the Director's office. While she was with the Director, the news of her child's impending departure and of her own exclusion from the Unit would be communicated to Pat.

Shortly after 1.00 p.m., Sue arrived to start her shift and another handover meeting took place. Sue was filled in on the morning's event by Cathy. She in turn, filled Cathy in on events of Friday evening. Sue felt that she had been left 'to sweep things up' on Friday. She thought that Tony was going to tell Pat what had been decided, but he didn't. As a consequence, Sue was inundated with requests from Family Unit residents for information about what was going to happen, requests which she had to parry as 'diplomatically' as possible. Sue reported that by the close of Friday evening, Pat assumed that she was not going to be 'thrown out' since nothing had been said and Sue did not feel in a position to enlighten her. In relation to the weekend, there were few clues as to how Tony had handled events on Saturday when he had worked all day, and had taken Pat, Sally and the children out. What was clear, was that nothing had been said to the two women about the decision that had been made to exclude them from the Unit.

When the news was finally broken to Pat, shortly before the arrival of her social worker, staff attempted to consult her on how the handing over of the child was to be managed. Not surprisingly, perhaps, Pat was too distressed to be able to have much of an input in this respect.

Once the decision had been communicated to Pat, Sally was left wondering whether she too would be similarly excluded from the Unit and have Tom taken back into care. When she asked Robin whether a similar decision had been made with regard to her, she was told that a decision on her case would be made at a meeting with her social worker on Friday. In replying to Sally's enquiry, Robin told her that 'no-one knows what will happen (on Friday)'. This assertion, however, contradicted my earlier conversation with him in which he made it clear that a decision had been made to exclude Sally from the Unit but allow her to move into the Main House, without Tom, if she so wished. Robin made it clear to me that the goal of Friday's meeting was to get Sally to agree to the decision that had already been made."

(July 1994)

Events surrounding Pat and Sally are a clear, albeit extreme, example of the way in which residents are excluded from the decision-making process. The days immediately preceding Pat's departure from the Unit were characterised by staff discussing the

events, making telephone calls and decisions behind closed doors. Residents were entirely excluded from the process until the final moment when Pat was asked how she would like the handing over of her daughter managed. Partnership working was nowhere in evidence. Even the meeting with Sally and her social worker was clearly going to be stage-managed in order to arrive at a decision which had already been made.

Features of the process outlined above are reflected in more mundane events in the Community. The weekly 'clinical', for example, is a meeting by staff to decide on which residents should occupy which positions in the House's Departmental structure. Residents are encouraged to put forward suggestions but have no direct access to the meeting in order to argue their case. Once the decisions have been made, the resident group is assembled so that staff can communicate the results of their deliberations. Individual residents are required to stand up as decisions about their future role in the Community are announced. Announcements are accompanied by applause and residents are expected to accept their new positions with pride.

While there is a good deal of evidence to suggest that residents are largely excluded from the decision-making process and that decisions were made about rather than with them, attempts to increase resident participation in decision-making are apparent. A conversation with Craig (staff member, Main House) revealed that he now gets the Tribe to vote on their own leader rather than impose his choice on the group. However, when I asked whether he ever vetoed the vote, Craig admitted that he did. Where he felt the choice was inappropriate, he would explain why this was the case and ask the group to vote again. This indicates that the handing over of responsibility for decision-making to the resident group is conditional on staff approval for the resulting decision.

Other attempts to increase resident participation can be seen in the Family Unit's approach to accepting new residents. Residents were encouraged to be involved in new admissions by showing them around the Unit and talking to them about the programme. I noted that in Sally's case, Kate had written to her, and that this contact had clearly been very important to her. But, as in the case of the Tribe leadership, there were limits to the involvement of existing residents in decisions to admit new clients.

> "Kate looked after Tom while Sally was being interviewed and, in the event, continued to have responsibility for him most of the afternoon. She was not involved in the interview, or in the decision which resulted in Tom being left in the Unit while Sally returned to Nottingham to pick up clothes. Kate was only briefly consulted on whether she wanted to continue to look after Tom for the rest of the afternoon and I wondered how much of a choice she had in reality. In the evening meeting it became apparent that Kate had enjoyed looking after Tom as it reminded her of playing with her own sons and seemed to be an important turning point in her day. Nevertheless, the problem of minimum consultation and her lack of involvement in the process which led up to the decision which meant that Tom would need supervision for the afternoon, remained."
>
> (July 1994)

The assumption of the authority to make decisions for and on behalf of residents rather than in equal partnership with them is a general feature of the therapeutic programme. The visit to the Women's Health Bus is a good example of this type of decision-making process in operation:

"..... I got into the mini-bus with the women and Linda (senior resident) asked where we were going. Carol (staff member) explained, while she drove, about the visit to the Women's Health Bus. It was clear that none of the residents had been involved in arranging the visit, or even in agreeing to it."

(August 1994)

Similarly, enquiries from residents to staff about the afternoon's Community group session, elicited a "wait and see" response from the two staff members involved in planning and running it.

Even events that have a more dramatic impact on residents, like the week's activity holiday in Wales for Family Unit residents, are planned by staff *for* residents. When plans for the holiday were revealed to the resident group, it became clear that they cut across the demands of a part-time course one resident was engaged in. Attempts were made to liaise with course tutors on the resident's behalf, but she remained angry and resentful at having to miss an important part of her course and at having holiday plans for her and her children imposed on her. Further difficulties arose out of resident's lack of involvement in decisions about the holiday when they complained that the food 'levy', decided by staff, was too high.

The planning of the holiday revealed the extent to which staff feel under little obligation to involve residents in the decision-making process. In discussing the decision-making process adopted by staff in the Family Unit, Robin commented:

"It varies very much from decision to decision....I mean, for example, we are going on holiday next week. That was a decision that was taken by us. It may be....I'm not sure...it may be... that one resident believes that she had a choice in it. But the bottom line is that she would have come. Everybody was going to come from day one. Having made a decision like that we'll try and bring people along with us."

It further revealed that where their decisions met with resistance, the fault was seen to lie with the resident group and the unreasonableness of their demands, rather than with the decision-making process itself.

Staff appear to have little hesitation about arranging activities and events for residents.

Cathy: Phoenix have employed an activities worker now.....so far he's organised a mother and toddler swimming group....he took them (Family Unit residents) caving....they came back covered in mud but loving it.

Me: Were the women keen to go?

Cathy: Yes, I mean, I was very much saying...don't tell them where they're going or they won't go....but somebody did tell them."

Staff assume responsibility for ensuring that the programme's emphasis on a structured day is maintained and a concern to ensure that residents are constructively occupied legitimates a strongly interventionist style.

"If I push them into doing things, they might winge a bit but they're not hostile, they weren't today. It wasn't (a case of)...do you want to (go out)...It was, you are going out this afternoon (because the kids are bored)". (Cathy - Staff Member, Family Unit)

"What I'm saying is that, if you're a resident, you won't be allowed to sit around and waste your time for very long. But you have a very considerable degree of latitude and choice about how you spend your time given that you are spending it in a way that we consider constructive, but we reserve the judgement about whether it's constructive or not."
(Robin - Staff Member, Family Unit)

4. Residents as Children

The assumption that staff are the chief decision-makers in the organisation and that they can and do act on behalf of residents, gives rise to an inclination to regard residents are less than adult. The propensity to diminish residents and regard them as recalcitrant children is apparent and illustrated by the following extracts from observations:

"The evening meeting in the Family Unit revealed the extent of Lesley's (former Unit Manager) power in the group. She demanded written work from two residents by 10.00 a.m. tomorrow and a self-assessment from another resident by Monday. Geoff (resident) remarked that he felt like a school kid when Lesley told him to stop hiding behind his leg....."

(September 1993)

"In the morning handover Jane (staff member) described Steve (resident) as 'having his bottom lip out' because she had told him to go through the proper channels in order to speak with her".

(July 1994)

"Tony (Manager, Family Unit) expressed concern that the 'hungriest chicks' (Mo and Kate) are demanding all the staff energies".

(July 1994)

"Roger (staff member), remarking on the improvement in Ken's (resident) attitude, observed 'at least he's stopped having tantrums and stamping his feet when he gets pulled'".

(July 1994)

"Jane, in distinguishing between two Family Unit residents described Hazel as 'the very girlie one'". (August 1994)

In discussing residents, it was not unusual for staff to comment upon, or to infer, childish behaviours and attitudes. Moreover, the way in which 'clinical' announcements are managed (see above) has many of the hallmarks of a school assembly. That residents are aware of their status vis a vis staff is evident from Geoff's remarks above and also from Jean's reactions to Rob's remarks outlined below:

"Rob's (staff member) reaction to the request from Radio Hallam to interview residents, was less enthusiastic. He said he didn't want 'his' Tribe getting involved in the kinds of self -revelation which media interviews encouraged. When he had left the room Jean (resident) remarked that Rob's attitude made her feel 'not capable...as if you're not grown up enough".

(July 1994)

5. Groupwork

An important way in which staff /client relationships are equalised and feminist practice developed, is through the use of group work techniques. Feminist group work is characterised by a diffusion of power among the group membership. Change is effected through the sharing of experiences and the generation of supportive group relationships rather than through the interventions of the expert. By and large, where a commitment to group work is strong, the likelihood of practice being in tune with feminist principles is greater.

However, while Group work is a basic therapeutic tool of the Phoenix House programme, the model employed embodies few feminist principles. Approaches to running groups at Phoenix vary from those which seek deliberately to enhance rather than mitigate the power of the professional, to those which encourage greater group control but which nevertheless operate with the hierarchical structure of relationships prescribed by the Phoenix programme.

The aims of the group work programme are both narrowly prescribed and pre-determined. The focus is on the individual, their former drug use and their progress through recovery.

"And I think (that) what a group provides is..er...the opportunity to see yourself in the eyes of others, if you see what I mean. And I think that's often really useful, er...that people can actually put to you what they see as being your problems or what they see you're doing. And I think if there's enough people doing that then you're more likely to own it, and I think that is really important. I think...you've got to, sort of, own stuff before you can look at dealing with it better. (Rachael - Staff Member Re-entry)

Group members determine the group process only within the confines of the organisation's overall aims and agenda. It is an agenda which operates on the assumption that drug use is, by a large, a weakness which the individual must overcome, and which pays little attention to the ways in which broader social and gender power structures are implicated in the process. Given the constraints of a pre-defined agenda for change, it is difficult to see how anything other than limited power can be devolved to group members. It is also difficult to see how the raising of political consciousness, a primary aim of feminist group work, can be achieved, since the issues have largely been de-politicised and rendered gendered neutral.

'Gender groups', i.e. a Men's Group and a Women's Group, are built into the therapeutic programme at Phoenix House and offer some limited scope for exploring gender specific issues. My understanding of the Men's Group based on discussion with male members of staff, suggested that while some pertinent topics are considered, there is little overall coherence to the Men's group programme. The Women's Group

operates in a similar, ad hoc, manner. Both groups are run by in-house staff whose ability to establish equal relationships within the groups are constrained by factors identified above.

During my first period of participant observation, it was clear that the 'Gender Groups' operated only very intermittently, although by my second visit, fortnightly groups operated consistently. This consistency, however, did not extend to the Women's Group having a regular staff member allocated to facilitate it.

> "Carol ran the Women's Group this week. She explained to me, before the group started, that she didn't normally do the Women's Group, as her prime responsibility was admissions. She complained of a situation in which all 'floor' staff (staff who run the day-to-day programme in the Main House) are currently men, which meant that staffing the Women's Group was a real problem.
>
> (July 1994)

During my first visit I was interested to note one Family Unit resident's view of the Women's Group in the Main House. (At the time, the policy was to include Family Unit residents in the Women's Groups run intermittently in the Main House).

> "Carrie said she had been relieved to find there was no Women's Group today as they were not what she expected or thought Women's Groups should be. They merely consisted of women in the Main House confronting one another about in-house issues."
>
> (July 1994)

Carrie's remarks are confirmed by Cathy's comments (see discussion of Family Unit) when she explains the reasons why the women in the Unit no longer participate in the Women's Groups.

My own observations of the Women's Group contradicted Carrie's view to some extent, as a clear attempt to give the group a more general focus was discernible.

> "Carol began the group by asking the women to draw themselves and used the drawings as a springboard to discuss body image and health issues. It was clear that the Women's Group had little or no identity as a group, and this might have accounted for the fact that the women seemed rather reticent. The discussion which followed the drawing demonstrated that a lack of trust between group members existed. This lack of trust was articulated mainly by a 'senior' resident who said she trusted men more than women, even though she had been more hurt by men. Lack of trust between women was not taken up and explored as an issue. Carol accounted for it by lack of regular group meetings rather than as being related to gender relations more broadly.
>
> An important issue for the women was their weight. Linda gave a graphic insight into the significance of this issue for women users when she said she had doubled her weight since entering the programme and now felt she was living inside a body which did not belong to her. Other women expressed similar concerns about their weight and one woman said she felt guilty about worrying about her weight and how she looked generally, as she felt she ought to be worrying about her children, not herself.
>
> Carol worked hard to challenge the women's negative views of themselves by drawing attention to their personal qualities and other aspects of their appearance. She also suggested that they supported each other in maintaining diets."
>
> (July 1994)

These observations indicate an enormous potential for working with some important 'feminist' issues but it is a potential which remained under-exploited. There was no attempt, for instance, to look critically at where the messages about 'desirable' bodies for women come from, or in whose interest they operate. Women's 'selflessness' similarly went un-remarked upon. Lack of co-ordination between staff and lack of continuity between groups suggests that such insights may never be fully explored.

My observations of the group nevertheless indicated Carole's concern to raise more general women's issues, and to this extent they contradict Carrie's comments. However, as the group progressed, I had an insight into the direction in which it could develop:

> "The latter part of the group discussion was concerned more with the women and their programme, with their relationships in the House, rather than with broader issues around women, their bodies and their health. I noted there was little interaction between the women and it became a succession of conversations between Carole and each individual group member in her turn."
>
> (July 1994)

While Carol succeeded in giving the group a woman-centred focus, it was not difficult to see how, in other hands, it could follow the more dominant 'encounter' group model which Phoenix has traditionally encouraged. The inclination of group members to address their comments to Carol, rather than each other, confirmed my view that the group work did little to *'equalise relationships'*. Group processes at Phoenix seem resistant to the levelling of relationships between client and professional which feminist groupwork sets out to achieve.

6. Sharing feelings and experiences

An important way in which relationships between client and worker are equalised in feminist practice is through the sharing of feelings, awareness and experience. One of the questions I took into the field, and into interviews, therefore, was how much of themselves do staff share with residents? Evidence from interviews with the women staff at the Family Unit suggested a willingness to share aspects of themselves and their lives with residents:

> **"Very often, when running a group, we'll share some of our experiences, or talk about us, as women, so it's not like the worker and the resident, it's US as women talking about things." (Cathy - Staff Member, Family Unit)**

I noted too that Carol, in the Women's Group described above, did her own drawing and took her turn in talking about how she felt about her body.

Other staff, in their interviews with me, suggested a keen awareness of the importance of maintaining appropriate boundaries between client and worker and a concern about 'overstepping the mark' in this respect.

> **"I have a sense of needing to be aware and cautious as to the extent to which I go in disclosing information personal to myself.....if I'm unsure, what I would need to do is check it out with my line manager to get**

clarification....." (Dean - Staff Member, Re-entry House)

Rachael: "I like to think that (I have) a purely professional relationship that is to do with what I can offer when I'm here at work..... It is not healthy, either for us or for residents, when people start blurring over boundaries."

Me: "So you mark out some fairly clear professional boundaries?"

Rachael: "Very definitely..... I'm probably more friendly with the women than I am with the men. ...I just don't think men know their boundaries very well....."

Me: "Do you find yourself sharing much about your own life with the women?"

Rachael: "Very minimal. Very minimal. When I hear other people doing that it's more about their own reassurance that somehow they're similar and that it's almost like showing off and I find it really uncomfortable. Maybe the residents do like to hear that there are some similarities and that you can identify with them but I don't really think that's the point of why we're here." (Rachael - Staff Member, Re-entry House)

Craig: "I mean once people are getting towards the end of the programme I think it is constructive that the boundaries break down just so that they start to see you as normal every-day people instead of someone who turns up for work everyday. I mean at times there are also people who you have to keep your barriers up with because they will become over-friendly...but I think it is good for the majority of people."

Me: "How much of yourself do you share with residents?"

Craig:"....I share a lot of experiences that are probably very similar to experiences they have had...

Me: "Like..."

Craig: "Former drug use, former criminality, I share that with them. Anything...I draw the line at anything from when I completed the programme. Anything that goes on in my life now, my family, where I drink, that's personal stuff....I wouldn't share anything personal about my relationship or about how my life is." (Craig - Staff Member, Main House)

Rachael's comments are interesting in that they indicate the importance for her of maintaining 'professional' distance but she makes a distinction between the boundaries she draws in relation to male residents and those she draws in relation to her women clients. This suggests that women workers may erect firm professional boundaries in order to deal with their male clients but adapt these boundaries when dealing with

women. However, establishing strategies to deal with male clients which are then merely adapted to take account of women's different needs, may obstruct the development of the most appropriate methods of working with women. This raises a number of questions. First, how far can women workers adopt feminist principles, which may leave them open to harassment, with their male clients? Secondly, if women have to construct defensive boundaries in order to deal with their male clients, how far can they adopt very different strategies in working with their women clients? And thirdly, does working with men inevitably determine the boundaries for working with women?

Craig is less concerned about maintaining firm boundaries as residents progress through the programme, but the areas he identifies as open to sharing and those distinctly closed, reflect the silences that men have traditional kept in relation to the private world of emotions and relationships.

Conclusions

The client/worker relationship in the TC is characterised by a clear demarcation of roles and responsibilities. Resident participation in the decision-making process is heavily circumscribed and workers assume the responsibility for making decisions on behalf of clients. There is a marked willingness to exclude residents from meetings where their progress is discussed and decisions are made about their futures. That this was such a noticeable feature of the social care practice in the TC may be a result of the residential nature of the service. Where clients are constantly on site, staff meetings and spaces from which they are excluded are that much more obvious. But the highly visible nature of staff meetings in the residential setting means there is a risk of undermining resident control over the recovery process. While staff clearly need to meet together regularly, the extent to which this means that residents are excluded from decision-making arenas needs carefully monitoring and managing. It is difficult to see how the strategies of exclusion which were a feature of the client/worker relationship in the TC can foster the principles of '*equalising relationships*' and '*challenging the power of the professional*' on which feminist practice can be built.

Self Esteem

> **"You come in here with low self -esteem, you don't need to be pulled down further". (Mo - Resident, Family Unit)**

A central concern of feminist social work practice is that of increasing client self-esteem. While it can be argued that increasing self-esteem should be an important first principle of all good social work practice, it has a particular significance in relation to women. Feminists see women's lack of self-esteem as deriving from their subordinate status in society. The task of increasing self-esteem when working with women is thus an important political challenge. The aim of the following discussion is to determine how far the Phoenix programme succeeds in increasing resident self-esteem and how far it undermines it. Mo's remarks above suggest the latter rather than the former, but it is an area in which tensions and contradictions abound.

The programme makes some clear and explicit attempts to encourage the growth of self -esteem. The celebrations which mark completion of the programme or progression from one phase to the next are perhaps the most obvious ways in which resident progress is recognised. Moving through the programme confers new status and new privileges on residents and can offer substantial gains in self-esteem. Holding a Departmental position similarly confers status and privilege and is a mechanism designed to encourage growth in responsibility and self-esteem.

The life story which residents are required to tell once they have established themselves in the Community also has the potential to increase self-esteem. My participation in life story events suggested that they were sensitively handled and could be a vehicle for residents to demonstrate their resilience in very adverse circumstances. The process facilitated self re-evaluation and a growth in self-esteem.

The groupwork programme similarly offered opportunities for increasing self-esteem. This is done either directly, by running assertiveness training workshops and groups specifically designed to focus on giving 'positive strokes' or indirectly by encouraging participation in group therapy, group discussion and group activity.

> **"I've seen people change as the months go by in the way they are in groups. Certainly, one of the women at the moment was absolutely terrified of groups when she came to re-entry and would just sit and wait for it to be over and say nothing. But now she's really vocal. And it's not aggressive and it's not about intimidating other people, it's just about saying what you think and having an opinion and it being fine to do that." (Rachael, Staff Member, Re-entry)**

> **"..I think at times it (groupwork) helps them build up confidence. But on the other hand, for certain people, it's quite intimidating and they never get used to it at all. So I suppose it's swings and roundabouts really." (Craig, Staff Member, Main House)**

Craig's comments neatly point up the pluses and minuses of groupwork in relation to increasing client self-esteem. The pragmatic approach he adopts, however, might usefully give way to a more critical scrutiny of which groups, or aspects of groups encourage the growth of self-confidence and which do not. The suggestion that it all balances out in the end pays too little attention the casualties en route.

Groupwork is just one example of how aspects of the formal structure which are designed, among other things, to encourage self-esteem, also have the potential to undermine it. It has long been recognised that an approach which relies on exposing and exorcising past drug-using habits, and the life-style and relationships that go with it, risks focusing too sharply on what has not been achieved rather than what has. This negative focus erodes an already fragile self-esteem. Similarly, a policy of abstinence, as has been suggested elsewhere, is inherently problematic in relation to encouraging greater client self-confidence. The goal of abstinence is difficult to achieve and presupposes a level of self-confidence that women in particular may have difficulty in attaining. An early conversation with Elli, a resident in the Family Unit, supported this view in that it revealed an acute lack of confidence in her ability to remain drug-free once her programme at Phoenix was completed.

Other aspects of the programme also pre-suppose a level of self-confidence which may not be in place. Morning entertainments, for example, devised as a way of breaking into post-breakfast despondency, require residents to sing, dance, mimic a T.V. star etc., supported by the rest of the Community. While this can be a vehicle for the growth of self-confidence it can also be a very daunting prospect. Craig (Staff Member, Main House) also identified the seminars that residents are required to do in order to move on, as an aspect of the programme which required a good deal of self-confidence and self-assurance.

> "Commenting on Heather's 'Tribe Seminar', Craig said that he thought she found it a bit daunting and that he's thinking of changing the way it is done. He pointed out that currently, a resident wanting to move into the Tribe is faced with having to give a seminar on the House structure to a group of residents already very familiar with it. Craig said he thought it would be better if the seminar was centred more on the resident themselves and their own personal issues rather than on the structure of the House."
>
> (July 1994)

Craig's comments indicate an awareness of the ways in which less confident members of the Community can feel intimidated by the programme's demands. He alerts us to the fact that the very mechanisms in place to increase motivation may have the effect of undermining self-esteem.

Further insight into the potential of the Peer Group structure to undermine rather than enhance resident confidence was gleaned through a conversation with Jean, a woman resident in the Main House:

> "Jay did his seminar and was accepted into Interphase. I was struck by Jean's comments when she heard the news. She was clearly envious of Jay's progress and saw herself as falling behind. "
>
> (July 1994)

Jean had experienced difficulties with the programme, 'splitting' at one point as she was concerned about her two children being looked after by relatives. Despite the

support that Jean received from staff and residents, the programme's structure meant that her progress was being compared to that of others who had arrived at the same time, albeit with very different sets of personal circumstances. It seems that on the one hand the Peer Group structure is a useful motivating mechanism, on the other, and where residents fail to keep up with their peers, it can underline their shortcomings and confirm low self-esteem. Perhaps the problem lies in the fact that 'progress' is defined too narrowly and takes too little account of problems other than drug misuse which residents may be grappling with. The experience of drug use and of the recovery process is mediated by gender, and by race and class but this is given insufficient attention in the TC which constructs drug use as the great leveller. This one-dimensional approach cannot differentiate sufficiently between the needs and progress, of a single drug user in the their early twenties and a woman, like Jean, in her mid-thirties with two children and a violent ex-husband. In comparison to Jay, Jean had a very different set of issues to make progress with. A programme narrowly structured around recovery from drug misuse cannot take sufficient account of these differences and the result can be a sense of individual failure.

A further feature of the Phoenix programme which has the potential to undermine rather than increase self-esteem, is the complexity of the structure in the Main House and the emphasis on an ordered community. It is very difficult for a resident to avoid being 'pulled-up', i.e. reminded of their shortcomings, most days. Indeed, a lack of 'pull-ups' can give rise to a concern that residents (and staff) are not being sufficiently vigilant and are 'selling out' in a bid for a quiet and collusive life.

In a number of important ways, then, the formal aspects of the therapeutic programme have the potential for undermining resident self-confidence. These, together with the informal exchanges which focus on resident shortcomings (e.g. parenting) and which will be considered further below, suggest there is a good deal of potential for undermining rather than increasing self-esteem. The undermining impulses in both the formal and informal aspects of the programme may go some way to explaining women's low completion rate in the Phoenix programme.

However, where women do stay in the programme and move through it, there is strong evidence to suggest a marked growth in self-confidence. A conversation with Tina, a Re-entry resident was revealing in this respect:

> "Tina told me that when she was in the Main House she had been put 'on contract' for not 'pushing' for Departmental positions. She was given the position of Department Head several times but consistently asked to be relieved from such positions and work as 'crew'. She added that she now felt confident in volunteering to co-ordinate at the Main House at the weekends, a responsibility which re-entry residents are expected to take on."
>
> (September 1993)

Tina's growth in self-confidence, particularly since moving into the Re-entry stage of the programme was evident from this conversation. The Co-ordinator's role is a pivotal one at weekends and carries a good deal of responsibility. Tina's willingness to take on this role indicates a marked change from her reluctance to head up a Departmental team at an earlier stage in her programme.

Perhaps the clearest testament to the Programme's success in increasing self-esteem, however, was Fran and Alli's handling of their joint 'Completion':

"By 4 o'clock the Lounge in the Main House was packed with current residents, Re-entry residents, staff, Fran's family and Alli's family. When the two women entered loud cheers went up and calls for 'entertainments' and 'speeches'. I was struck by the women's self -assurance and moved by the testament they paid to the support they had received both from Phoenix House and their families. They expressed confidence in their ability to resume the care of their children and to live a drug-free life."

(August 1994)

Conclusion

Fran and Alli's handling of the occasion was impressive and clear evidence of the fact that where women do succeed in completing the programme, the pay-offs in terms of increased self-esteem are substantial. Nevertheless, while there clearly are encouragements to increased self-confidence, there is also much that pulls in the opposite direction. While individual staff are mindful of the need to challenge resident's lack of self-esteem many opportunities for 'positive feedback' are missed and the focus on resident's shortcomings is sharp. This final extract from my notes, commenting on Tessa's 'Re-entry seminar', highlights some of the contradictions and ambiguities which my exploration of the TC's ability to generate increased self-confidence amongst its client group has raised:

"I was impressed by Tessa's confidence in addressing a large, mainly male group of Re-entry residents.....Tessa's seminar focused on her needs as an ex-user and the dangers of relapse but she acknowledged that she had needs as a mother working towards being reunited with her children. Once the seminar had been presented and Tessa had answered the questions put to her, she left the room while a decision about whether to accept her into Re-entry was made. The discussion which followed identified the points which were to be feedback to Tessa and the emphasis here was mainly on what Tessa was not doing, what she still needed to do and the dangers that awaited her release from the safety of the house. There was little recognition, either in the seminar or the subsequent discussion, about what had already been achieved.

Annette (staff member, Main House) suggested that the feedback to Tessa should include a direction to take more care of herself as she had put on a lot of weight (!) but Steve (Re-entry resident) felt unwilling to minute this and it wasn't included in the feedback. Tessa was accepted into Re-entry on the basis of what was felt to be a 'good' seminar and the whole group was taken up to the Main House by mini-bus to announce and celebrate Tessa's success."

(September 1993)

SEX-ROLE STEREOTYPING

An important principle of feminist health and social care practice is that of challenging sex-role stereotyping. A feminist analysis of services and interventions must therefore consider how far treatment strategies are underpinned by a rejection of traditional sex-roles. My discussion of the Family Unit has already explored some of the ways in which sex-role stereotyping operates at Phoenix House. Women in the Unit are responded to primarily as mothers and a focus on monitoring and improving women's parenting skills is apparent. The following discussion aims to take this analysis further by considering the operation of sex-role stereotyping in the programme as a whole and by examining the ways in which traditional gender roles are challenged as well as reinforced. A number of interrelated themes have been identified and form the framework for the discussion.

1. Women and the Phoenix House Programme

> **"There's a lot of rubbish that goes on at Phoenix for women. I mean, I feel it as a female member of staff.. ..ranging from sort of suggestion to intimidation - and I'm quite sure the women get it a lot of the time. Maybe (they) don't even identify it as that, as they're so used to it, and they're not necessarily assertive in that way...."**

> **"I see the women succeeding through different means than the men I think.....maybe not in terms of their recovery but in terms of their getting on with other people which has an effect on their ultimate recovery. (This operates negatively as well as positively)...negatively, they are seen as a sexual object or item, or as vulnerable and a bit of a victim, needing to be rescued and helped and sort of...protected. And that gives a man a role and it makes them feel good and I think the women respond well to making the men feel good, even if in their rationale somewhere they're sick and tired of that, it's a quick and easy role. But more positively, I think women often get into the role of being quite supportive, quite popular because of being able to be supportive and being prepared to put aside time to talk and be generous and understanding." (staff member)**

This extract from an interview with one of the women staff highlights some of the experiences of women who enter the treatment programme at Phoenix House. The comments suggest that women are put under pressure in a male-dominated environment and use a variety of coping strategies to survive. Some of the strategies draw upon and in turn reinforce, traditional role options for women - the seductress, the 'damsel in distress', the carer. The following is an attempt to look more closely at the issue of sex-role stereotyping and in particular, how far it is challenged and how far it is reinforced by the intervention strategies and model of social care practice in operation.

Women-as-mothers

My analysis of the Family Unit has pointed up the emphasis on confirming and buttressing women's identity as mothers and their responsibilities for child-care. While there is a good deal of evidence to support this contention, there is also evidence which indicates an awareness of the need to challenge the notion of child-care as women's work. The appointment of a male as well as a female child development worker is an explicit attempt to provide an alternative model of masculinity and to challenge traditional assumptions about male and female roles. While the value of the this challenge must be recognised, however, it's limitations need addressing.

In providing expert help in the form of child development workers, the Unit underlines women resident's shortcomings and need for expert help in looking after their children. To this extent, the challenge that Robin's appointment provides, is mitigated by his status as expert. Moreover, the appointment of child-care workers to the Unit means that the dominant ideologies of motherhood and women's responsibilities for children which underpin training in this area are imported uncritically. No awareness of feminist concerns about the role of the expert (Rich, 1977; Richardson, 1992; Ehrenreich and English, 1979) in undermining women's own caring strategies and self confidence was apparent. Indeed, Helen (Robin's co-worker) expressed pride in her ability to be forthright in telling women residents that **"they are boring parents"**. The giving of expert advise to women in the Unit was recognised as an important part of the staff's role and was not seen as the prerogative of the child-care workers. While support with child-care issues was often welcomed by residents, it was equally clear that, at times, the women felt that their childcare skills were being undermined:

> "Kate was complaining this morning that Robin did not believe her when she said Suzie (18 months) had a temperature and that he insisted on taking it with the thermometer. When the temperature was confirmed, Robin took charge of administering the Calpol, holding Suzie while instructing Kate to put the medicine into the baby's cheek." (July 1994)

Prompted by the concern to improve women's parenting skills, a concern guided and legitimated by the appointment of child-care experts, women's domestic and child-care tasks were closely monitored. Conversation in the office was frequently punctuated by staff expressing concern over the women's perceived shortcomings:

> "This morning's handover was dominated by Helen and Cathy's concern about Mo's reluctance to tidy the children's bedroom. Later in the day further, similar, concern was expressed - Mo was not changing Dee's bed often enough. (Dee is enuretic)."
>
> (July 1994)

> "In this morning's handover Helen reported that it was a good evening in the Unit since activities and events were centred around the children's needs. However, Mo (Unit resident) 'needed directing all the time'; she couldn't get the children to bed and their room was a pig-sty."
>
> (July 1994)

> "There was further concern this morning about the women's level of child-care skills. Helen expressed concern that Mo didn't have her children all day on Sunday. Later in the day, when Dee (Mo's daughter) remarked that she had waved to me last night, Helen commented, rather pointedly, that that was 9.45 p.m. and the children were still up."
>
> (July 1994)

> "In this morning's handover (Main House) Jane (staff member) reported on Heather's visit from her children. Jane expressed concerned about Heather's lack of parenting skills, the behaviour of the children, and Heather's methods of chastisement".
>
> (August 1994)

While there were clearly some undermining impulses operating in respect to women's child-care skills, there was also an awareness amongst some staff of the dangers of consistently criticising women.

> "In discussing how Heather's review with her social worker had gone, Craig said that he hadn't raised the question of Heather's inappropriate methods of chastising her children as he didn't want to undermine her in the presence of her social worker. He said he felt that it was an issue which needed taking up with Heather less publicly. In relation to Jean, another resident in the Main Programme, he commented that she clearly experienced problems with her children at weekends but staff were only able to tell her what she should not be doing, they had no time to help her with what she should be doing. He said he felt that this had undermined her confidence to such an extent that Jean now didn't want to have her children visit at weekends.
>
> (July 1994)

Evidence of such awareness was limited, and outweighed by the evidence of staff demonstrating concern about women's inadequacies in relation to their child-care responsibilities.

The role of the child-care expert in the Unit is a key one and has had an important impact on the Unit's aims and orientation. In addition to the concern with monitoring and teaching parenting skills, I was struck by the way in which some fairly mundane events and behaviours were reconstructed as inappropriate and pathological from the perspective of the child-care expert:

> "Later in the afternoon Robin fed-back the events of the morning's shopping trip to Tony. Robin had spent most of the trip helping Sally, the Unit's newest resident. Sally had experienced some difficulty in stopping Tom, her 4 yr. old 'doing the shopping for her', as Sally described it, by taking items from the shelves and putting them in her basket. What seemed to me to be fairly normal behaviour from an assertive 4 yr. old was described by Robin as symptomatic of Tom's taking adult responsibilities which in turn derived from Sally's drug use. Robin did not describe his activities as helping Sally do the shopping but as modelling alternative ways of dealing with Tom's inappropriate behaviour. The rather mundane activity of shopping had thus been elevated into a therapeutic intervention aimed at re-establishing appropriate mother-child interaction."
>
> (July 1994)

The professional model operating here emphasises rather than challenges the power of the expert. Feminist principles of partnership are rejected in favour of an approach which privileges the power of the professional to diagnose and treat.

In relation to the issue of sex-role stereotyping there is much evidence to support the view that the Unit, and to a much lesser extent the Main House, is concerned to reinforce and strengthen women's traditional caring skills. Robin's appointment is an attempt to challenge taken for granted assumptions with regard to sex-role stereotyping but it is a limited challenge and ultimately compromised by the model of professional practice adopted. Women residents are left in no doubt as to their shortcomings as

mothers, there is a tendency to pathologise rather than normalise children's behaviour which is then seen to require expert intervention, and women are assumed to be inadequate rather than adequate mothers.

> **"Another interesting thing is that when people come here, I've very rarely seen people bring toys for the children. They haven't got any. A couple of books and a rattle, perhaps, that level. It's very rare for anyone to have toys for the children. Lots of clothes, designer jackets, 'rebox' ('designer' training shoes) and everything. But few toys. And it's quite startling for people to be told that actually children need toys, they learn through play. To you it might look like a bit of plastic but they're actually learning things through it". (Cathy, staff member, Family Unit)**

In examining and critiquing the emphasis on improving women's parenting skills, it is important not to loose sight of the fact that the women themselves will often identify a need to strengthen and improve relationships with their children.

> "Families admitted to the Unit are asked to give a self-assessment on the form provided. Sally's self -assessment states..... 'I want to learn how to be a good mum to Tom....."
>
> (July 1994)

> "In the evening review, Sally spoke of wanting to rediscover and strengthen her relationship with Tom who's literally all she has. She said that tonight had been the first time for many months that she had bathed Tom herself and told him she loved him...."
>
> (July 1994)

Other evidence reveals women's concerns about their mothering abilities:

> "The evening group revealed the guilt that women feel with regard to their children. Kate spoke of her panic when Suzie gets ill and how she feels it must be because she has pumped in all this bad stuff' (drugs) which has made her baby ill."
>
> (July 1994)

A feminist critique of sex-role stereotyping must take account of the fact that some of the women come to the Unit actively seeking help to become better mothers. A blanket rejection of encouragement to mother is not therefore sustainable. Just as some disabled women (Morris, 1995) seek opportunities to be 'ordinary' mothers, so women who use illegal drugs may seek opportunities to become 'normal' mothers. Motherhood cannot be defined as universally oppressive. The roles which white, able-bodied feminists have viewed as stereotypical and in need of challenge may be the very roles to which other women, marginalised by disability, race, sexuality, or, in this case, drug use, aspire to. Assisting women to improve their abilities to mother, cannot in itself, be deemed problematic from a feminist perspective. Where women define their needs in these terms, as Sally did, help with parenting skills and mother-child relationship issues seems highly appropriate. What is more problematic is the assumption that most women coming into the Unit will need to improve their parenting skills since this both reinforces the notion of women as mothers and undermines women's already low self-esteem. Mystifying the helping process and privileging the power of the expert is also problematic, since a feminist approach to treatment requires the establishment of equal relationships on which a partnership can be built.

The concern to improve women's child-care and related skills is a feature of the programme in the Family Unit rather than in the Main House, although, as we have seen in relation to Jean and Heather, when children visit, a woman's ability to cope may well come under scrutiny. Historically the Therapeutic Community has paid little attention to resident's familial relationships and responsibilities, and while this is no longer the case, the Main Programme often seems to struggle to recognise women's responsibilities for, and anxieties about, children being looked after elsewhere. Special arrangements are made to allow women to have telephone contact with children in the early stages of their programme and visits are facilitated at weekends. Such arrangements sit somewhat uneasily within the programme's structure since they have been added on in the form of a special set of privileges attaching to women with children. This means that telephone calls, just like all calls, have to be requested and monitored, and that visits to children have to be accompanied until women have attained a stage in the programme which allows them to travel outside the locality unaccompanied by their peers.

I had a number of insights into the difficulties faced by women in the Main Programme in trying to make arrangements for contact with children.

> "Jean was on telephone duty in the office where I was observing and we began to talk about her contact with her children. I was struck by Jean's comment that it seemed rather unjust to her that her estranged and violent partner, who is still using, has more contact with their two children (twice each week) than she does - "and it's me who is trying to address my drug problem"".
>
> (July 1994)

> "Heather came into the office to use the telephone in order to try to arrange a visit from one of her five children at the weekend. She had a lengthy conversation with her social worker which resulted in an elaborate set of arrangements for picking up her daughter (who was to be accompanied by an Uncle) at Bradford Station. Heather would be accompanied by one of her peers, they would pick the child up, bring her back to Phoenix for the day, then reverse the arrangements early evening in order to return the child to her grandmother."
>
> (July 1994)

During my observations in the Main House, an 'away-day' was planned for staff, facilitated by two consultants, to consider the problem of child visits and child-care in the Main Programme. This was both an acknowledgement of the problem and an indication of the will to address it. My observations of, and reflections on the day revealed a number of issues.

> "One of the agenda's which emerged early in the session was the feeling on the part of some staff that they had come to Phoenix to work with adults and didn't feel confident (interested?) in working with children. The impression was that some staff would have preferred not to have the extra worry of having children around at the weekends and in fairness, staffing levels are extremely low at such time (one member of Staff for the Main House, one for the Family Unit)"
>
> "Children are seen to be the responsibility of parents, supported by a member of their 'peer group' rather than the responsibility of the whole Community. This presents problems where older children are visiting since they roam freely through the building and attach themselves to various groups and activities. It is virtually impossible for a parent to insist they spend the entire weekend with either themselves or their identified peer."

"The Director's preferred option for dealing with the childcare issue is to charge extra or to ask Social Services, where they are involved with children, to provide adequate childcare support for visits."

(August 1994)

In reflecting on the issues it seems that a fundamental problem is that the Phoenix programme was designed for single adults. Children have been added in at weekends in order to accommodate the needs of parents, particularly but not exclusively women, entering the programme in greater numbers, but no attempt has been made to radically redefine the programme's aims and orientation so that children are more readily accommodated. Identifying the solution as requiring greater intervention by Social Services would seem to confirm the view of children as 'extras', and standing outside the programme's main aims and focus. This view does not reflect the fact that children are an integral rather than peripheral part of many female, and some male, resident's lives. In many ways the Phoenix programme has a rather Janus-like approach to children. In the Family Unit they become the main focus of concern, women's identities are subsumed under their identities as mothers and the Unit seems as much concerned with child protection as with helping women recover from problematic drug use. I was struck with the way in which Roger, in his interview with me, related the work of the Unit to the NSPCC and Banardos. This was some confirmation of the confusion I felt was apparent in the Unit's aims and identity.

The Main Programme, in contrast, struggles to accommodate women's needs as mothers and while there is evidence to suggest a genuine concern to address these needs, there is a reluctance to do anything other than add women and children into the existing structure. This means that tensions and difficulties are inevitable and result in women, particularly those with children, having a very different experience of the treatment programme offered at Phoenix House.

Breaking Out: Women into Work and Education

Against the evidence which suggests the reinforcement of women's traditional role as mothers, is evidence of an initiative which arose out of a concern to present opportunities to women for work and education.

"I would like to open up more opportunities outside of this Community for the residents. I'd like to link with....agencies that offer short, educational/training programmes, such as three months schemes for people returning to study or training because I think that's a particular issue for women. They often have it drummed into them by all sections of society that the minute you're a mother you're no good as a worker or that you're precluded from the workforce. And there are difficulties, I know, but that premis is just false."
(Tony - Manager, Family Unit)

Tony's concerns had led him to liaise with a group of young people who had set up a short course for those wishing to learn about film-making and video. The result of his liaison was that women from the Unit and the Main House had become involved for a while. The initial intention was to offer eighteen places but by the time I became involved in my field studies, only three women were attending the workshops. Tony's explanation of why this was the case hinged around the reluctance of the staff in the Main House to 'push' women to attend the course regularly. Lack of commitment on

the part of staff to women's involvement in projects outside the Community was apparent from Cathy's interview:

> **"It (involvement in the project) was disastrous for us in the Unit..... The programme just stopped. I didn't like that at all. Yes it was valuable, for someone like Sue who had completed their programme. But for the people here who've only got six months to sort out themselves and their kids, it was a disaster. I think Tony realises now, how disruptive it was to the programme. When Mo was going down there, there was loads of stuff she needed to work on, loads. Detailed stuff..... She'd drop the kids off at school in the morning, go off to SHIFT (film-making workshop), come back, pick the kids up, have tea and that was it. Programme over. I don't think it can work in the context of this programme." (Staff member, Family Unit)**

Cathy's remarks indicate how Tony's concern to offer women broader educational/recreational opportunities was resisted by staff who saw such initiatives as undermining the programme's aims and treatment strategies. Further insight into the ways in which the demands of the programme compete with the development of educational and recreational opportunities was gleaned through my observations at the Re-entry House.

One of the aims of Re-entry is to encourage residents to engage in education and/or voluntary or paid work. It was clear, however, that choice in relation to courses of education was constrained by the requirements that residents attended group meetings at regular times in the week. One resident, for example, was struggling to find an opportunity to develop her Italian language skills at a time which did not conflict with programme commitments and did not entail a costly bus journey. Another finally left the programme early when she was unable to meet the demands of attending two groups a week and pursue her College Union activities. This particular woman was determined to pursue her own interests and left the programme to live in a hostel while awaiting re-housing. In the event, the Re-entry Team Manager was able to maintain a workable relationship with the young woman concerned but this particular set of events indicates a level of inflexibility in the programme's ability to encourage women to either break into, or resume their involvement in the world of work and education. Similar constraints are experienced by male residents wanting to pursue educational or work opportunities but since men more readily assume and expect to engage in such activities, they may perceive the constraints differently, as delays rather than barriers to their ambitions.

Within the Main Programme, women are expected to take their place alongside men in the Departmental structure. Their limited numbers often means that women are significantly absent in positions of responsibility such as Department and Assistant Department Heads but there was no evidence to suggest that individual women were denied equal opportunities to work on all the departments or in positions of responsibility. The lack of such opportunities for women in the Family Unit means that their primary work opportunity in the Community, is, as we have seen, child-care and related domestic tasks.

Women-as-vamps

One of the issues which frequently emerges in the mixed therapeutic community is that of sexual relationships between men and women. It is, not surprisingly, an area fraught with difficulties, and contradictions abound. Sexual relationships between men and women in the Community are not encouraged and where relationships do develop there is a concern that they should be discussed openly with peers.

The concern not to encourage sexual relationships, while it offers some protection to women in a community dominated by men, does not stem solely or even primarily from a concern about gendered power relationships. Rather, the concern is that too close an involvement with another detracts from the process of self-examination which is seen as fundamental to the success of treatment. From this perspective, women are seen to be a distraction for men, and vice versa. The implications for women is that they risk being cast in the role of temptress.

The sexism which gives rise to such attitudes, once rife in such communities, has largely been exorcised, but remnants live on. From time to time staff expressed concerns about women using what they perceived as their sexual power over men to manipulate situations and event. At the same time, however, staff expressed concern about men forcing their attentions on women.

> "In today's hand-over Steve (male resident) was described as 'sniffing round' Paula. Vicky, the member of staff giving the hand-over, acted out a description of Paula pinning Steve up against the wall, much to everyone's amusement."
>
> (July 1994)

On the one hand women are portrayed as victims in need of protection, while on the other they are suspected of using their sexual powers to distract men from the therapeutic task and avoid embarking on the process of self-examination themselves. I found little evidence to suggest that women were encouraged to be self-defining sexual beings in control of their sexual relationships and activities.

One particularly disturbing example of the sexism which continues to operate and define standards of conduct for women involved one of the women in the Family Unit.

> "In response to comments from staff and residents, and presumably because he took the concerns seriously, Tony rang Jackie Hill (Nottingham Community Drug Team) to ask her to bring some more clothes for Sally as she only seemed to have 'street clothes'. When I look puzzled, Helen explained that some of Sally's clothes were too revealing, too 'sexy' and, by definition, inappropriate. She proceeded to describe one particular outfit, comprised of tight black lace shorts over black knickers and a white top 'with her bust hanging out', as an example of what had provoked the concerns."
>
> (July 1994)

This concern about the appropriateness of women's appearance has a long history in the therapeutic community and I was surprised to still find evidence of it. Traditionally, the concern has been that women were 'setting men up', i.e. dressing in a deliberately provocative manner to tempt and distract men. It was not clear to me how far it was this particular concern which led to Sally's dress becoming an issue and how far the concern

was related to Sally's apparent unwillingness to reject her 'old' image and therefore her 'old' life-style - of drugs and prostitution. What was clear, was that the concern was underpinned by a set of assumptions as to what constituted an appropriate femininity, a set of assumptions which, from a feminist perspective, need confronting not confirming. A style of dress which, from a woman-centred perspective could have been read as evidence of Sally's self-confidence and willingness to assert her sexual identity, is read entirely differently from a perspective which defines women only in relation to men. The effect is to impose on women patriarchal definitions of acceptable femininity and to reinforce rather than challenge sex-role stereotyping.

Hysterical Women

A third and final concern in examining the operation of sex-role stereotyping in relation to women at Phoenix, is the resistance by some staff to respond to women's concerns about their health. There seemed to be a general pressure on staff both in the Unit and the Main House not to take symptoms too seriously and to be wary of resident's sliding out of their responsibilities on the grounds of ill health.

> "I noted that Kate had been labelled a 'drama queen' on account of the trouble she is experiencing with her toothache. Robin explained to Tony that he had taken charge of Suzie on the shopping trip 'while Madam (Kate) was having her drama in the van'..... Kate's fears, anxieties and pain following the tooth extraction have consistently been dismissed by staff."
>
> (July 1994)

> "In the morning handover it was reported that Linda (resident) was in bed ill but her symptoms were quickly dismissed as 'avoiding behaviour'. Ian's (temporary staff) report of the altercation between Phil and Linda the previous evening served to confirm the opinion that Linda was 'avoiding' (work and involvement in the Community)."
>
> (July 1994)

> "In the morning handover Tony reported on the serious nature of Pat's health and the events leading up to last night's emergency admission to hospital. Pat has a serious heart condition and although Tony clearly acted promptly and efficiently in getting her to hospital he nevertheless seemed to feel the need to admit to the possibility that she was 'swinging the lead' and that at least some of her behaviour 'over-dramatised' her condition. I felt he needed to do this in order to retain credibility with the staff group and not be seen as 'gullible'. The pressure is such, that even in circumstances with a well-documented medical history of heart disease, some acknowledgement was needed of the possibility of Pat 'over-dramatising'.
>
> (August 1994)

Similarly, women's unhappiness or anxieties about their programme or their progress are not always dealt with seriously:

> "In the morning handover it was reported that Laura wanted to leave. Rather than treat Laura's desire to leave seriously, however, Vicky (staff member giving handover) commented 'you can tell it's PMT'. Any legitimate reason Laura might have had for wanting to leave the programme early was thus dismissed as a symptom her menstrual cycle."
>
> (August 1994)

Women's concerns over their weight are treated more seriously and attempts are made to provide an alternative, low-calorie menus. However, there is a resistance to seeing the issue of weight gain in gender specific terms.

> **"Everybody puts on weight when they come to Phoenix, it's par for the course." (Craig - staff member, Main House).**

The day-to-day dismissal of women's anxieties about their health contrasts with initiatives designed to give women's health issues serious attention and a higher profile. During my observations, a visit to the Women's Health Bus was organised for women in the Main House (but not the Family Unit). I accompanied the women on the visit and it was clear that they appreciated discussing personal and general health issues with the staff on the bus.

This was an interesting initiative which demonstrated a recognition that there are particular issues around women's health which need addressing, particularly where women have been heavy drug users. However, I noted that no female staff were available to accompany the women - that role, to some extent, had been thrust onto me. I also noted that there was no follow-up to the visit and therefore no opportunity for staff or the women residents to reflect upon or follow-up on the issues it raised. While the visit itself suggested that the specific health-related issues which women face are recognised, there appeared to be no sustained attempt to integrate them more fundamentally into the programme's structure. Like children, specific attention to women's health has been added on and has yet to be fully integrated into the treatment process. This lack of integration may account for the apparent contradiction between a resistance to taking women's complaints about their health seriously and an initiative specifically designed to raise the profile of women's health issues.

Conclusions

Contradictions, such as those surrounding women's health issues, are a characteristic of the Phoenix House programme and result from repeated attempts being made to encourage greater participation by women in what has been recognised as a male-dominated environment. Initiatives designed to encourage a more woman-friendly ethos, however, tend to be added on to what already exists and take on a 'special case' status. This has a number of consequences. It means that women's issues become marginalised when resources are stretched, as they often are. It also means that women, as a group, can become the focus of resentment in a community in which privilege is earned rather than conferred.

Marginalisation and resentment obstruct a full understanding of the nature and operation of the gendered power relationships in the organisation. Without this understanding it is difficult to see how the programme can be restructured in such a way as to reflect a stronger commitment to feminist principles of practice which, in turn, might have an impact on its ability to attract and retain a significant proportion of women residents.

2. Sex-role stereotyping: Men and Masculinity

I have argued elsewhere that a concern with men and masculinity is an important aspect of a feminist analysis of services to illegal drug users and that the drugs field offers fertile territory for an examination of the ways in which these issues are engaged with. Until recently, the study of men and masculinity has had little attention in the

feminist social work literature but with the publication of Working With Men: feminism and Social Work (Cavanagh and Cree, 1996), this seems set to change. The following is an attempt to contribute to the emerging debate by examining how far the treatment programme at Phoenix House challenges traditional models of masculinity which are oppressive to women.

In examining the structure and organisation of the Phoenix House programme I have suggested that it is androcentric, resulting in women and women's issues being marginalised, that men are over-represented both as staff and as residents, and that it is characterised by a hierarchical chain of command which is masculinist in its conception. Within what appears to be an unrelentingly male order, however, challenges to stereotypical notions of masculinity, and men's oppression of women, are discernible.

The Men's Group

An important vehicle for this challenge is the Men's Group which now operates fortnightly, but which was run very intermittently when I first embarked on the study. Even with more regularity, the Men's Group, like the Women's Group has less status than the Peer Groups and the Community Group which are run weekly. Nevertheless, its existence demonstrates an awareness of men's issues and a concern to address them.

Getting an insight into the work of the Men's Group proved difficult. Neither I nor the men running the group felt my presence as an observer was appropriate and in any event, since the group was run in parallel to the Women's Group, to observe it would have meant missing the opportunity to participate in the Women's Group which I would have been reluctant to do. In the event I had to rely on second-hand accounts from the men running the group, accounts which I had to elicit for myself since there seemed to be no formal feedback channels operating. This in itself is significant, as it meant that there was little co-ordination between the work of the Men's Group and the work of the Women's Group and little possibility that issues raised in the two Groups would be taken up and developed in other arenas.

I was able to get some insight into the nature of the group and the issues that were dealt with, through conversation with a member of staff who currently ran the group and who had experienced being part of it when he himself was a resident. My conversation with Craig revealed some of the themes which were tackled in the group. Male abuse emerged from time to time, although on the whole men found this difficult to admit to and talk about. Media images of men were used to critically explore the dominance of a macho stereotype and the constraints that this imposes on men's experience of themselves and others. Relationship issues were explored, e.g. how and why men get into relationships, what needs they meet. Sexuality was also a key theme which Craig identified.

In addition to talking with Craig about the Men's Group in general, I also took the opportunity to speak with him when he had just finished running a group:

> "I asked Craig over lunch what he had focused on in the Men's Group and also asked a resident at the desk what he had got out of the group. Both Craig and the resident explained that the focus had been men's relationships with their fathers and how they would like their relationship to be with their own sons. Craig raised the question of how group members would react if a son told them he was gay and explained to me that the reason he had raised this as an issue was that he was concerned about

> the macho-centred style and feel of the community right now. He said he felt it was important to address the intolerance/lack of understanding and awareness with regard to homosexuality that he felt was around."
>
> (July 1994)

Craig's comments indicate an awareness of the need to address not only the sexism but the homophobia of the therapeutic community. There was some evidence to suggest that this alertness to the issues of male sexual identity succeeded in making the community comfortable for gay men. A conversation with an ex-resident who called into the community while I was there and who identifies himself as gay, suggested he had encountered few problems of discrimination. He told me he felt he got the support he needed from the programme, was still in touch with his former peers, and liked to keep in contact with the House. While there is no way of knowing how representative this experience was, it does suggest some success in making the community comfortable for gay men.

Given the way in which data from the Community Drug Team revealed an unwillingness to tackle the issue of domestic violence, I was particularly keen to discover whether this was an issue addressed in the Men's Group. Craig said it was, and described the way in which he had introduced it. He had started off the discussion by talking about football hooliganism and this had led on to violence against partners. While I was interested to learn that male violence towards women was an issue for the Men's Group, I was equally interested in the way in which it had been introduced. How far had the equation between football hooliganism and domestic violence obscured a crucial difference in their origins? i.e. men's power over women. Attempts to clarify how far this was the case were inconclusive but further evidence (see below) in relation to responses to domestic violence suggests that they are not underpinned by an awareness of unequal power relationships between men and women.

Further discussion with Craig about the operation of the group revealed that he found it difficult at times to get men to take the issues seriously and he expanded on this point in his interview with me:

> ....**the difficulty I've found in the last few Men's Groups, (is that) you always get one or two of the hard-core that, no matter what you say or what you do or what you talk about, they're going to be dickheads for the rest of their lives basically....and those two will set a good majority of the group up to act the same way. And then it's very difficult to break it down....."**

and later, in relation to the issue of domestic violence:

> **"I mean you always get...when I was talking before about...you always get the two people who try to pull things down and turn it into a joke...you can guarantee that if you're talking about relationships and family life-styles, you can always guarantee there will be someone, if you bring up a scenario and say 'what would you do in that situation', you can always guarantee that someone'll turn round and say 'I'd slap them'...you can guarantee it.**

My discussion with Craig also revealed that his only experience of, and training for, running the Men's Group, was his own experience of it as a resident. I was left with the impression that while attempts were made to tackle the issues and problems of men, the group's aims were vague, it lacked a pro-feminist theoretical framework and when resistance was encountered it was hard to manage.

Despite the apparent limitations of the Men's Group, there was evidence to suggest that men were being encouraged, either through the group or through other aspects of the therapeutic programme, to challenge sexism. I had an insight into this challenge when I observed an Interphase seminar (a resident applying to move on in the programme).

> "Jay was confronted by the all-male group about what they saw as his abuse of his girlfriend. He was urged to treat her more honestly and not use her as some kind of security blanket for reliable sex whenever he goes back home."
>
> (August 1994)

Challenging male violence towards women

As I note above, there is evidence to suggest that male violence is tackled as an issue in the Men's Group. It is also addressed in other, perhaps more effective ways. The following extract from my fieldnotes gives an insight into the way in which the life-story that residents are required to tell once they have reached a particular stage in their programme, can provide a vehicle for both men and women in the community to explore and reflect upon their experience of violent relationships.

> "Jean's presentation of her life-story offered an in-depth insight into a life characterised by violence, abuse and the tragic death of a child. The resident group gave her a sympathetic ear and some excellent 'feedback' which indicated not only that many of them had listened intently but that they could relate to and reflect upon what they had heard. One of the women residents emphasised to Jean, in relation to her abusive partner that 'she was worth more than that' and 'didn't have to take that shit'. She urged her to re-evaluate herself. The men in the group also condemned the abuse she had suffered at the hands of her male partner and urged her to cut the bonds of that violent relationship.
>
> Initially I had felt uneasy at the thought of Jean having to expose her life to a mixed group but my unease was unfounded as it seemed to be a valuable experience both for Jean and for the group as a whole. The women were able to identify with much in Jean's life, and the events she described also provided the possibility of holding up a mirror to the men in the group which may have reflected some of their own abusive behaviours. Above all, it brought home to the men the impact of male violence on women."
>
> (July 1994)

While Jean's life-story presented a valuable opportunity to examine the issue of male violence towards women, there was no evidence to suggest that this was used as a springboard for further work or discussion. No staff were present at the time the life-story was being told and this suggested that the opportunity to use the experience as, say, a basis for a Men's Group, was not capitalised upon.

Through the use of vignettes I was able to gain further insight into how staff viewed male violence towards women and how they responded to it. While it was clear that men's abusive behaviour to the women in their lives would be taken up as an issue,

it was equally clear that male violence was seen as a relationship problem, rather than a problem of male power. In describing what he would do if faced with evidence of a male resident abusing his partner on a visit home, Craig commented:

> **"...it would certainly have an impact on his visits home because I wouldn't want him to be going home if 'Brenda' didn't feel safe or if he was going to end up getting into difficulties with the police. I think I'd sit down and talk to him and find out if there were any sort of problems in his relationship, maybe refer him to RELATE...maybe on his own at first...and then maybe as a couple...if 'Brenda' wanted to."**

There is sound evidence to suggest that male violence towards women is an issue which is taken seriously and that efforts are made to emphasise its unacceptability. However, it was an issue that was dealt with largely on an ad hoe basis. There was no evidence to suggest that it formed part of a coherent programme aimed at examining men's abusive behaviour towards women:

> **"I would fault ourselves in as much as we, we somehow or other lose the (Men's) group from time to time, so we lose that continuum, that consistency, and I would fault ourselves that we don't have, therefore, a programme in place. We don't have a programme whereby we do one group which leads on to the next group which goes on to next group...." (Dean, Member of staff, Re-entry Team)**

Nor did the issues appear to be underpinned by a perspective on domestic violence which emphasises its roots in gendered power relationships and some staff, at least, felt they lacked training and awareness in this area:

> **"I think also that as a (gay) male I would need to go on a training course to become more aware of issues particularly relative to... male-female violence." (Dean)**

Dean made a further interesting point with regard to the way in which the issue of male violence is dealt with in the organisation:

> **"I think that what happens is that there is..amongst certain residents..a suppression of that (male violence) because of the rules that are in place. So I don't therefore...we're not addressing it."**

Dean's comments suggest that the issues are suppressed rather than addressed. The house rules which prohibit both violence and unacknowledged sexual relationships, and which censor material which is displayed on walls, protect women from the more overt forms of sexual harassment and sexual abuse and are important in this respect. They may, however, serve to suppress the issues if the rules are merely imposed rather than used as a springboard for exploring the impact of violence and harassment on the lives of residents in the community. Dean's comments would seem to suggest that the rules are helpful only in containing abuse and violence, leaving its roots in place and unexplored.

Men's emotional work

I have suggested that through the formal channel of the Men's Group and opportunities such as life-stories and seminars, male identity, stereotypical behaviours and attitudes are challenged. More broadly, the treatment programme, with its emphasis on exploring personal and interpersonal issues, encourages men to explore and embrace 'feminine' qualities of caring, intimacy and emotional expression. Physical contact between men is encouraged - the hug rather than the handshake becomes the standard greeting as well as a means of ensuring that group sessions end on a note of affection and mutual support.

The therapeutic community aims to engender a caring and supportive environment and to encourage warm and intimate relationships between its members. It aims to break into the repressed emotions and fear of intimacy which are important defining characteristics of traditional masculinity and to this extent succeeds in presenting a challenge to some stereotypical views of masculine identity and ways of being.

While an ethos which presents such a challenge is to be welcomed, it is not entirely without problems. Encouraging physical contact, in the form of hugging, between residents, while it breaks down the inhibitions and barriers between men, means something very different in the context of male/female relationships. The warmth and intimacy which it is intended to engender between equals can become potentially abusive, sexual and threatening where relationships are not equal. There is some evidence to suggest that there is a recognition that not all residents will welcome physical contact and that this resistance should be respected, but this appears to be a general concern rather than one which emanates from an awareness of the specific gender implications of encouraging physical contact between residents.

A second problem is the ease with which an ethos of male bonding can be hijacked by reactionary and anti-feminist impulses working to re-establish a male potency and virility that some feel has been lost. The work of John Bly (1991) is an example of this kind of thinking and while there was no evidence that it informed the work at Phoenix House, literature outlining the services of other therapeutic communities for recovering addicts, indicated that at least one community specifically recognises the work of Bly as an influence on its work. Certainly some of the messages of this new masculinist literature, which emphasises the importance of 'learning to get in touch with feelings' 'finding your inner man', and 'bonding with other men' (Thomas, 1993; Lyndon, 1992) resonates with the aims of the treatment programme offered at Phoenix and other therapeutic communities.

A third problem is that a focus on emotional expression tends to be translated rather narrowly and places a heavy emphasis on the ability to rage. Expressing anger - in a controlled group setting - is seen as a clear achievement and mark of progress by both staff and residents.

> **"I have been in groups where...people have been able to vent their frustrations, their anger about what's going on or about how other people are behaving towards them. ..and it's very powerful stuff. And without a doubt, I believe it is a necessary experience - to know that you can be angry, even rage, and do it in a safe way...a way in which you don't hurt yourself or hurt another**

> **person.....the fact that you've experienced that you can get in touch with the emotion is particularly important. Because of course otherwise it's held in and it's acted out in other ways." (Dean - Staff Member, Re-entry)**

Dean's comments illustrate the therapeutic significance which is attached to the ability to express anger openly and forcefully, but he goes on to suggest that it is perhaps overemphasised and that it over-shadows the expression of other emotions:

> **"And whilst I'm saying that the expression of rage and anger is important, that's only one of the spectrum of all the emotions that should be encouraged to be expressed"**

A further insight into the emphasis placed on the ability to get angry was gleaned from my observations of the weekly 'Clinical' in which the staff-group considers residents' progress. On this particular occasion a male resident, Chris, was under discussion.

> "Staff seemed very impressed with the standard of Chris's written work which they felt demonstrated a depth of self knowledge and reflexive insight not apparent in group work or counselling sessions. But concern was expressed about Chris's inability to express his emotions in groups, particularly his anger. One staff member felt very strongly 'he needs to get fuckin' angry' and couldn't understand why he didn't, given that he was 'put upon and walked over by just about everybody.'"
>
> (July 1994)

The emphasis that is placed on residents being able to express anger indicates that the potential for breaking into established masculine stereotypes is only partially exploited since ultimately, it is the strong "masculine" emotions - anger, rage - which are the ones most highly prized by the therapeutic programme.

Challenging misogyny

In examining her work with men who have been convicted of violence towards their partners, Monica Wilson (1996) admits that it is a constant source of surprise to her how little men understand the damage they do to those they profess to love and how difficult it is to get men to own the responsibility for their actions. She goes on to say that while it is important to establish "rapport and co-operation" with the men she works with, it is equally important that she is alert to the danger of men feeling that you are "on their side". A sympathetic ear, she suggests, can all too easily drift into collusion. While Monica Wilson's work and comments are specifically related to working with violent men, I would suggest that the problems she identifies - of getting men to empathise with women and avoiding the trap of colluding with their view of events - are common to many social work and social care settings. My observations at Phoenix House illustrated some of the ways in which this collusion operates. It is a collusion which fails to challenge men's view of themselves as victims of mistreatment by women who are variously labelled as 'heartless' (therefore 'unnatural'), as 'whores' and as 'gold diggers'.

The data on which I base my analysis of the issue, was gleaned when I accompanied Annie - the outreach worker - on a visit to an ex-resident. Greg was in the Re-entry stage of the programme when he left prematurely, after becoming involved with Jackie, who had 'split' from the programme after only a few weeks. Greg had recently

taken possession of a rented flat, Jackie had returned to the programme, and Annie was responding to a request from Greg for a support visit.

> "Early in the interview it became apparent that Greg was distraught about the fact that his relationship with Jackie was over. He said that he'd provided Jackie with love and support and somewhere to stay and that he now felt betrayed and used. He went on to say that this seemed like one of a series of relationships with women where he had been hurt and betrayed, giving examples of a girlfriend who had run off with his best mate while he was in prison and an ex-wife who had refused him contact with his children.
>
> Greg then returned to the reason he had asked Annie to visit - he had relapsed. He had been to a club where he had used 'E's and 'speed'. He tried to explain how and why this had happened and related his relapse to receiving the news about Jackie and their relationship.
>
> (July 1994)

I was struck by Annie's lack of challenge to Greg's view of events and her collusion with the view of Jackie as an manipulative woman and an emotional bruiser. Admittedly it was difficult for her to take both a non-punitive stance towards the relapse and launch a challenge to Greg's view of women. But the non-judgemental approach to the drug-using, when applied to Greg's view of his relationships with women, had the effect of confirming him in the role of 'abused man' which had led him back into drug use.

A conversation with Annie in the car after the visit was revealing:

> "Annie said that she wasn't surprised at Greg's news as she had visited Jackie at the Main House shortly after her return, taking some flowers that Greg had sent. Jackie had been very short with her and asked if Greg had sent any tobacco. Annie remarked 'He'd spent £18 on flowers and all she was interested in was tobacco!"
>
> (July 1994)

The conversation in the car, which also involved some comments on a letter Jackie had sent to Greg and which Annie had read, left me in no doubt that Annie's view of the situation accorded with Greg's and that she saw him as the victim of Jackie's 'games'. Had Annie been working only with Greg and not Jackie, her willingness to accept Greg's view of events might have been more understandable though not excusable. This was not the case as Annie had also been supporting Jackie while she decided whether to return to Phoenix or not.

The scenario I have outlined is a familiar one in work with men in a social work setting. Annie's unwillingness to challenge the misogyny which lies at the heart of Greg's view of events indicates an acceptance of a masculinist view of women as devious, manipulative and not to be trusted. A feminist approach to the issues would emphasise the need to challenge rather than confirm the assumptions that are embedded in both Greg and Annie's view of the relationship problems he describes.

In contrast to Annie's anti-feminist practice with Greg, I also had an insight into a more robust, pro-feminist response to a similar case. This indicates the existence of contradictory approaches in the same organisation.

> "Mark (resident) came into the Re-entry office to say that Ray, a Main House resident due to come down for the day, was unable to do so. Ray was devastated by

the fact that he had had his divorce papers through this morning and was too distressed to come. Mark said that he had a good deal of sympathy with Ray who he saw as being in a similar position to himself - still loving his estranged wife, wanting her back, but having a divorce inflicted upon him. Bev's (staff member) comment was to ask whether Ray's response (and by implication, Mark's) was justified - 'Was he really surprised? Did he really expect anything else?'

(September 1993)

The exchange was a short one and there was no evidence to suggest that a more sustained and critical exploration of events leading up to Ray's or Mark's divorce was attempted. Nevertheless, it indicated an unwillingness to collude with Mark's view of Ray (and himself) as victims suffering at the hands of their former partners and to this extent contrasted with Annie and Greg's encounter.

Conclusion

It would seem that the treatment programme offered at Phoenix House offers a good deal of opportunities to work with men along pro-feminist lines, challenging their sexism, their oppressive behaviours and attitudes and freeing them from the constraints of a repressive masculinity. Some of these opportunities are taken up but in a way characterised by ad hoc strategies and impromptu responses. No clear or coherent framework was discernible, either in terms of day to day practice or its theoretical underpinnings.

Men are expected to respect women, and other men, in the community and are challenged when they fail to do so. This demand for respect, however, may serve to conceal the misogyny which often underlies men's responses to women and indeed women's responses to other women. There is evidence to suggest that when this misogyny is inevitably revealed, a challenge to it will not necessarily be forthcoming. Where a challenge does take place, there is no evidence to suggest that it forms part of a coherent strategy of resistance to the oppression of women. A more developed awareness of the extent of the problems created by gender inequalities is probably necessary, if a coherent, co-ordinated and committed response to challenging women's subordination is to be incorporated into the treatment agenda for recovering addicts.

Campaigning and Making Alliances

Feminist commentators on social work practice stress the importance of building bridges and alliances between health and social care agencies working with women. In order to assess how far this principle of practice is in place I shall discuss evidence from both research sites together. I have chosen to deal with the data in this way as there are marked similarities in the way in which the sites relate to other agencies and in their limited commitment to *'campaigning and making alliances'*.

My observations at both the CDT and at Phoenix House suggested that staff energies were largely absorbed by their respective client groups and that opportunities for inter-agency alliance building were limited and not a priority. Where liaison with other organisations was evident it was largely related to individual cases.

Women's Aid has a high profile in both the areas in which the research sites are situated and might be an obvious ally. But while it was clear that both sites had contact with Women's Aid, it was in terms of an onward referral agencies for women experiencing problems with male violence, rather than as a political ally. Similarly, a Woman's Centre which has been established close to the CDT, was seen not as a source of political support but as a resource for individual clients.

The CDT's relationship with Rape Crises was similarly structured around individual cases and referrals:

> **...we can actually refer people on to more appropriate agencies if it's a particular thing... Rape Crisis for instance.....I can think of one example....a user got himself a girlfriend who had been raped and used us to plug her into the Rape Crisis centre....I'm quite willing to be used in that way." (Dave, CDT)**

Dave's comments suggest that he sees Rape Crises as an organisation which has more appropriate skills for dealing with cases that go beyond his area of expertise. There is little sense of any awareness that the CDT and Rape Crises might share a common political agenda.

Phoenix House similarly refers clients to Rape Crises where they feel they lack the skills to assist residents with experiences of rape and abuse.

> **"We refer people to Rape Crises...we're not involved with them in any sense. I mean, residents have it and it's available and they'd be encouraged if they wanted to do that." (Rachel - Staff Member, Re-entry)**

> "Linda (resident, Main House) has been referred to Rape Crises for help in working through the trauma of a rape she experienced before coming to Phoenix."
>
> (July 1994)

Since a large proportion of women residents in the Phoenix Programme are recognised as having experienced sexually abusive relationships, the lack of staff skill in this area and

lack of a relationship with Rape Crises (and Women's Aid) over and above individual case management, is somewhat surprising. Linda's case also demonstrates the limitation of a treatment programme narrowly focused on problem drug use.

Over and above the links that are made through individual clients, the two agencies are occasionally involved in interagency working parties and one-off events.

> "Once a year the Women's Centre invite us to the Women's Health Day. But our input never goes down very well...we're not having a stall this time, we're talking in terms of having a video, putting some posters up and having discussions around parents and drugs or women and drugs at set times." (Sue, CDT)

> "We used to have contact with the Women's Housing Forum and we've had odd contacts with Women's Aid. The Women's Health Bus is coming...and....I have a bit of contact with the Women's Health network but not nearly enough". (Fiona - Team Leader, Re-entry, Phoenix House)

All the evidence in relation to the building of broad political alliances around a feminist agenda for change points in a similar direction. Contact with other organisations is apolitical, limited to either individual referrals or ad-hoc meetings around specific issues - a health day, women's housing needs etc. A similar picture emerges in relation to building alliances around social rather than specifically feminist issues. Asked about contact with other welfare agencies, Sue replied:

> "We have a reasonable relationship...the woman at the unemployment office rings up from time to time to complain - 'they 're leaving needles and syringes in my toilet'....and I try to talk to her and explain the problems. And she's gone from 'they should stop' to 'well can you provide us with some bins and I'll put them in'. So there's a change there and that's what it's all about." (Sue, CDT)

The team's role, from Sue's perspective is raising awareness and levels of tolerance among individual staff in other organisations. While this is undoubtedly important it is a long way from the campaigning and alliance-building strategies outlined in the feminist literature on health and social care.

In addition to the informal contacts outlined by Sue, the CDT also has more formal involvement with other local and national agencies. These are organisations and committees set up specifically to tackle the issue of drug misuse and again, have little commitment to broader political alliances and strategies for change.

Conclusion

Since both the agencies studied are underpinned by a model of professional practice which is largely gender blind and focused on change at the individual level, it is not surprising that little priority is given to building broader alliances around an agenda for social change. The formal and informal relationships with other organisations which do emerge, like the Drug Advisory Committee which Harry (CDT) chairs, are centred on common concerns around drug misuse, AIDS and HIV. Other, more informal links are

forged as a way of harnessing expertise for clients on a case-by-case basis. There is little evidence to suggest that either of the organisations studied recognise the value or potential of building alliances which seek to challenge the established gender order.

SUMMARY

This analysis of findings on the second research site began with an exploration the organisation's *Professional Ideology and Practice*. The discussion identified the characteristics of the therapeutic community and explored its emphasis on *abstinence, managing chaos, voluntarism* and the *concept of self-help*. I described how these key principles and assumptions operated, and critically appraised them using feminist principles of social care practice. Attention was drawn to ways in which the work of the Family Unit differed in emphasis and orientation from that of the of the Main House and the implications of the differences were examined.

The discussion then moved on to consider to question of *access* and again it looked at the differences between the Family Unit and the Main House. It was revealed that access to the Main House where the resident group is predominantly male was relatively easy to accomplish. This contrasted with the smaller Family Unit where funded places were more expensive, making it a much more difficult service to access. It was also revealed that women with children were accessing a very different service to men and single women.

The feminist social care principles of *'increasing self-esteem'* and *'rejecting sex-role stereotyping'* were used to gain further insight into the ways in which the service meets the needs of its women clients. Evidence of the programme's ability to *increase self-esteem* was apparent where women completed, but it was also suggested that there was much in the structure of the therapeutic programme which had the potential for undermining self-esteem. In relation to *sex-role stereotyping*, similar problems to those identified at the CDT in respect to the service's willingness to challenge men's sexism and abuse of women were revealed. In the TC, however, men's groups operated and there is some evidence of attempts to counter the culture of an aggressive masculinity in the community's emphasis on sharing feelings and expressing emotions.

In relation to women, the discussion revealed a willingness to embrace rather than reject some of the stereotypical roles which define and constrain women's lives. My analysis of the Family Unit demonstrated its concern with women's mothering skills and responsibilities. It was suggested that the role of child care expert undermined rather than supported women's confidence in their child care skills since it assumes a parenting deficit and uncritically incorporates a concern with women as the coping stone of the family. I considered how the heavily structured therapeutic programme militated against women's ability to pursue educational interests and how staff responses reinforced stereotypical notions of femininity. In my view, and perhaps rather ironically, the Family Unit, set up largely to meet women's needs, ultimately served women less well than the Main Programme. While the latter shared some of the problems of the Family Unit and incorporated many of the same assumptions, it offered opportunities for women to head up Departments, engage in confrontation via encounter groups, assert themselves as responsible members of the therapeutic community and, most importantly, it provided time and space for self-reflection.

The final discussion, using the feminist social care principle of *'campaigning and making alliances'* relates to the findings on both research sites. As might be expected from services which reveal a concern with *individualising* rather than *re-defining* social problems, there was little evidence to be found of a concern to forge political alliances with other agencies.

CHAPTER 10

Social Care Practice and Feminist Politics

The aim of this final chapter is to highlight and further reflect upon some methodological, technical and substantive issues raised by my research into services for illegal drug users. The first part of the discussion revisits the principles of feminist practice from which the research's analytic framework was derived. The second offers some further reflections on the research's methods and methodology. The third reviews the research's findings and explores their policy implications. Finally, the main contours of a feminist approach to services for illegal drug users are set out.

1. Feminist Principles of Health and Social Care Practice Revisited

A central concern of this study has been to use the principles of feminist social care practice as a way of understanding the operation of services and their ability to meet women's needs. The discussion here offers an overview of findings in relation to feminist practice and a critical appraisal of the principles themselves.

Re-defining Social Problems

Evidence in support of services' commitment to de-individualising social problems is weak. On both research sites attention centred on the individual, their personal strengths and weaknesses rather than on the wider structural constraints within which individual's experience their dependency on drugs. Some insight into the fact that unemployment, homelessness and poverty were relevant to and had an impact on client's use of illegal drugs was evident. Dave's analysis (CDT) in particular demonstrated this awareness. There was also an awareness of the particular problems encountered by women in relation to drug use and its treatment. All the workers at the CDT cited cases where they had worked with and supported women who were either trying to come to terms with sexual abuse from a father or male partner or were involved in a physically abusive relationship. However, this awareness of wider social issues and gendered power relationships expressed itself in a concern to help individuals deal with the emotional and to some extent the practical difficulties which poverty, unemployment, male violence etc. presented them with. There was little evidence of a consciousness-raising approach to the counselling agenda which would have enabled clients to relate their individual, personal issues to the wider social structure.

At Phoenix House the counselling agenda looked inward to the individual's drug-use, emotional life and responsibility to others in the Therapeutic Community rather than outward to the social structures within which recovery was being experienced. The treatment agenda in the TC was narrower and more closely focused than that offered by the CDT. Issues which were deemed to lay outside the expertise of staff, like sexual abuse and HIV, tended to be referred on and residents were encouraged to contact 'Rape Crises' or the Aids Counselling service for assistance with these particular issues. This paring down of the counselling and treatment agenda made it difficult to see how the Therapeutic Community can hold out much possibility for developing the connections which need to be made if problems are to be de-individualised and re-defined.

This commitment to individualising social problems and to treatment within the confines of the Therapeutic Community is what Ettorre (see Chapter 2 p.39) describes as a 'clinical' self help model of practice. The work of the CDT is underpinned by a more developed awareness of social and gender issues and a wider agenda of counselling concerns. It also recognises the possibility of a more participatory and politically empowering model of social care practice (see p.123). Ultimately, however, it too adopts an approach which individualises social problems and embraces the 'clinical' model of self-help identified by Ettorre. In relation to the two research sites it is clear that there is much evidence of a 'clinical' or 'treatment' approach but little to support the existence of the alternative 'structural' model which Ettorre identifies and which depends on a commitment to de-individualising social problems for its development.

The concern to re-define social problems is germane to development of a feminist social care practice and to this extent has been a key concern of the research. It needs to be recognised, however, that an explicit concern with the ways in which race, disability and sexual identity as well as gender, mediate the construction and treatment of illegal drug use, is needed. My analytic framework included a concern to assess how far social problems were re-defined in the treatment process. I was concerned to discover how far services recognised the wider social and gender dimensions of problematic drug-use, but this concern with 'the wider social dimensions' needed refining to include questions relating more specifically to the impact of race, sexual identity and disability. It was difficult to 'see' the way in which race, for example, mediated the treatment process precisely because the analytic framework worked with a rather universalised notion of gender. I asked questions about how far services recognised the specificity of women's experience of illegal drug use but failed to develop a specific focus on, e.g. black women's experience or on lesbian women's experience. Had the principle of re-defining social problems included a specific concern with race and heterosexuality, the ways in which 'white' as well as 'male' and 'heterosexual' power inheres in the construction of illegal drug use and its treatment might have been exposed.

Challenging the Power of the Professional

Ettorre's contrasting models of self-help, similar to those outlined by Young (see Chapter 2 p. 38-39), are also useful in elucidating the feminist principle of social care practice which is concerned to challenge the power of the professional. There would appear to be evidence to suggest that this principle operates on both the research sites. The CDT stresses the importance of working to their client's agenda and Phoenix House is a self-help community. But while the principle clearly operates, it does not seem to bring the services any nearer to the development of feminist practice. The distinction that is made between 'clinical' and 'structural' (Ettorre 1989) or between 'treatment' and 'empowerment' (Young 1994) models of self-help, is necessary in order to understand why this is so. The principle of '*challenging the power of the professional*' needs to be further refined in order to capture some of the problems with self-help models which are clearly designed to challenge the power of the professional but which operate within a 'treatment' paradigm and which, in the case of the TC re-invent the power of the professional in its hierarchical structures. Ettorre's and Young's analyses of self-help approaches to health and social care practice enable a more precise identification of what challenging the power of the professional means in relation to feminist practice.

Equalising Relationships

A number of issues are raised by a consideration of the feminist principle of social care which stresses the need for workers to share experiences with their clients, explore common ground, and thus strive to equalise relationships. First, the principle is heavily compromised, as has been suggested, by the controlling strategies deemed necessary in working with illegal substance users. Secondly, the principle which is similar to that which pertains in relation to feminist research, assumes a working relationship between women. The concern to equalise relationships, as was demonstrated in my discussion of methodological issues, is too simplistic a strategy to accommodate the complex power relationships which have to be negotiated between women workers and their male clients. Rachael's comments (p.212) and my analysis (p.213) draws attention to the fact that women workers may feel the need to adopt more defensive strategies when working with male clients.

Thirdly, I was struck by the similarities of the responses to my question designed to identify how far the client/worker relationship conformed to feminist principles. Workers on both research sites stressed the need for establishing and maintaining clear boundaries in relation to their clients and while all agreed they shared some personal information and insights, there was a careful monitoring of the extent to which they did so.

However, in reflecting on these responses, particularly in relation to Phoenix House, I consider there may have been a problem of validity inasmuch as my questions were unable to capture the precise nature of the 'sharing' which the development of feminist practice relies upon. In an organisation which is concerned that staff do not become over-involved or over familiar with residents, questions relating to boundaries between clients and workers have a particular resonance and a particular set of meanings attached. A concern to establish clear boundaries is generated by the residential situation in which private and public worlds collide, where staff eat with residents and sleep in the House from time to time. It is also generated by an organisational structure which relies on some ex-residents making the transition from resident to staff-member, which in turn depends on a transition from addict to abstinent member of the wider community. Boundaries between residents and staff are thus not unconnected to the boundaries between using drugs and being abstinent. Staff insistence on clear boundaries has to be understood in this context.

How far these boundaries inhibit an exploration of the common ground between women workers and their clients on which feminist practice depends, is difficult to assess. My questions designed to elicit understanding in this respect were overlaid with worker's concerns about appropriate boundaries rather than with my concerns about establishing common ground. Interestingly, shortly after completing my interviews, one member of staff was suspended (since reinstated) following concerns that appropriate staff/resident boundaries were not being maintained. At the CDT there was a similar insistence on the importance of constructing appropriate professional boundaries.

Evidence from observations would seem to confirm that while some attempt is made by staff to reveal aspects of themselves and their lives to their clients, revelations are limited to those deemed relevant to assisting residents in their recovery from drug use, or to those deemed necessary to ease staff/client interaction. There is little evidence

to suggest a commitment to raising awareness of gender relations through the staff/worker encounter.

Equal relationships should not necessitate the abandonment of boundaries between workers and their clients and it may be that my concern with boundary setting was something of a red herring in trying to establish how far equal relationships obtain in the social work setting. A more accurate assessment might be available only through a closer scrutiny of the counselling relationship, since it is the willingness of workers to share aspects of their experiences as white heterosexual/gay men and white heterosexual/lesbian women (there were no permanent black members of staff on either of the two research sites) which is the issue. The extent to which staff engage in this sharing is, as I have explored above, difficult to access for research purposes.

Finally, in reflecting on how far the principle of '*equalising relationships*' operates, I have considered (p. 128) whether there is anything intrinsically 'feminist' about this principle of social care practice. I concluded that there is not and that the principle is indicative of good rather than of feminist practice. I also concluded however, that it provides a necessary basis upon which feminist practice must build in order to ensure that worker's sexual orientation, their racial and gender identities are brought into the social care relationship as a legitimate focus for discussion. An insistence on the importance of fracturing the boundaries between a worker's personal and professional identity, of drawing on personal experience to assist the development of consciousness-raising in the counselling relationship, are some of the specific ways in which 'equalising relationships' must operate in a feminist practice.

Rejecting Sex-role Stereotyping

I suggested in Chapter 9 (p. 230-235) that while the TC offers opportunities for challenging men's sex-role stereotyping they are taken up in a rather ad hoc manner and a clear framework in which men's oppressive and stereotypical behaviour can be understood and challenged is lacking. The CDT similarly fails to provide a coherent challenge to men's sexism and to their stereotypical behaviour. In contrast, the CDT's work with women clients demonstrates a much stronger commitment to rejecting sex role stereotyping although it is not always extended to wives, partners and mothers of clients. Work with women in the TC suffers from a readiness to reinforce oppressive stereotypes and to collapse women's and children's needs together.

The value of applying the rather broad criteria of 'rejecting sex-role stereotyping' to an assessment of health and social care practice needs examining critically and a more precise identification of precisely *what* is being rejected, is probably needed. As with the principle 're-defining social problems' a concern with racial stereotyping is also necessary in order to take account of the impact of differences *between* women on service delivery. Nevertheless, the use of this principle of practice as an analytic device has revealed some significant ways in which services fail to serve women interests. While the feminist literature on social care practice focuses exclusively on the concern to reject the sex-role stereotyping of women, I have made use of the principle in relation to both men and women. This has enabled me to expose the lack of coherent strategies for dealing with men's sexism and male violence which is explored above. My view could have been further extended by a consideration of the operation of racial stereotyping and of heterosexist assumptions which underpin the construction of 'masculinity' and 'femininity'. In order for the principle of 'rejecting sex-role

stereotyping' to provide a necessary underpinning for the development of practice, it needs to be able to capture the diversity of stereotypes which constrain women, and men's experiences and behaviour.

Increasing Self esteem

There is a good deal of evidence to suggest that the social care practice of the CDT succeeded in encouraging its clients' growth of self esteem. Practice in the Therapeutic Community was more ambivalent in this respect. Opportunities for failure are built into the programme. The emphasis on the ordered community means that opportunities for transgressing rules and failing to meet standards are many and varied. The goal of abstinence, the length of the programme and the pressure to maintain a forward momentum means that the rate of failure to succeed is high. However, where residents do complete their programme the pay-offs in terms of increased self esteem are substantial, precisely because of the difficulties en route.

While there is evidence to suggest that the principle of '*increasing self esteem*' operates in relation to the CDT and, with more ambivalence, in relation to Phoenix House, we have to consider whether, like the principle of '*equalising relationships*' it is not simply an indication of good practice rather than of specifically feminist practice. Certainly it is a principle which must underpin feminist practice but there is a need to recognise that increasing self esteem is what all good social care practice should be aiming for. Rather than simply concerning itself with increasing self esteem, a feminist practice needs to understand and pay attention to the gender specific ways in which self-esteem is undermined and how women's self confidence can best be increased. Since there was some resistance to acknowledging the gender specific issues attached to drug use and its treatment, any encouragement to increased self esteem which is offered by services will result from good practice rather than specifically feminist practice.

Aiming for change not adjustment

My analysis of the data does not draw very explicitly on this principle although it clearly relates to some of the issues discussed in relation to sex-role stereotyping and particularly to the work of the Family Unit with its heavy emphasis on adjusting women to their role as mothers. As a principle it relies on consciousness raising for its realisation and is clearly fundamental to an emancipatory model of social care practice. There was little evidence of the use of consciousness raising techniques in the work of the two research sites although a closer, more sustained scrutiny of counselling and groupwork concerns may have revealed more. The principle is closely connected to that of '*de-individualising social problems*' and of '*rejecting sex-role stereotyping*', and was largely subsumed within these for the purposes of my analysis.

It may be that while the principle is important for the development of feminist practice generally, it has a particular relevance to work with women who use illegal drugs. Drug use may be related to a need to break out of the confines of conventional lives and to escape the responsibilities of womanhood. To simply work to re-adjust women to the very circumstances which, through drug-use, they have found an escape, may well be counterproductive.

Recognising the complexity of women's problems

Again I have made little explicit use of this principle in framing my analysis of the data although it has clearly influenced my thinking in relation to a number of issues, not least those raised above in relation to specialist services. The development of services designed to focus on the problems of drug misuse, together with a resistance to en-gendering the treatment agenda, means there is a failure to recognise the multi-dimensional source of women's problems. Of the two services under scrutiny, the CDT, with its range of skills, offers up more possibilities for recognising and working with the complexity of women's problems than does the Therapeutic Community with its more narrowly focused treatment agenda. Both services, however, lack a strong commitment to locating women's problems within the wider social structure and thus to understanding drug misuse as just one of a number of interrelated issues which women need support in addressing.

As a principle, recognising the complexity of women's problems must have a central place in a feminist response to health and social care problems since it might suggest a starting point quite different to that identified by service providers. Women, and men, might only be able to address their problems with drug misuse once issues around housing, child welfare and/or general health have been resolved. A narrowly defined treatment agenda which focuses on drugs and drug-use may simply not be the primary presenting problem for many women.

Campaigning and making alliances with other agencies

The operation of this principle is, as we have seen, not discernible on either of the research sites. Relationships with other agencies are characterised by exchanges over individual clients rather than by the building of political allegiances. Where more formal inter-agency forums operate, they focus on drug use rather than on women's issues or gender politics. Findings here reflect the lack of concern to de-individualise social problems and the dominance of a 'treatment' rather than an 'empowerment' approach the issues. Where the key feminist principle of '*de-individualising and re-defining social problems*' is weak, it is not surprising that evidence of other feminist principles is lacking, except where they overlap with and form the basis of good social care practice.

2. Reflections on Process

Methodological Issues

In Chapter 3 I considered the principles of feminist research and how they might be reflected in my research design and implementation. I suggested that my research orientation embodied some important feminist principles, but that it was unclear how the research might fulfil a commitment to social transformation. In reflecting further on the issues it is clear that in order to effect change, the research would have to be disseminated with a view to influencing social care policy and practice in relation to drug misuse. Alternatively, or additionally, the research process itself might serve as a vehicle for change. Of the two strategies, the latter offers the more immediate possibilities and the discussion below considers the extent to which these possibilities were realised.

In considering the impact of the research process on practice in the two sites, it is possible to identify a number of instances where the research operated as a consciousness raising mechanism among service providers and to this extent generated a change in thinking and perception, if not directly and immediately in practice. It was clear, for example, that interviews were often used by service providers to reflect on practice and that this reflection raised awareness. The extract from Dave's interview on p.120 is a good example of this. In considering the issue of client control and input into decision-making, he identified an alternative - more empowering - model of service delivery which the team could operate:

> **"We could have got the thirty-odd people together (clients being prescribed methadone). We could have got them together and said, 'look, this is the score, what do you want?' But we didn't.....*it's only just occurred to me now..... It would have been top of my list once....."***

Jackie's interview also reveals the impact of the research on her awareness. In response to my enquiry about the issue of male violence and its treatment within the service, she remarked

> **....we've never particularly talked about it till you popped up on the scene" (see P. 147)**

Other evidence of the fact that the research had the effect of raising practitioner consciousness with regard to male violence as a social care issue is cited on p.146. Fieldnotes quoted here confirm the fact that my presence in the organisation had prompted the team to explore their strategies for confronting male violence to women.

Evidence of consciousness raising was less apparent on the second research site (Phoenix House). There was a willing engagement with the researcher and some critical reflections on practice featured in the interviews (see comments on p.218 and Dean's comment on p.225). However, there was little evidence to suggest that these reflections resulted from the researcher's presence in the organisation. Neither is there any evidence to suggest that the setting up of a working party shortly after the completion of my fieldwork, to address the problem of the under-representation of women in the programme, was directly related to my involvement. Nevertheless, it is possible that the research had an impact on keeping the 'woman question' on the organisation's agenda of concerns and the invitation to be involved in the working party gave me the opportunity to feed in my perceptions of the problems the organisation faced with regard to women's involvement in the therapeutic programme. We discussed at some length the problems posed by a peer group structure which divides what is always a small group of women amongst the three peer groups. There was a reluctance to abandon peer groups altogether but the need to create stronger support networks between women in the community was recognised by the working party. A favoured option was to encourage special friendships between women already established in the community and those newly recruited. While this would provide some much needed extra support, I was concerned that once again women were being singled out for special treatment and that a further layer of support was simply being grafted on.

While I remain concerned that my claims to be engaged in feminist research are at their weakest in relation to the clarity of its strategies for bringing about social change,

there is some limited indication that the research prompted *some* critical reflections on service delivery. Some of these reflections *may* result in change but how far such changes will further a feminist political agenda is unclear. And ultimately, the limits of the research's ability to generate social change have to be recognised. Maynard (1994) is surely right to emphasise these limits in respect to feminist research more generally and feminists may have to settle for a less than clear relationship between undertaking research and generating social transformation. Political commitment in the research process may not translate easily or directly into social or political change. There is a danger that if feminists set their sights too resolutely on the need for their research to effect social change, much research will either not get done, or not 'count' as feminist research.

The research process is explored in Chapters 5 when the researcher's identity and role in the organisation is critically examined. Early in the research I was alerted to the danger, so well set out by Alison Lurie (1967) in her novel 'Imaginary Friends', of the observer gradually becoming the participant. I felt that the risk of such a metamorphosis had a particular resonance for me as the practitioner turned researcher. My exploration of field work experience in Chapter 5 focuses on this volte face. The discussion emphasises the possibilities as well as the problems in this role switch and the interrelationship of the researcher and the practitioner role. My experience demonstrated that strict role demarcation, between researcher and researched, was not always necessary or productive and that practitioners contributed some crucial insights to the analysis of services. Moreover, a practitioner perspective was revealed as a significant motor in developing the research agenda in the first place and in having access to 'experience recollected in academia' (Bulmer 1982).

In Chapter 7 I turn my attention to the issues which are raised in relation to doing feminist research. Of major concern here is the contradictions which are exposed in adopting a feminist perspective in a situation where men predominate. Principles of feminist research, which stress partnership in the research process and non-hierarchical research relationships, produce tension and strain where the research site is composed of men as well as women and where a commitment to feminist politics cannot be assumed. Research relationships cannot simply be equalised since the power of the researcher is mitigated by the wider structure of gendered power relationships and the privileging of male identity

The issues were further compounded on the research site - Phoenix House - which is modelled on self-help principles since this has the effect of privileging, albeit informally, the status of the ex-addict over that of the professional social care worker. My power as the researcher was thus doubly mitigated when interviewing or observing male workers who were also ex-addicts. A further layer of complexity was added when I was interviewing staff who had been resident in the Community when I had worked there as a senior practitioner. In these cases our previous relationship, which was characterised by the hierarchical staff/resident relationship outlined in Chapter 9, had to be re-constructed to meet the needs of the feminist research encounter. Such complex power and status structures have to be carefully negotiated by the researcher. She cannot endeavour to simply establish an even playing field, nor can she return to the traditional model of research relationships.

Turning the research into a partnership would also have required me to engage in dialogue with service providers which exposed the feminist insights which I was drawing

on in my analysis of the service. While some of these insights were shared, on the whole, and as I make clear in Chapter 7, I felt it wise to be cautious in this respect. This further compounded the problems of endeavouring to make the research into a joint enterprise between researcher and researched.

In developing a feminist perspective on services, my aim has been to produce an alternative 'reading' of the meanings embedded in health and social care practice. Such a 'reading' is made necessary because feminists, like critical theorists, argue that knowledge produced under conditions where structured inequalities obtain, is flawed by systematic distortion. Power is surreptitiously incorporated into the knowledge production process and this incorporation needs to be revealed and challenged Thus, one of the aims of feminist scholarship is to lift the constraints on understanding imposed by patriarchal discourse and by so doing, undermine its dominance. This enables a movement towards the establishment of a view of social reality, or more specifically in this case, of health and social care services, which is unencumbered by the distorting effects of patriarchal power relations.

A feminist perspective cannot claim to offer an undistorted view of social reality since power inequalities other than gender inhere in what we know. It can however, move us towards a less partial understanding by disrupting and destabilising the dominant discourse and by offering an interpretation of the social world which penetrates taken-for-granted assumptions underpinned by gendered power relations.

In claiming to offer a less distorted view of social reality, the feminist scholar is engaged is revealing an alternative and suppressed reality. But how can she be sure that the reality which is revealed is not simply a product of the ground on which she stands and what gives her claim to know any greater validity than the one she sets out to challenge? In an attempt to counter the charge of merely seeking to replace one set of ideological arguments with another, the feminist scholar acknowledges her interests and exposes her position to critical scrutiny. She embraces the partiality of her perspective and her commitment to social transformation, and thus alerts us to the possibility of distortion.

The test of validity for the knowledge which feminists produce lies not in the internal processes of the research, but in its ability to produce insights which resonate with the ways in which gender inequalities are experienced and which can provide the impetus for political action. The notion of validity thus embodies the concept of dialogue and, ultimately, the ability of that dialogue to produce liberatory strategies and political change.

Methods and Techniques

The problem of 'seeing' parallel events, discussed in Chapter 6, was an issue which arose from my choice of method. Observing the work of health and social care services has to somehow take account of the multiple and often conflicting demands on the researcher's time and attention. Where services are provided on a 'drop-in' basis, as is the case for much of the CDT's work, the issues are particularly acute. What to observe and participate in are on-going decisions which the researcher has to make with little time for reflection. How to understand the services from what were episodic and often fragmentary observations was a major challenge.

As a researcher seeking to understand the work of the CDT, I was also faced with the challenge of inserting myself into the social work encounter and into an established relationship between client and worker. Where clients were simply 'dropping-in' my involvement was relatively easy to negotiate but where they were keeping a formal appointment which formed part of an on-going series of counselling sessions, the problems of participant observation were more acute. Where I was able to gain access to one-to-one client/worker counselling sessions, it was in the role of co-worker rather than 'fly-on-the-wall' observer. Even where my participation in the actual interview was minimal, the workers themselves expected that I would adopt the role of co-worker in feeding in insights about the client, his/her future needs, level of commitment to change etc. My ex-practitioner status, explored in Chapter 5 and referred to above, was crucial in gaining the confidence of staff to engage me in this way.

Home visits, hospital visits and prison visits provided more comfortable opportunities for me to observe the client/worker encounter than did the office interview. There were a number of reasons why this was so. First, the office space was very limited and one of the interview rooms in particular was very small. Inserting myself into the intimacy of the client/worker encounter proved easier where there was sufficient physical space for me to move in and out of the conversation as I deemed it appropriate. Secondly, hospital, home and prison visits gave workers the opportunity to fully appraise me of the client's background, circumstances etc. as they involved a car journey in which this could be accomplished easily and without interruptions. This enabled me to feel more informed and therefore more confident in making appropriate contributions. It also enabled workers to feel more comfortable with my presence since they were confident it was an informed one. And thirdly, where clients were being visited at home, hospital etc., it was more likely to be part of the routine support offered by the agency rather than part of an intensive programme of counselling.

Accessing the groupwork which is central to the treatment process at Phoenix House presented a problem only in relation to the men's group (see p.228). My role in the mixed groups and the women's groups which I regularly accessed was that of group participant rather than that of co-worker described above. From this perspective I was able to gain important insights into service delivery and the orientation of the group work programme. In the service which relied heavily on groupwork rather than on one-to-counselling sessions with staff, observing and participating in the encounter between client and worker proved more straightforward and easier to negotiate. Gaining access depended on my ability and willingness to participate in the groups alongside residents which might have been more daunting, had I not been familiar with the Therapeutic Community and its style of therapeutic groupwork.

The most difficult encounters to access were undoubtedly the one-to-one interview where a programme of psychotherapeutic counselling was being undertaken. Workers were aware that for those clients who were engaged in exploring painful and traumatic events in their lives, the introduction of a third party, however sympathetic, would be inappropriate and disruptive. Work of this kind was a small but significant aspect of the services being scrutinised and since techniques of participant observation were inappropriate, other strategies had to be devised to access the insights into the service which these encounters might provide. Case notes and files were of little value since they contained only the briefest outline, if any, of the sessions. Discussion with workers prior to and after their sessions with clients elicited some insights but discussion was often cut short by the forward momentum of other events and demands on worker's

time. The *vignettes* used in the interviews I conducted with workers and originally designed to prompt workers into revealing attitudes towards clients and the orientation of their practice, proved to be a more effective technique, since they often elicited reflections on actual cases which workers were, or had been involved in. Since such reflections were developed in the context of an interview, they were far less likely to be interrupted than my attempts to insinuate discussion about casework into the dynamics of an ordinary working day.

It is clear that there are limits to the extent to which the researcher can rely on the technique of participant observation in scrutinising the social work encounter. In some situations it is too intrusive and too inclined to jeopardise the relationship of trust which has been established between a worker and her client. Other techniques have to be developed in order to gain access to this aspect of service delivery. Interviewing staff and inviting narrative accounts of their work with clients would seem to offer a way forward, particularly where interviews can be undertaken away from the ongoing demands of the service. *Vignettes* are useful in generating these accounts and in providing a distancing device where confidentiality is an issue. *Vignettes* are hypothetical cases and thus may provide the necessary disguise which workers need in order to discuss a client's case with a researcher.

3. Policy Implications

The substantive issues raised by the research are explored in Chapters 8 and 9. The following highlights some of the major findings and discusses their policy implications.

Male Violence

A major finding of the research is that work with male clients, the major users of the service, is centred on their misuse of drugs and pays little attention to their abuse of wives and partners. It is men's offending behaviour in the public arena rather than their offensive behaviour in the private sphere which is the focus for treatment and intervention. Given the evidence of a high incidence of male violence towards women amongst the client group, there would seem little justification, from a feminist perspective, for not highlighting it as a cause for concern and intervention. Evidence from the research suggests that men's abusive behaviour toward women is consistently side-lined and that there is a failure to develop coherent strategies for addressing it.

Where some work on male violence towards women does take place - in the Therapeutic Community - it lacks a coherent approach and tends to be treated as a pathological condition which affects individual men. There is little evidence of an awareness that the roots of men's violence towards wives and partners lay in a gendered power structure which needs to be recognised if it is to be challenged.

There was a good deal of evidence of services assisting women to seek help with problems of male violence. There was a willingness to liaise with the Women's Aid organisation, to refer clients on and to seek their advice. There was no suggestion that services condoned male violence; the problem was one of a refusal to recognise that they might have a central role to play in tackling it. The solution for the CDT and for Phoenix House was to refer women on to Women's Aid rather than to work with their own

clients on the issue of men's abuse of women. This resulted in a situation where opportunities for tackling the issue of male violence towards women were being lost.

The reasons for the failure to develop strategies which challenge male violence towards women, are closely related to the fact that services to drug-users are seen as specialist agencies, requiring specialist knowledge of a difficult client group. In a concern to develop their specialism, services lose sight of other pressing social care issues. Evidence from the data collected on both sites confirmed a concern with developing and maintaining the specialist nature of the service. The CDT, for example, regularly demonstrated a concern to ensure that referred clients were, indeed problem drug users, rather than, say, problem drinkers or men and women suffering from other mental health problems (see p.110/111). In respect to Phoenix House, its reputation has been built on its knowledge of problem drug use and how to treat it. Its model of self-help stresses the importance of the role of ex-addict staff who confirm and reinforce the organisation's specialist nature and its claims to specialist knowledge derived from experience.

This concern with the specialist nature of services militates against the ability of workers and clients to address other pressing social and mental health issues, like male violence towards women, which are unconnected to drug use. The establishment of specialist agencies encourages a narrow focus on one aspect of client's lives and if other issues are recognised, they are likely to be reduced to the effects of drug use (see p.151) in order to retain the service's coherence and claims to specialist knowledge. The key feminist principle of 'recognising the complexity of women's problems' cannot be implemented in services where the problem is narrowed down to the misuse of illegal substances. The result is a treatment agenda which cannot begin to help women, and men, grapple with the many and varied problems which they encounter in addition to their drug use.

Even where problems connected to drug misuse arise, services may lack the skills to address them if they are not associated with their specialism. In the Therapeutic Community I was struck by the service's reliance on other agencies to help clients with marital problems and with sexual abuse since they lacked the skills themselves. In their concern to develop specialist skills, well funded agencies, like the TC are simply not able to offer their clients the intensive help with other issues which may be intimately connected to their drug use. Similarly, the CDT is aware of its lack of ability to do much to assist clients with chronic housing and associated problems. At best other problems are addressed where possible as a means of getting them out of the way so that the *real* problems, i.e. drug misuse, can be tackled.

Other problems derive from the development of specialist services. The existence of Women's Aid, an organisation specialising in helping women take refuge from violent men, means that services can deal with the problems of domestic violence which they encounter amongst their client group, by referring women on to the specialists rather than by tackling the issues themselves. Given the fact that Women's Aid developed precisely because existing services were not providing women with protection from violent partners, it is somewhat ironic that their success in doing so means that services can continue to abrogate their responsibilities by referring problems on to the new experts. The notion of the service as specialising in drug misuse, together with the existence of the Women's Aid organisation, combine to ensure that the development of an effective social care practice which is concerned with challenging male client's

violence towards women, is not being developed in the context of services to illegal drug users.

Strategies for working with domestically violent men are increasingly being developed (Dobash and Dobash, 1992; Morley, 1993), but the concern is with developing a network of specialist services rather than with devising ways of inserting work on the issue of male violence into existing services. Given the danger that these developing services to men who have been convicted of domestic violence will be in competition for funding with Refuges (Morley, 1993) and given the extent to which male clients of existing services are involved in domestic violence, the argument for capitalising on opportunities for challenging male violence within the context of current services would seem to be a strong one.

The specialist nature of services and their narrowly defined treatment agendas needs to be reviewed. The proliferation of specialist services may be politically expedient since it encourages the view that 'something is being done' but it obscures the fact that drug-use, for example, is experienced as just one of a number of problems that individuals face in their lives. It also fails to recognise that some social problems could best be addressed within the context of existing services, re-shaped to enable them to encompass the complexity of their client's problems.

Men's abuse of women, for example, could be addressed by existing services although some change in focus would be required. Work with men around issues of violence towards women needs to be pro-feminist in its orientation if it is to be effective. It needs to be underpinned by a model which seeks to reveal and confront men's abuse of power over women rather than one which seeks to treat individuals and their pathological behaviours. Services would have to acknowledge the significance of gendered power structures in structuring their clients lives. The model of treatment which currently underpins services to drug users is one in which the individual is assumed to be largely gender-neutral. The resistance to en-gendering clients' problems means that the operation of oppressive gender relations is difficult to 'see' and therefore effectively challenge. This resistance would have to be overcome if existing specialist services were to work effectively with men around the problems they create for women.

Drug Abuse and Child Abuse

The lack of attention to male violence towards women contrasts markedly with the willingness, in one of the services, to see women's child care practices as a legitimate focus for intervention. This is some confirmation of the fact that the specialist nature of services cannot, by itself, account for the lack of attention given to men's abuse of women. It also confirms that where services try to take issues of gender into account, the result is a concern with women and their 'special needs' rather than with men.

The orientation of the treatment programme in the Family Unit (see p. 182-192) was quite different to that offered in the Main House or at the Community Drug Team. The treatment programme in the Unit was noticeably child-centred. This contrasted both with the client-centred approach of the CDT and the emphasis on self-reflection and self realisation in the Main Programme at Phoenix House. In its concern to offer women with children access to residential treatment, Phoenix House has set up what is now a quite separate Unit offering access to a very different programme of rehabilitation. It

operates on similar principles to the projects outlined in Chapter 2 (p.131-133) and from a feminist perspective, has all the problems which I suggested were associated with Odessey House and the Family House at Eagleville Hospital and Rehabilitation Centre (USA). The similarities between the two projects developed in the 1970s and the Family Unit at Phoenix House developed in the 1990s, suggests a marked resistance to feminist concerns to challenge traditional stereotypes of women as primarily mothers and carers within the confines of the privatised family. Given the developments in feminist health and social care practice in this period and the evidence that some of this thinking has permeated into residential work with women drug users and their children (see Roulston in Henderson, 1990), the anti-feminist orientation of the work at the Family Unit is disappointing. The development of the Unit demonstrates a resistance to, or lack of understanding of, the nature and construction of gender inequalities. When the weak feminist strategy of adding women and children into existing services exposed the problems with this approach, a radically different programme was devised. The design of this different programme uncritically incorporated traditional values and sexist assumptions about women's work and women's roles and in so doing, revealed the absence of any real understanding of the oppressive forces at work in women's lives.

The Family Unit resulted from the need to accommodate children into a treatment programme originally devised to meet the needs of single, largely male, drug users; but it came increasingly to see itself as there to protect children rather than simply, and primarily, to accommodate them. In discussing the role of the Unit, its manager linked its work to that of Barnardos or the NSPCC (see p. 223), a clear confirmation of the way in which the initial need to accommodate children had given way to a perceived need to protect them.

That the Family Unit developed separately and in a direction which takes little account of feminist principles of practice, suggests that the Therapeutic Community is no nearer to providing a treatment programme which meets women's needs. Alternative, feminist inspired approaches to residential treatment for women drug-users and their children (Henderson 1990) throw into sharp relief the extent to which the Family Unit's approach to women and children looks backward, to a pre-feminist era, rather than forward. The Therapeutic Community has simply incorporated the male bias which has long been recognised as a problem (Levy and Doyle, 1974; Doyle et. al., 1977; Mandel etc. al. 1979; Rosenbaum, 1981; Ettoree 1989; Sargent, 1991), into its services for women and children. This is a particularly worrying state of affairs since the Therapeutic Community's approach to the treament of drug use is a favoured one among funders and policy makers. It is an approach which has experienced rapid growth in recent years and which looks set to continue. The failure of the service to take on principles of practice which reflect the developments in a feminist approach to health and social care suggests that the Family Unit is inherently flawed in its approach to women and children. It may be that the weight of its history as a service catering largely to male users means that the Therapeutic Community cannot make the necessary changes to enable it to meet the needs of women with children and that policy makers need to look in another direction entirely. Organisations which start from an understanding of women and their problems of dependency on a wider range of substance may be more able to offer the multi-faceted approach which women's use of illegal drugs demands but which services as specialised as the TC are unable to develop.

Any social care situation which involves children needs to be alert to child protection issues but the contrast between the Unit's response in this respect and that of the CDT is stricking. The CDT saw itself as primarily an advocate of parents (see p.119) and was concerned to question the assumption that drug abuse inevitably leads to child abuse. The Unit, on the other hand, emphasised its role in relation to child development and in closely monitoring standards of child care amongst its residents. The CDT's strategy challenged the equation between drug abuse and child abuse, the Unit's subtly confirmed it.

Kearney and Norman-Bruce's paper (1990) reviewed in Chapter 2 is a clear indication that services to drug users have yet to successfully resolve the accommodation of child protection issues within their ambit. My findings suggest that the opening up of residential treatment opportunities to women with children may be accompanied by too close a scrutiny of child care practices and too great a concern with child protection. The work of the CDT offers the possibility of an easier alliance between drug misuse and child care issues and suggests that more woman-friendly policies than those which inform the work of the Family Unit, can be adopted. The explanation for the different approaches on the two research sites may lay in the fact that at least one member of the CDT had an extensive background in social work with families and children and a firm commitment to women's rights. This background brought a confidence and an expertise to the team's work in situations where child protection might be an issue. The Family Unit, in contrast, was staffed by a team which had a combination of skills in child care and in drug rehabilitation but which lacked expertise in family orientated casework. This suggests that if services to drug users are to work effectively with women, while at the same having an eye to children's safety, they need to look to and import social work expertise underpinned by woman-centred values and practice.

Male Bias

The discussion so far has highlighted what I consider to be the two major findings of the research, i.e. the failure of services to problematise masculinity and to challenge men's oppressive behaviour towards women, and the willingness, in one of the agencies, to deliver a service to mothers rather than to women. Other findings also warrant some further attention, in particular, the issue of overt male bias in services and the more subtle male bias which is revealed when the controlling nature of services is scrutinised.

The discussion in Chapters 8 and 9 draws attention to the ways in which agencies continue to bias their services in favour of male clients. The CDT's decision to work with steroid users but to limit their involvement with clients experiencing a wider range of mental health and dependency problems had the effect of further skewing service provision in favour of men.

Male bias in services is mitigated when the they are willing to work with partners and families of drug users. Evidence of services expanding their boundaries in this way was found on both sites. However, the ethos of the Therapeutic Community which emphasises the needs of the individual drug user and the importance of the close-knit Community as a major therapeutic tool, means that work with partners and families remains peripheral. Families are regarded as visitors to the House rather than as an integral part of the therapeutic programme.

Treatment policies which make a clear distinction between the users of illegal drugs and those dependent on prescribed or legal substances, would seem to encourage the predominance of men as service users. Given women's predominance as users of prescribed drugs, policies which encourage users of e.g. minor tranquillisers to access the services, would go some way to redressing the gender balance. If, in addition, services routinely integrated work with partners and families into their approach to drug misuse, the current male bias would give way to services which more readily address women's as well as men's problems with drugs. This would require services to work with a broader definition of drug-misuse and with a model of treatment which sees the individual drug user as just one of a number of actors caught up in the process of dependency.

Care and Control

Work with illegal drug users throws the controlling nature of health and social work intervention into sharp relief. The discussion in Chapters 8 and 9 has demonstrated how the social carer is overtly implicated in controlling and monitoring their client's drug use while at the same time offering them counselling and support. Chapter 8 looked at how monitoring prescriptions for methadone and amphetamine at the CDT generated tensions and contradictions in workers' relationships with their clients and Chapter 9 examined the impact on staff/client relationships, of the concern to ensure and maintain a drug-free community. Interviews with care staff on both sites gave an insight into the strains of both policing a client's drug use and engaging in in-depth counselling work (see e.g. p129-130 and 201-203). By and large, however, workers accepted their policing role as an inevitable if unwelcome part of the social work task in relation to illegal drug use.

The inevitability of the controlling aspect of the client/worker relationship needs examining more critically, however. In particular, services need to consider whether the need for external controls are an inherent part of the recovery process for all addicts who have to been denied the drugs for which they crave, or whether the controls are in place largely as a response to some highly visible and demanding service users. I suggest in Chapter 8 that the group decision-making which operated at the CDT in relation to clients' requests for an increase in their 'scripts' was a device for protecting individual workers exposed to the anger of clients who have their requests turned down. I suggested that the client who was being responded to here was the volatile, experienced user, usually male, who was prepared to assert his demands forcefully. These are not the characteristics of all clients but the controls which are in place underpin the service and therefore operate universally across the agency. Similarly, the controls which operate in the TC were originally designed to handle large numbers of predominantly male users who had extensive experience of illegal drug use and probably some experience of imprisonment. One has to ask how far these controlling mechanisms are a necessary part of working with all drug users and how far they have been put in place as a response to a predominantly male client group which has traditionally made heavy demands on services.

The experience of the Family Unit illustrates the point well. The boundary controls operated by the TC in the interests of maintaining a drug-free Community had to be radically revised once women with children moved in. It was not possible to maintain restrictions on movement when children had to be taken to school, nursery, doctors etc. and shopping had to be done. Rules which were designed to control the single,

predominantly male user living as part of a community, were inappropriate for women with children living in the Family Unit.

The controls which operate in relation to the illegal drug user are seen as an intrinsic aspect of the social work task. They are deemed a necessary device for dealing with clients driven by their dependency and thus in need of external constraint. The analysis of my data suggests that the controls which are in place have been set up in response to a particular drug user and have been generalised to all users. The controls are heavily gendered in as much as they have been devised to deal with a predominantly male client group which has traditionally made demands on services and whose behaviour has necessitated the development of controlling strategies.

The perceived need to incorporate control into the caring relationship hinders the development of feminist principles of social care practice. '*Equalising relationships*' for example, is highly problematic when the carer is empowered to demand urine samples, to refuse egress from the Therapeutic Community, or to deny access to family and friends on the grounds that they are involved in illegal drug use. It is always possible to relax, abandon or radically overhaul controls, as the Family Unit has had to do. It is possible to open out the closed ranks of the decision-making process a little as demonstrated by the CDT's willingness to allow clients access to team meetings (p. 118/9) But the issue becomes one of considering how controls can be adapted to suit special needs, as in the case of women with children at Phoenix House, rather than one of considering which controls are strictly necessary and which are not. The need for overtly controlling mechanisms remains the norm, a norm, which I have suggested is heavily gendered. While the Therapeutic Community can and does accommodate women, it does so either by constructing them as a special case and a deviation from the norm, in the case of Family Unit residents, or subjecting them to stringent controls, which may be inappropriate and unnecessary, in the Main Programme.

The policing strategies devised to deal with the difficult and threatening male client sit uneasily with a feminist ethic of social care practice. That they are appropriate in dealing with some clients is not in question and it is clear that the team decision-making process at the CDT offers some protection to staff, particularly perhaps women staff, when dealing with difficult clients. But there are problems in establishing the need for control as the benchmark against which other strategies are measured and devised. On both research sites the controls which operated had the effect of generating distrust and marking out clear divisions between worker and client, thus preventing the establishment of equal relationships and a participatory model of care. This may go some way to explaining why a model of social care practice designed to politically empower rather than to treat, and identified by both Ettorre(1992) and Young (1994) (see Chapters 1 and 2 respectively), has failed to emerge in relation to drug use. There is an urgent need to reassess policies which universalise the impulses of the addict and which centre treatment strategies around the perceived need for control and constraint. The behaviours of some clients of services for drug users, like the behaviours of some clients of social and health services more generally, *will* generate the need for controlling strategies to be in place. These behaviours should not, however, be allowed determine the shape of the service for *all* clients.

4. A feminist health and social care practice

Drawing on the above discussion of the policy implications of the research's findings and my earlier discussion of feminist principles of practice, we can now consider what the main features of services to illegal drug users, underpinned by a commitment to feminist practice, might be.

Re-defining service users

First, services would not be confined to users of illegal drugs. They would have a much broader brief and include a concern with other problems of dependency. Services would be centred on substance use and/or dependency problems more generally. The use of prescribed drugs and of alcohol together with illegal drug use would be a primary focus for concern, although eating problems and self harm might also legitimately be included within the ambit of services. The definition of 'client' would also need to be expanded to include close family and friends of those presenting for treatment. This would have the effect of bringing the care of, and relationships with children of *all* clients into the treatment arena as a natural extension of the services parameters rather than as a particular issue for scrutiny.

Expanding the treatment agenda

Secondly, services would need to be able to offer help with a range of problems which may accompany, or be the root of women's and men's dependency problems. This means that they would need to offer a wider range of treatment strategies than is currently on offer. They would need to be prepared to look beyond the problem of dependency and to offer interventions which helped clients to address deep-seated traumas, like sexual abuse. In addition to a concern with personal trauma, services would need to take on issues deriving from external sources, e.g. housing, financial and legal advice. They would need to allow these latter issues to be the primary presenting problems and to address them accordingly.

By extending the treatment agenda outwards and by opening up services to clients with a wider range of dependency issues, the emphasis on controlling the client, which accompanies the treatment of those who use illegal drugs, would no longer operate as a general principle underpinning the service. The perceived need to control the client which is embedded in the response to illegal drug misuse would no longer be a central concern since users of illegal drugs would not longer be the only, or even predominant user group.

Politicising treatment

Thirdly, in addition to the question of *who* services work with, on *what* issues, treatment strategies need to be re-orientated. They need to be able to raise awareness of the wider social and political arena in which the individual is situated and in which their problems of dependency are experienced. An approach which incorporates consciousness raising strategies would underpin such treatment. This would need to go hand in hand with a concern to maximise client involvement in the design and implementation of services. The notion of empowerment would need to extend beyond the control of the counselling agenda to the operation of the service more generally. It

would depend on the development of a participatory model of treatment which does not simply re-invent hierarchical relations in the name of 'self-help'.

The creation of women-only services, or women-only spaces, need not be of paramount concern. Services aimed at a wider client group, i.e. those dependent on substances other than illegal drugs, and prepared to re-orientate their treatment programmes to take account of the wider network of relationships and social structures in which individuals are enmeshed, would be sufficient to ensure that women's needs were met. Treating men as well as women in the context of such services would ensure that the problems that men create for women, as well as the problems that their substance dependencies create for themselves, are addressed. Moreover, treatment strategies which take account of the ways in which power relations other than those structured around gender, operate in client's lives, would hold out the possibility of ensuring that services worked in the interests of all women.

Re-structuring the helping relationship

Fourthly, making consciousness-raising a primary focus of treatment would mean service providers being able to recognise and mobilise their own identities and experiences in the helping relationship. It would require the recognition that the race, gender, class, sexual identity of the counsellor is a central dynamic of the counselling relationship. Where emphasis is placed on the importance of sharing experiences as black/white/lesbian women or as black/white/gay men in the client/worker relationship, the need to ensure that service providers are able to offer a range of experiences on which to draw takes on a new significance. If services do not have any black counsellors, for example, their ability to develop consciousness-raising techniques which recognise different and diverse experiences among their client group is seriously limited. Black women counsellors may be able to undertake consciousness-raising work with white women clients and vice versa but only if they themselves have regular and ongoing opportunities for developing their own awareness, through dialogue, of the ways in which racial and cultural differences change the nature and experience of women's oppression.

Adopting consciousness-raising techniques are as important for work with men as they are for women. The use of such techniques can ensure that men's oppressive relationships with women become a central rather than a peripheral concern of the helping relationship. A feminist approach to health and social care services depends on a willingness to problematise masculinity and femininity in the social care encounter and account needs to be taken of the ways in which race, sexuality and disability mediate the social construction of masculinity and feminity. The client's race, gender, physical ability and sexual identity are thus moved centre-stage and personal issues of dependency are given a political reference point.

This movement from the personal to the political ensures that helping strategies are not confined to simply adjusting clients to prescribed social roles which are either oppressive to them or to others. The feminist principle of aiming for change not adjustment must underpin the treatment process to ensure that women and men are able to resist the very roles and relationships which may contribute to their problematic use of substances.

Creating political alliances

Fifthly, services would need to embrace a campaigning as well as treatment orientation. They would need to make strong links with organisations committed to resisting the sexual and violent abuse of women which often underpins or accompanies women's dependency on substances. The feminist principle of 'campaigning and building alliances' would have to be extended to a concern to challenge and resist racism and homophobia in society and might also include a specific concern with the criminal justice system. Links other than those made on a case by case basis would have to be developed and service users would have a central role to play in campaigning and alliance building.

Responding to drug misuse

Finally, it may be that the need for a refuge which a residential community offers may continue to have a part to play in the response to problems of substance dependency. It may present precisely the opportunity for reflection and reappraisal that those caught up in a cycle of dependency need. But it would need to be underpinned by principles of feminist practice and a 'structural' rather than 'clinical' model of self-help. It would involve children only insofar as they need to remain with their primary carers rather than as a focus of treatment and intervention. Minimum controls would operate sufficient only to ensure that the community remained free of illegal substances.

Illegal drug use must be dislodged as an issue in people's lives which requires separate and specialist treatment. It needs to be seen as just one of a wide spectrum of substances on which people become dependent. Re-defining illegal drug-use as a more general health issue and re-designing services accordingly would challenge the current masculine bias of services. It would enable them to move away from a concern with control and surveillance and would open them up more readily to the possibility of re-orientating the treatment agenda to take account of feminist principles of health and social care practice. Such principles would themselves need to be re-visited in order to ensure that they can challenge the ways in which services incorporate racist, homophobic, disablist and sexist bias into their treatment programmes. Without such a radical re-orientation, it is difficult to see how existing services to illegal drug-use can reflect the diversity of need amongst those who become involved in the problematic use of substances.

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APPENDICES

VIGNETTES : as used in interviews with Community Drug Team

Mark and June

Mark has been referred to you for treatment/support. He is accompanied to the agency on his first visit by his wife, June, who has recently discovered her husband is a committed drug user - mostly heroin, some amphetamine. Mark has recently lost his job because of absenteeism. They have an 18 month-old child and are buying their own home. Mark and June live locally and have supportive parents who are now aware of the problems the couple face.

Can you envisage how the agency might respond? What type of support might be offered? What would June's role be?

* * * * * *

After Mark's initial visit, a further appointment is made for him which he fails to keep. He also fails to keep a subsequent appointment but this time his wife and his mother come to apologise for him. How might you proceed now?

Maureen

Maureen is a 35 yr. old single woman who has a long history of alcohol and drug abuse. She has a 14 yr. old son who lives with her parents and she has recently expressed a desire to change her life-style and become drug-free. She is interviewed for entry to a residential project but needs to undergo a detox. programme before she can be admitted. You arrange the detox. and agree to take her to the residential facility some 30 miles away once it is completed. Maureen stays in the residential programme only four days, after which time she leaves of her own accord, saying she can't 'hack it'.

What is your response when she next appears at the agency announcing that she has 'blown it' once again?

* * * * * *

Six months later Maureen decides to try again for long-term residential treatment. She succeeds, with your support, in getting accepted into a residential facility much further away from her home town. She contracts to remain in the programme for a twelve-month period but after four months she is asked to leave following an incident in which she was physically violent towards another resident.

Shortly after leaving the residential facility she is re-referred to the agency following a charge of cheque-book fraud. How might you proceed?

Jane

Jane is a 19 yr. old 'recreational' user who has a 6 month old baby and an established relationship with staff at the agency. She has recently moved in with her boyfriend but in a recent counselling session she complained that his refusal to accept any child-care responsibilities or do any household chores was becoming an increasing burden on her and an increasing source of tension between them.

She seeks your advice. Can you envisage your response?

Mary

Mary is a 20 yr. old single parent who is currently being maintained on methadone. She has serious rent arrears and unpaid fuel bills. She has three children, all under 5 and has recently come to the agency saying she feels very depressed an 'at her wits end'.

What would your concerns be here? What type/s of support might you consider/suggest?

* * * * * *

Social Services agree to accept all three children into a local Family Centre for three half days each week. The Centre encourages Mary to accompany the children and participate in play and learning activities. Mary feels she needs the time for herself but feels under pressure from the Family Centre to participate in their group activity programme.

Can you envisage how you might respond?

Mel

The agency is preparing a court report and arranging a detox. for a young man who is up on a charge of supply and possession. On a recent home visit you noticed his partner had her arm in a sling and had bruising to her face. When you remark on this the couple tell you they have been fighting.

Can you envisage what might have happened next?

* * * * * *

The young man's partner subsequently visits the agency to complain of his further violence towards her.

Can you envisage what might happen now?

Ann

Ann is a 24 yr. old married woman with one child aged 5 yrs. Both she and her husband are long-term, but at the moment, fairly stable drug users. They have been involved with the agency for about 18 months. Ann has recently become pregnant again and she is considering whether to proceed with the pregnancy.

Can you envisage how the agency might respond?

* * * * * *

Ann is now four months pregnant and the result of a recent test confirms that she is HIV positive. Her husband's status remains negative.

What are some of the anxieties that Ann now faces?

Can you envisage what might happen?

Joyce

Joyce, the partner of a long-term client, calls for a supply of needles. She is in a hurry and makes it clear she is collecting the needles for her partner who is 'too idle to come himself'.

Can you envisage your response?

. . . . . You can't help noticing that Joyce has bruising to her cheek - do you comment on this? Can you envisage what might have happened if you did decide to comment?

VIGNETTES : as used in interviews with Phoenix House staff

John

John is a 23 yr. old chaotic user who was recently accepted into the programme but who eventually 'split'. Subsequently, you are approached by John's mother, in a distressed state, asking if you would take John back into the programme. Mrs. Johnson is a supportive, but concerned and anxious parent who you have already had some contact with.

Can you envisage your response to Mrs. Johnson's request?

Ken

NB: There are three parts to this 'case'. Please respond to part 1 before moving to part 2 and to part 2 before going on to part 3.

Part 1

Ken is a 23 yr. old man who has been in the programme for six months. He has a wife and young child and it has recently been agreed that he should spend a weekend at his home in Liverpool with them. It is agreed that Brenda, his wife, will accompany him back to Phoenix House on the Sunday to ensure his safe return. On their return you notice bruising to Brenda's face.

Can you envisage your response? What might be your concerns?

Part 2

It eventually becomes clear that Brenda's bruising was as a result of Ken's violence towards her over the weekend.

How might this information impact on Ken's programme?

Part 3

In discussing the issue in the weekly men's group, it becomes clear that a number of other men in the group have a history of violence towards their wives and partners.

What is your view of this?

Can you envisage how you and your colleagues might proceed?

Maureen

NB: for the purposes of this case, imagine you are part of the Induction Team, or giving advice to the Induction Team.

Maureen is a 35 yr. old single woman who has a long history of alcohol and drug abuse. She has a 14 yr. old son who lives with her parents and she has recently been accepted into the programme after expressing a desire to change her life-style and become drug-free. Maureen has had two previous attempts at becoming drug-free, although not with the help of Phoenix House.

Maureen remains in the programme for less than a week before leaving, saying she can't 'hack it'. Three months later, with a court appearance pending, Maureen approaches Phoenix asking if she can re-enter the programme.

Can you envisage your response?

Mark and June

Mark has approached Phoenix House, via his local Community Drug Team, for entry to the programme. He is asked to attend for interview, which he does, accompanied by his wife, June. June recently discovered that her husband was a committed drug user - mostly heroin, some amphetamine - when he recently lost his job because of absenteeism. They have an 18 month-old child and are buying their own home. Mark and June live in Rotherham and have supportive parents who are now aware of the problems the couple face.

Mark is accepted into the programme. Can you envisage what June's involvement with Phoenix might be?

Janice

Janice is a 28 yr. old single woman with a history of chaotic drug use. She first entered Phoenix House in 1990 but eventually 'split' after about four months in the programme. She was accepted into the programme again towards the end of 1992 and this time successfully reached Re-entry. After six weeks in Re-entry, however, Janice was asked to leave after repeated bouts of heavy drinking and some illicit drug use.

Janice has recently asked if she can return to Phoenix, can you envisage your response?

Women's Group (1)

NB: for the purposes of the 'case', imagine you are facilitating a women's group.

A dominant theme of women's group this week was the lack of support offered to women from their male partners, when they were living at home. Few of them were able to rely on consistent help with either the children or the household chores.

Can you envisage what your response, as group facilitator, might be, to these complaints?

Women's Group (2)

Two women in this week's women's group complain of being allocated menial chores in the house cleaning rota by their male 'Department Head'. They felt they were being treated just like their husbands/partners/fathers treated them when they were living at home.

Can you envisage your response, as group facilitator, to these complaints?

INTERVIEWS : AIDE MEMOIRE

- Why do people become involved in drug-misuse?
- Do women get involved for the same reasons as men?
- Are the problems which women drug users face any different from those which male drug users face?
- What does the service offer to men and women who are involved in drug misuse?
- How do clients access the service?
- Does the service offer anything specifically to its women clients?
- (CDT) How does the adoption of a prescribing policy affect the nature of the work/relationship with clients?
- (Phoenix House) How does an abstinence model affect the nature of the work/relationship with clients?
- (Phoenix House) Can you tell me about the **departmental** and **peer group structure** and the use of **'contracts'**? What in particular do they offer to residents and what role do they play in the treatment programme?
- (CDT) You do quite a bit of work with steroid users, what is the significance of this work? Why did the service decide to expand in this direction?
- (CDT) What is the aim of your work with the women in the massage parlours? How did the service come to develop this aspect of its work?
- (Phoenix House - Family Unit) Why was the Unit set up? What are its aims?
- (. . . . Family Unit) Are there any differences between the way in which the Unit and the Main House, work? What issues are raised by having children on the premises?
- (Phoenix House) What are the specific aims of the group work programme?
- (CDT) Does the service involve its clients in group work?
- How would you describe your relationship with clients?
- (for women staff) When working with women clients do you ever talk about your own experience as a wife/mother/daughter etc? Can you give any examples? What do you think you achieve by sharing these aspects of your experience?

- How would you describe the nature of the boundary between client and worker?
- How do you decide on a particular course of action/treatment with a client? Can you give any examples?
- What mechanisms exist for clients to challenge a decision made about their treatment?
- What has been your experience of sexist behaviour/attitudes/comments when working with clients? How did you deal with them?
- Can you give any examples of cases where male violence has become a central issue of concern for you when working with a client?
- How are decisions made in the team/organisation? What is the role of the team manager/co-ordinator?
- What campaigning or policy-making groups is the service involve in? Any around women's health, domestic violence etc.?