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Relational autonomy and service choices in social worker-client conversations in an outpatient clinic for people using drugs

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RELATIONAL AUTONOMY AND SERVICE CHOICES IN SOCIAL WORKER–CLIENT CONVERSATIONS IN AN OUTPATIENT CLINIC FOR PEOPLE USING DRUGS

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Abstract

This article focuses on how clients' self-determination is accomplished in social worker-client conversations when discussing choices of clients' future services in a low-threshold outpatient clinic in Finland targeted at people who use drugs. Self-determination is approached from the point of view of relational autonomy, meaning that choices are never made completely independently but within certain societal and interactional contexts. The article applies interactional analysis to data from 10 social worker–client conversations, which include 48 instances of 'choice talk'. The results demonstrate how social workers work hard to promote clients' self-determination, and how this is carried out with different emphases within the frame of relational autonomy. Social workers do not perform ethically questionable manipulation practices. Quite the reverse, their contributions in the conversations can be interpreted as endeavours to increase clients' self-confidence and autonomy competencies. However, a concern from an ethical point of view is that real service options are rather scarce for the clinic's clients. This considerably reduces the clients' capacity for self-determination. Furthermore, it also reduces the autonomy of social workers, who have limited opportunities to organise the services their clients desire, and that the social workers themselves consider are the best options.

Keywords: social work, ethical principles, self-determination, relational autonomy, interaction

Introduction

Self-determination is an enduring core ethical principle in social work. Foregrounded in the classic text by Biestek (1957) on the casework relationship, it features prominently in the most recent *Statement of Ethical Principles* of the International Federation of Social Workers (2018). Here, self-determination is described as follows: 'Social workers respect and promote people's rights to make their own choices and decisions, provided this does not threaten the rights and legitimate interests of others' (Principle 4). Furthermore, it emphasises that social workers should promote people's 'full involvement and participation in all aspects of decisions and actions that affect their lives' (Principle 5). In Finland, where this study is located, the ethical principles of social work (Talentia, 2019, pp. 12–13) state that social workers should respect clients' self-determination, and tell clients about their choice of available options. It is, however, highlighted that some people's life situations are so difficult that their ability to make their own choices is limited.

Common to the statements is that social workers are described as playing an active and responsible role in promoting clients' self-determination. Self-determination is not just about having the freedom to make choices (negative freedom), but also about supporting people to increase their ability to make choices (positive freedom). McDermott (1975, p. 4) explained the motivation behind this view: 'Although most human beings are capable of self-determination, their capacity to exercise it rationally and constructively varies from person to person, and from time to time in the life of the same person'. These characterisations of positive self-determination in social work (analogous to Berlin's [1969] classic concept of positive liberty) resonate with the work of more recent moral philosophers who approach self-determination as relational autonomy, particularly in some of the feminist literature (Mackenzie and Stoljar, 2000; Mackenzie, 2014). According to this literature, relational autonomy challenges libertarian

approaches, which see human beings as individual agents exercising choices in isolation (McLeod and Sherwin, 2000, p. 260). Instead of an individual accomplishment, autonomy is 'both defined and pursued in a social context and that social context significantly influences the opportunities an agent has to develop and express autonomy skills' (McLeod and Sherwin, 2000, pp. 259–260).

Understanding self-determination as a relational phenomenon links to the ideas developed in relationship-based social work (Ruch et al., 2018), which understands worker–service user relationships as the heart of social work, including intertwining both 'the psychological and social contexts of people's lives' (Ruch, 2018, p. 22). Since each social work encounter is unique, interventions channelled through collaborations challenge neoliberalist and managerialist views on choice making as a purely individual and rational action (Ruch, 2018, pp. 28–32). This emphasis on relationship and uniqueness brings us, in turn, to research approaches that concentrate on the practices of everyday encounters in social work (e.g. de Montigny, 2007; Hall et al., 2014).

Although client self-determination has been much discussed in social work (e.g. Spicker, 1990; Ejaz, 1991; Ewalt and Mokuau, 1995; Banks, 2012, pp. 42–49; Beckett et al., 2017, pp. 103–118), little research has examined how it is accomplished in social worker–client conversations. In this study, we analyse conversations in a low-threshold outpatient clinic targeted at drug users. Our focus is on how social workers promote clients' self-determination, and how clients respond to this in discussions about their choices of future services. In analysing talk on choices in relation to self-determination, we apply the concept of relational autonomy.

Relational agency and relational autonomy

An argument for relational autonomy can be found in relational sociology (Burkitt, 2016; Donati, 2011), which instead of defining human agency as an individual phenomenon, conceptualises it as inherently relational. According to Burkitt (2016, p. 335), this means seeing persons as interactants who 'act in multiple webs of interdependence in which no one is ever completely independent or dependent but always somewhere in the continuum between these two abstractions'. Therefore, when interacting with each other, people can be both 'active and passive, powerful and yet vulnerable to various degrees, acting on others and being acted on by those others' (Burkitt, 2016, p. 336).

Relational agency entails that people's capacity to make choices occurs in webs of interdependence. Choices are never made completely independently and people's autonomy is always relational. This becomes evident especially in situations where people's control over their own lives is diminished. For example, patients in healthcare settings are dependent on advice from their doctors regarding treatment options (Dodds, 2000, pp. 224–226). In addition to the 'momentary' situations of dependence, people sometimes have such severe experiences of oppressive and violating encounters with other people and societal institutions that their self-trust and autonomy competencies are diminished (Dodds, 2000; McLeod and Sherwin, 2000). Hence, in regard to the continuum described by Burkitt (2016), they are nearer dependency. Traditional responses to diminished autonomy competencies tend to be parentalist (the gender neutral term for 'paternalist'), which means making choices and decisions on behalf of clients (McLeod and Sherwin, 2000, p. 267).

Walter and Friedman Ross (2014) present two approaches that impact our understanding of autonomy and what we regard as ethically acceptable practices. The first is called 'the in-control agent model'. In this model, agents are characterised as 'highly individualistic and having an ability for deliberation and rational transcendence of emotion, prioritizing the rational over the

emotional' (pp. 17–18). For these kinds of agents, it is enough to get information on, for example, different services, so they can make reasonable choices among the available options. This model coheres with the prevailing neoliberal ideology that sees citizens as individual consumers in social and healthcare markets.

If we take the premises of relational agency and autonomy seriously, 'the in-control agent model' could be regarded as a myth – albeit one of the 'myths we live by' (Midgley, 2011). For interdependency is inherent in human nature: '[. . .] none of us is the sort of autonomous individual imagined by the in-control agent model' (Walter and Friedman Ross, 2014, p. 19). In particular, oppressed people in vulnerable positions cannot be expected to make informed choices on their own. However, uncritical parentalism is not an ethical solution either. Hence, we argue that the 'relational autonomy model' that Walter and Friedman Ross (2014) present as an alternative to 'the in-control agent model' offers an ethically sustainable conceptualisation of autonomy and self-determination.

Practising the relational autonomy model in social work means that the responsibilities of social workers include negotiating with clients about the choices they have in a given situation. The social workers' responsibilities are not, however, only limited to contributing to actual choice making. They also include strengthening clients' self-trust and capacities, so that they gradually become more confident in their rights to state their wishes, are able to assess their own needs and make choices, and are treated by others respectfully as responsible agents (McLeod and Sherwin, 2000, pp. 261–262; Benson, 2000, p. 82; Dodds, 2000, p. 214). The common criticism towards this kind of approach is that social workers influence clients' choices, even manipulate them and, thus, move towards parentalist practices. McDermott (1975, p. 12) pondered this danger:

> To be given information by others is no doubt to have one's future behaviour influenced by them. But the acquisition of such knowledge does not make one less self-determining; on the contrary, it is likely to help one achieve one's own goals more effectively. Similarly, to be persuaded into seeing a situation in a new light by someone is not necessarily to have his [sic] will imposed upon one, nor need it make one's subsequent behaviour any less self-determined. In other words, there are a great many different kinds of persuasion and influence, and it is not until the ethically significant differences between them have been systematically examined that the requirements of the principle of client self-determination can be properly understood.

Following McDermott's advice, our aim is to examine within the framework of relational autonomy how service choices are negotiated in social worker–client conversations, and to increase our understanding about how self-determination is promoted in everyday social work encounters.

Setting: a low-threshold outpatient clinic

The setting of this study is a low-threshold outpatient clinic for people with severe drug use, run by a national NGO located in a large Finnish city. The staff comprises three social workers, two psychiatrists, four nurses and two front-desk workers. The clinic is committed to both rehabilitative and harm reduction approaches, depending on clients' individual situations. Being a 'low-threshold' service means that the clinic offers easily reachable support based on clients' voluntary engagement and avoids unnecessary bureaucracy. It can be contacted anonymously and without referral or appointment. Clients are neither required to be sober when visiting the service nor to be aiming at abstinence. These kinds of services are needed, as people addicted to drugs often have diminished capacities to function, and they can easily 'drop' between different social and healthcare services (Virokannas, 2019).

The clinic can be described as a gateway to 'higher threshold' services. The city purchasing services from the clinic, defines it as a first step in clients' treatment pathways. In order to proceed with their personal treatment pathways, clients have to negotiate their service choices with the clinic's workers. In principle, there are several service options to choose from: withdrawal and rehabilitation units, opioid substitution treatment, specialised outpatient clinics and a peer support group. However, there are structural limitations and criteria to access and receive these services. For example, the peer support group is based on abstinence, and the specialised outpatient clinics are targeted at people with certain diagnoses or in certain age groups. Furthermore, when seeking institutional rehabilitation, clients need to make an application with the clinic's social worker, who then sends the application to the municipal social worker responsible for making the final decisions within the available service options. There are also other obstacles in choice making, such as waiting lists in the desired services.

As there are several service options available, although not always reachable, our data that comprise social worker–client conversations in the clinic include a lot of counselling talk about choices of services. Alongside this kind of counselling, the workers seem to promote the clients' self-determination in service choices more widely. This led us to study the data from the point of view of relational autonomy.

Methods

The data comprise 10 audio-recorded social worker–client conversations in the low-threshold outpatient clinic for people using drugs. The total length of the recordings is 6 hours and 31 minutes, with an average length of 39 minutes per conversation. The data include one to three conversations per client (one female and five male clients). The clients are native Finnish adults

(around 20–40 years old), and they have been clients in the clinic for several years. They are typical of the clinic's clientele.

We did not make any pre-selection on the recorded conversations. All volunteer clients were invited to participate in the study during the data collection period (3 months in 2012). In addition to written research bulletins in the clinic's waiting room, the workers informed their clients about our interest in finding participants and about the study in general. They were also informed that they could refuse to participate at any stage of the research. Both oral and written consents were requested. The Regional Ethics Committee has confirmed that the study is ethically sustainable.

Our data are naturally occurring in the sense that the conversations are part of everyday work in the clinic. Furthermore, they can be characterised as institutional talk with certain professional aims, such as supporting clients and planning their treatment pathways (Drew and Heritage, 1992). In analysing the conversations, we draw on ethnomethodological interaction analysis, concentrating on the orientations of the participants in the conversations, and their collaboration in creating meanings (e.g. de Montigny, 2007; Hall et al., 2014; Matarese and Caswell, 2018). In this sense, the research equally values both the clients' and the workers' voices in the conversations.

Using the ATLAS.ti 8.0 program, we started the analysis by coding the whole data corpus (10 conversations), and selecting all instances where social workers and clients discuss service choices. In this 'choice talk', the participants negotiate clients' future transitions from the clinic to other substance abuse services. The talk contains instances where choices are weighted between two or more services (for example: 'So, what are you thinking at the moment? 'Which one would be a better option for you for withdrawal?'), or where it is assessing whether a certain

service is suitable or not (for example: ‘But, of course, it’s your decision, whether you are able to participate that often’). We located 48 instances of this kind of ‘choice talk’. Closer interactional analysis revealed that discussions on service choices always accompany talk that is somehow related to clients’ self-determination. We also noticed that ‘the in-control agent model’ was not present in conversations, but all the conversations exhibited relational autonomy in action (Walter and Friedman Ross, 2014). The absence of ‘the in-control agent model’ means that we did not find such ‘choice talk’ in the data, where clients present themselves solely as knowledgeable about the service they want to choose, and the social workers merely accept this.

In the next section we explore the ‘relational autonomy model’ in action by concentrating on the following questions:

1. How do the social workers promote clients’ self-determination while discussing their future service choices?
2. How do the clients respond to this ‘promotion work’?
3. How is relational autonomy talked into being in the conversations?

Findings: relational autonomy in action

In the following, we analyse in detail four rather long ‘service choice talk’ extracts to make visible complex choice negotiations and the interactional nature of relational autonomy, which would not have been possible with shorter data extracts. In choosing the extracts, we paid special attention to their representativeness in regard to the located 48 instances of ‘choice talk’. First, each extract deals with a different client case. Second, in every extract, the ‘choice talk’ concerns different substance abuse services. Third, the extracts demonstrate the variations of

relational autonomy in the continuum of independence-dependence (Burkitt, 2016), according to which the sub-titles of this section have been named. This is the most important criterion for the selection of extracts, since the main aim of the study is to demonstrate the various ways in which self-determination is accomplished in social-worker conversations in the frame of relational autonomy. The first extract is located nearer to the dimension of the client's independence, whereas the second is in the middle and the last two are closer to dependency. Furthermore, the last extract discloses how the social worker's autonomy is also relational, as she depends in her counselling work on available and reachable service options. We have anonymised the data extracts using fictitious names.

Extract 1. *Supporting the client's choice*

This extract is taken from a meeting between the social worker, Emma, and the client, Matti. The conversation concerns a choice about whether it is now time to take the next step in a treatment pathway. However, the clinic's other social worker, who previously took care of Matti's matters, is now on leave. Thus, Emma suggests returning to the issue later next week:

1. *Emma*: Would it be okay with you if we called you up next week? And Iris [name of Matti's own social worker] returns, so we could think about this together. She had been meeting with you during the summer, I mean, in early summer, she was involved in thinking about other kinds of support for you. And we can also discuss this in our team. [Municipal service purchaser] was questioning a bit whether it's a good option for you to visit our place. However, we know here that in that case, there is a need to find another place, get to know it, and so on.
2. *Matti*: Yeah.
3. *Emma*: What would be your own wish?
4. *Matti*: Well, I'd rather stay here, so I wouldn't have to visit different places again and again.

5. *Emma*: Of course A-clinic is one place where our people often go, like, for follow-up treatment, having conversations and dealing with medical treatment. But they also don't take people who use injected drugs. So, if we think of it that way, it would probably be good for you to stay here for the present.
6. *Matti*: Well, they [A-clinic] also just said that I should rather be here.
7. *Emma*: Yeah, and I'm thinking that at the moment we won't revolve you anymore.
8. *Matti*: Yeah.

By establishing whether Matti agrees with proceeding in the way she has suggested, Emma shows respect towards Matti's self-determination about his own affairs. There is also a lot of 'we-talk' in her first turn. On the one hand, this 'we-talk' seems to include Matti, but on the other hand, it looks as if it refers only to the clinic's workers. Thus, it excludes Matti from the discussion concerning his forthcoming services (turn 1). Emma seems to realise this possible violation of the client's self-determination, as immediately after Matti's minimal response, she asks Matti what he wishes (turn 3). This echoes the ethical principle of respecting and promoting clients' self-determination. Before the question, however, Emma hints at what a 'right' answer would be, as she indirectly criticises the view of the municipal service purchaser that perhaps it is not a good option to continue visiting the low-threshold clinic, but if it is not continued, there would then be a need to find another suitable service for the client.

Matti responds to the question concerning his own wish: 'Well, I'd rather stay here so I wouldn't have to visit different places again and always'. Emma does not directly confirm Matti's wish, but instead gives a justification why the best place at present is the low-threshold clinic: A-clinic, which would be the logical next step in the treatment pathway, does not 'take people who use injected drugs'. Interestingly, Emma simultaneously creates the vision that in the future, this next step should be taken; thus, there is work to do to stop using injected drugs. Here and now, Matti's choice is nonetheless the right one and Emma supports it (turn 5). Here

we see a hypothetical construction, with Emma using the subjunctive mood ('it would probably'), which is softer than advising and encourages a process of exploring options together (Sennett, 2012, pp. 22–24). Matti strengthens the choice by referring to the similar view of the A-clinic workers. Emma confirms the choice once more by responding emphatically to Matti's wish of not having 'to visit different places again'. The conversation ends with joint agreement (turns 7–8).

To sum up, Emma promotes Matti's self-determination, as she supports his wish to stay at the low-threshold clinic for now. This is a good example of relational autonomy. Emma informs and advises Matti about 'realistic' choices and gives an indirect suggestion about what would be the right preference. Overall, there are not many service choices for people who use injected drugs, and that limits the autonomy of both Matti and Emma in planning future treatment pathways.

Extract 2. *Challenging but accepting the client's choice*

The second extract occurs between Julia (social worker) and Niko (client), who is currently carrying out his outpatient withdrawal from opioids in the clinic. They continue the discussion that they recently had about Niko's plans after withdrawal. Niko has a possibility of joining a group in a local NGO that organises peer support.

1. *Julia*: The conversation we had yesterday was fruitful anyway in the sense that, whether you participate in the group or not, I know there are young people close to your life situation. If you go, you'll certainly find something that may suit you. But, of course, it's your decision, whether you are able to participate that often.
2. *Niko*: And my motivation is of course to get sober. But is my motivation good enough to go at a certain time of the day on a certain day of the week to play badminton, or baseball, about which I couldn't care less? It's not about that, of course. I'm especially

interested in the conversations, because they prevent relapse. I mean, if you have some kind of shit going on, you can talk to somebody else, like the way you do in therapy. But I can't see any [point]. I have enough things to do; there is no need to send me to any badminton games. I hated sports in school. I've always been that kind of guy who's into music and who's lazy in sports. If this badminton stuff was some kind of music stuff, then it would be okay. It was mainly the theme group and those things that sounded good.

3. *Julia*: Yeah, well, would we still find out more precisely whether there's a chance to participate in the group part of the week? Would you like to call by yourself [to the group leader]?
4. *Niko*: No, I mean I was just thinking if it's like that everyone else goes there every day except me, then I don't even want to be the guy who's involved only once a week. Because it makes me feel a little like an outsider. If it's like a daycare centre for druggies, I'm not interested in it. I'm not into it then. I would certainly stay sober without any badminton games.

Julia's first turn reveals that Niko has not been eager to join the group thus far, but Julia still seems to want to clarify whether Niko has had second thoughts and brings up the promising prospects of joining the group. This delicate encouragement, using the subjunctive voice, is a sign of respecting Niko's self-determination in the matter. The end of the turn makes this respect very clear. It is Niko who has the right to make the ultimate decision. In his response (turn 2), Niko gives a long account, explaining why the group is not a good choice for him. He displays an understanding of the fact that Julia believes participating in the group would be a sensible choice for him; thus, he needs good arguments to act against this suggestion. Hence, he engages in dialogue with Julia, displaying a capacity to reason. He explains that rejecting the participation does not mean he lacks the motivation to get sober. The reason for not choosing this service is that the group's activities, such as playing badminton or baseball on a regular basis, are simply not suitable for him. Instead, he would prefer therapeutic conversations or music-based activities.

In spite of Niko's clear resistance, Julia still continues exploring the peer support option by appealing to the possibility of joining the activities on a part-time basis, and she presents a way for Niko not to participate in sports, showing she has listened to him (turn 3). She also treats Niko as a self-determining agent by asking whether he wants to call the group leader himself to ask if he can participate less than the other group members. In his answer, Niko is determined and starts accounting for why part-time participation is not reasonable: it might disturb the functioning of the whole group and present him as an outsider. Furthermore, Niko criticises the basic idea of the group as childish. He also repeats that he does not find a group of this kind useful in regard to the aim of staying sober (turn 4).

To sum up, Julia respects and promotes Niko's right to self-determination regarding whether or not to join the peer support group. Niko's choice is that he would not benefit from the group. Although Julia supports Niko in making his own choice, she also presents her own view in an attempt to encourage Niko to see the potential benefits of participating in the group. This encouragement is a good demonstration of how relational autonomy is accomplished in conversations. It is possible that the discussion about group participation will continue between Niko and Julia after this conversation, and Niko might change his view on the matter, or Julia might become convinced of Niko's arguments justifying non-participation.

Extract 3. *Negotiating pros and cons of two choices*

In this extract, Marko (the client) is having a conversation with the social worker, Emma. Marko has sought help for his polydrug use. Marko has decided to seek withdrawal and drug rehabilitation. In principle, there are two inpatient options available: the Drug Withdrawal Unit and the Substance Abuse Psychiatry Ward in the hospital. Marko and Emma have discussed the possible services earlier. They continue this discussion:

1. *Emma*: I didn't yet sign you up for the Drug Withdrawal Unit, where you have been before. But I have made a note for myself that the Drug Withdrawal Unit is full and Substance Abuse Withdrawal [general withdrawal unit located together with the Drug Withdrawal Unit] as well. Also, there's a waiting list. But withdrawal in the Substance Abuse Psychiatry Ward is one option for you, too. You can decide which one you prefer. But I can't say for sure about the Drug Withdrawal Unit because it's overcrowded. The waiting time might well be over a month.
2. *Marko*: Yeah, I know. Last time it took three months.
3. *Emma*: Yeah, and with regards to substance abuse psychiatry, it's a psychiatric hospital. They have one ward that specialises in Subutex withdrawal, and you need a referral from the doctor. If you think that you could manage to stay that time in a psychiatric ward, it's a good treatment. But it's a hospital ward. We can choose to go that route, too. The most important thing is that you get the support you need for the withdrawal period, both in terms of medication and conversational support. And in any case, there are nurses in both places and—
4. *Marko*: How long does the treatment in the psychiatry ward last?
5. *Emma*: Three weeks.
6. *Marko*: Yeah.
7. *Emma*: But you have a good experience from the Drug Withdrawal Unit.
8. *Marko*: Mm.
9. *Emma*: So, what are you thinking at the moment? Which one would be a better option for you for withdrawal? The Drug Withdrawal Unit, which is familiar but you might have to wait a little bit longer, or the psychiatric ward? You'd have to wait for that as well, but that might be available faster.
10. *Marko*: Since it's a psychiatric hospital, can you just walk away from there?
11. *Emma*: Well, the treatment there is voluntary. But the fact is, if you leave, your rehabilitation plan is terminated.
12. *Marko*: Right.
13. *Emma*: Do you think it would be easier for you to do the withdrawal in the Drug Withdrawal Unit?
14. *Marko*: Yeah, I'm a little hesitant about [5-second pause]

15. *Emma*: And Marko, I also think that you're using so heavily at the moment that if you start withdrawal and rehabilitation now, there's always a risk of relapse. But if you prepare yourself well for the treatment with our support, it might actually—
16. *Marko*: Are you looking for an apartment for me at the same time?
17. *Emma*: It's the third important thing, yes.
18. *Marko*: In my opinion, it's the first thing to do here.

Emma informs Marko that signing up to the Drug Withdrawal Unit has not progressed because the Unit is full and has a waiting list. She then presents another choice: the Substance Abuse Psychiatry Ward. She strongly promotes Marko's self-determination ('you can decide which one you prefer'), but at the same time, she reminds him about the waiting list for the Unit. Marko confirms that he is aware of the long waiting time. Emma continues delivering information by explaining the Ward's recruitment criterion and treatment practices (turn 3). While doing that, she again invokes Marko's self-determination ('if you think'). Despite this invocation, Emma immediately displays 'we-talk', including herself and Marko, thus implying a shared decision rather than Marko's individual choice. She also advises on what is 'the most important thing' in making a choice.

During the rest of the conversation, Marko seeks more information on the Ward's treatment practices and rules (turns 4 and 10). Emma answers the questions, but simultaneously reminds Marko about another option and its advantages. She again encourages Marko to use his right to self-determination by assessing himself 'which one would be a better option'. She still seems to imply that Marko should prioritise the Unit instead of the Ward. However, she uses the question format in a way that leaves the final assessment on the right service choice to Marko (turn 13). Marko's response is hesitant, signalling difficulties in making a choice. In the end, Emma evokes a question as to whether this is the right time to start withdrawal and rehabilitation. A time-out period may be needed to prepare carefully for the treatment.

To sum up, the conversation demonstrates how Emma respects Marko's self-determination and encourages him to use it in choosing between two options. Relational autonomy is present in Emma's turns in which she elicits Marko's self-determination, thereby increasing Marko's capacity for autonomy. Instead of making a choice on behalf of Marko, Emma gives him information about different service options. In other words, she approaches Marko as a person who is competent to assess what kind of service suits him best. Marko responds to this encouragement by asking for more information on the option that is unfamiliar to him. In the end, Emma even challenges Marko to consider whether drug withdrawal should be postponed. This can be interpreted as a sign of the ethos of relational autonomy adopted by Emma and prevalent across the whole clinic. If their clients do not succeed in drug withdrawal, this might restrict their chances of getting the same treatment in the future. Emma is trying to avoid the risk of Marko making the 'wrong' choice.

Extract 4. *Supporting, but not necessarily able to fulfil the client's choice*

In the last extract, the social worker, Laura, and the client, Maria, discuss Maria's withdrawal from drugs. It can either be carried out as an outpatient in the low-threshold clinic or in the inpatient Drug Withdrawal Unit. Laura and Maria are discussing these options:

1. *Maria*: And I was just thinking that what if I don't get a place in the Drug Withdrawal Unit? I would say that it's almost impossible for me to make it here by ten every morning.
2. *Laura*: Right. And you need to discuss with the doctor then, who is [name of the doctor], our senior physician, who has a long experience. He can tell, if anyone can, if there is a need, and how it can be realistically carried out. And [name of the nurse] is present. And as I said, it's on next Monday, 12:30 pm. But—
3. *Maria*: What is that then?

4. *Laura*: This doctor's appointment is just in case, if that withdrawal place does not work out. It has to be done during this week; I will call the Drug Withdrawal Unit again tomorrow. Then, I will get information about what the situation looks like before our team meeting. And then it could already be a bit, oh, but we don't have a doctor here tomorrow. Well, the doctor is here on Monday to assess what can be done if there is not a place in the Unit.
5. *Maria*: The Drug Withdrawal Unit would be so good, as there is something to do. Or a kind of routine and rhythm, since I get frustrated alone at home. If one has no strength to maintain any activities in that kind of a condition and so on, then it can be—
6. *Laura*: It's so true, I agree. So it's nice to hear your own idea. And that your idea that a group could be useful and supportive has strengthened. And there [in the Unit] the workers are available all the time. At home, if the parents are mainly at work and you are alone a lot, it's more challenging. It's not that you wouldn't survive on it, but it demands for us to make a very supportive plan. And it demands a lot from yourself as well, that you are able to stay in the plan, although you would feel like whatever. But it will be successful, too. I will really try to talk now to the Unit to say that you need that withdrawal place. And although you are not using [drugs] that much, withdrawal at home probably does not work out because of your day rhythm and difficult morning wake ups. We'll see what they say.
7. *Maria*: Yeah.

As shown in Maria's first turn, her clear preference is the inpatient Unit. She gives reasons for her choice with a self-assessment that she is probably not able to come to outpatient treatment regularly every morning. Later, she gives more justifications for her choice: the Unit would provide her with 'something to do' and add 'routine and rhythm' to her day (turn 5).

Regarding self-determination, Maria's clear preference creates a difficult position for Laura. She supports Maria's choice and, thus, her self-determination by confirming Maria's justification of the benefits of a 24-hour treatment place and emphasising how nice it is to hear her own idea. Furthermore, she gives positive feedback on the progress in Maria's thinking

(turn 6). However, she also prepares Maria that her first choice may not necessarily happen, although she will try to do her best to get a place for her in the Unit. Furthermore, she assures Maria that she would manage with another more challenging and demanding option if it was accompanied by 'a very supportive plan' (turn 6).

To sum up, Laura's struggle with two options is related to her relational autonomy as a social worker. She respects Maria's first choice and promises to do everything to fulfil it. In this sense she acts as Maria's advocate. However, she is not in a position to decide on the placement, and if the outpatient option is realised, Maria's current preference will not be respected. Hence, Laura prepares Maria for the realisation of the second choice. This deliberation might in the end help Maria to accept and commit to outpatient treatment if that is the only choice.

Conclusion and discussion

In this study we analysed how social workers and clients worked together in a low-threshold outpatient clinic for drug users to achieve decisions and actions that would both benefit the clients and respect their preferences about future substance abuse services. As a theoretical starting point, we applied the concept of relational autonomy based on feminist ethics and relational sociology. These theories suggest that people are never totally independent nor dependent in choice making, but always somewhere in the continuum between them (Burkitt, 2016; McLeod and Sherwin, 2000; Walter and Friedman Ross, 2014). Furthermore, people in vulnerable positions or at the margins of society are often regarded as nearer the dependency end of the continuum.

The social workers worked hard to promote clients' self-determination, as guided by the ethical principles of social work. This promotion was carried out in the frame of relational autonomy with different emphases. The novelty of this study was its scrutiny of naturally occurring choice

talk and the demonstration of how clients' self-determination in the form of relational autonomy was present and talked into being in conversations between social workers and clients. It also made visible how relationship-based practices (Ruch et al., 2018) were accomplished in choice-making situations with people who used drugs.

Social workers respected clients' self-determination by asking about their wishes and underlining their rights to make their own decisions. In addition, they treated the clients as experts in assessing whether a particular service was suitable for themselves. However, they also delivered information on available choices, gave advice on what choices might work best, and challenged clients to reconsider their first choices and self-assessments. The clients, in turn, asked for information about available options, disclosed their preferred services, and gave grounds and justifications for their preferences, especially if the preferred options seemed to differ from the social workers' opinions.

All of the above described actions embody variations of relational autonomy in social worker–client conversations. The variations cover instances that are close to the individual 'in-control' model (information delivery, informed choices), and even instances that have some parentalist elements (strong advice giving and funnelling of choices by social workers that comes close to persuasion). However, we are mindful of McDermott's (1975, p. 12) argument that getting information and advice from social workers or being persuaded by them does not make clients less self-determining: 'on the contrary, it is likely to help one achieve one's own goals more effectively' or to see one's situation in a new light. In the data analysed in this study, we did not identify signs of social workers performing ethically questionable manipulation practices. Quite the reverse, social workers' contributions in the conversations can be interpreted as endeavours to increase clients' self-confidence and autonomy competencies (McLeod and Sherwin, 2000).

A concern from an ethical point of view is that real service options were quite scarce for the low-threshold outpatient clinic's clients. This fact – which is probably the reality for clients on the margins of welfare in general – considerably reduces the scope of clients' self-determination. Furthermore, it also reduces the autonomy of the social workers, who have limited possibilities to organise services preferred by clients and that they themselves consider the best options. Final decisions on services are made by professionals in other agencies, whom the clinic's social workers (in collaboration with the clients) try to convince and persuade to make decisions that respect the clients' wishes and self-determination. Quite often these efforts are unsuccessful. Therefore, the social workers can sometimes present and promote only those service options that can be realistically fulfilled. Furthermore, in cases where the desired service is obtained, the pressure to succeed in treatment increases because possible 'failure' may lead to tightening the criteria to get a second chance.

To conclude, this study has revealed how self-determination is a relational phenomenon rather than an individual achievement. The concept of relational autonomy offers a valuable tool for social workers to reflect on and develop clients' self-determination especially when working with people in such vulnerable situations and positions that have diminished their autonomy competencies.

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