

AN EXPLORATORY STUDY OF CARE GIVEN TO DRUG USERS
BY HEALTH CARE AND SOCIAL CARE PROFESSIONALS,
FOCUSSING ON KNOWLEDGE AND ATTITUDES

JAMES CARROLL B.A. R.M.N.

DEPARTMENT OF NURSING STUDIES
AND DEPARTMENT OF SOCIAL WORK AND SOCIAL POLICY,
UNIVERSITY OF GLASGOW

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ABSTRACT

The research is concerned with exploring the relationships between professionals and drug users, particularly in terms of their knowledge and attitudes. The general aims of the study are as follows: Firstly, to explore the relationship between the knowledge and attitudes of professionals and of drug users; Secondly, to identify the influence, if any, of such characteristics as age, sex, occupation, and work area; Thirdly, to identify the relationship, if any, between knowledge and attitudes and perceptions of service delivery; Fourthly, to compare the views of professionals and drug users about the characteristics of professionals considered to be conducive to therapeutic relationships.

Both the attitude survey and the knowledge scale were administered to professionals and drug users. However, the knowledge scale administered to drug users differed from the scale given to professionals insofar as it was partially written in "street language". The third part of the instrument used asked both groups about their perceptions of service delivery.

The main study was carried out in 4 Health Boards, 4 Prisons and one Regional Social Work Department in the West of Scotland. The results indicated that there was a relationship between knowledge and attitudes among both professionals and drug users. A significant relationship

was found between the characteristics of professionals and knowledge and attitudes. No such relationship was found among drug users. A significant relationship was found between knowledge and attitudes and the perceptions of professionals about service delivery, but no such relationship was found among drug users. Finally, professionals and drug users were found to show significant differences in evaluating the characteristics of professionals which were conducive to therapeutic relationships.

The research concludes that there is a need for much greater education and training as the knowledge base of both groups was found to be lower than expected. As the attitudes of professionals were found to be inimical to good practice, further research is needed to explore the reasons for this finding.

The characteristics of professionals were shown to be associated with attitudes but further research is needed to clarify the nature of this relationship. The relationship shown between knowledge and attitudes is significant in the case of professionals, although slight.

Finally, a divergence was shown between the views of professionals and drug users which may be due to differing perspectives and expectations. However, this divergence must be reduced if the relationship between the two groups is to be improved.

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AUTHOR'S DECLARATION

This is to declare that this Thesis is entirely my own work and has not been previously submitted to any other University.

Signed: _____

C.H.A.P.T.E.R. . . 1

INTRODUCTION

Preface

My interest in this area stems from my experience of working with drug users in a specialist role; an unusual position for a health care professional. During this period, I was frequently surprised by the beliefs of other professionals about drug users.

Many seemed to have the same stereotyped views about drug users as the lay public. Such views were usually negative, despite having greater knowledge about drug use and HIV/AIDS. This phenomenon stimulated my interest in researching this topic in a scientific manner, and I embarked on this study.

The Nature of Drug Use

Drug use is a worldwide phenomenon, and, historically, it always has been (1). The use of mood-altering substances is common to virtually all societies, and attitudes to such use have fluctuated from time to time, and country to country. In the 20th Century, attitudes to drug use have generally been negative and punitive.

However, British attitudes were relatively liberal compared with other countries, eg USA (2). The so-called "British System" prevailed until the 1960's when the nature of the drug using population changed. Prior to this decade, it had

been predominantly respectable, middle-class, and often medical in nature. The new group of drug users was mainly composed of working-class youth, and this group were perceived by authority as representing a challenge to the values of society (3).

As a result of this perception, official views became less tolerant, and the focus shifted from a sympathetic, medical approach to one which was legalistic and punitive.

The licensing arrangements for the new methadone clinics illustrated this change. Licenses were granted only to a few Doctors, who were regarded as specialists, and were conservative in their views. There was no opportunity for prescribing by sympathetic, liberal, General Practitioners. Moreover, the licenses were issued, not by the Ministry of Health, but by the Home Office. This change, in itself, may indicate that the clinics were seen primarily as a means of social control by the Government.

In the last 20 years there have been some remarkable changes of direction in drug policy. The de-medicalisation of the subject has resulted in a wide range of people becoming involved in this field. The discovery of HIV/AIDS, and the link with intravenous drug use, has further widened the range of professionals involved.

However, remarkably little has been published on what particular groups, eg Nurses, think and feel about the role

they play, although many such staff had no expectation of working with drug users. They have been thrust into a caring role by the health and social traumas which usually accompany intravenous drug use, eg overdose. The literature remains sparse on the attitudes of such professionals towards drug use and drug users (4).

Some recent studies among GPs have indicated that they are reluctant to treat drug users (5). Such an option is not open to most caring professionals, who are obliged to treat drug users who present for treatment, eg Nurses in a Casualty Department. The degree of contact which Nurses have with such patients is also usually more prolonged and intimate than that of other professionals.

Attitudes of Professionals

Professionals are part of society, not isolated from it. Therefore, it is likely that their views will be affected by the views of society in general. However, relatively little research has been carried out on the attitudes of professionals involved in the drugs field, particularly on the attitudes of Nurses.

This is despite the growing involvement of Nurses in caring for drug users, especially due to HIV/AIDS. The research that is available on health care staff is mainly American, and/or focussed on medical attitudes.

However, there has been one recent example of British research among Nurses, which focussed on the knowledge and concerns of staff towards people with HIV infection or AIDS. This study, by Tierney & Bond (6), identified intravenous drug users as a major risk group for transmission of HIV infection. Consequently, the degree of stigma carried by drug users was very great.

The study, carried out in Scotland, looked at a stratified sample of Community Nurses, ie Health Visitors, School Nurses, Community Midwives, Community Psychiatric Nurses, and Community Nurses. The results suggested that many of the respondents felt ill-prepared to care for such patients, and their knowledge base was often limited. A substantial minority of respondents also felt that they should be able to refuse to care for patients with HIV/AIDS.

An earlier British study, by Kelly & May (7), reviewed research into Nurse-patient interaction. However, it did not look specifically at drug users but at patients who were seen by professionals as "difficult, unco-operative, or self-destructive". Such descriptions are often applied to drug users, and the authors of this study felt that it was the Nurse's judgement which was significant, rather than any inherent qualities of the patients, ie the degree of stigma carried was decisive.

Such perceptions may add further to the stress experienced by professionals. According to a study by Davies (8),

professionals regard drug users as "lying, manipulative, aggressive, and lacking in motivation". Clearly, such perceptions make it very difficult for professionals to slot drug users into a typical "patient" role.

The potential exists for conflict and mutual incomprehension between professionals offering care, and drug users seeking care. Each group is only interested in care delivery on its own terms. Professionals expect drug users to co-operate in getting well, while drug users only seek help in a crisis, not a drug-free regime which they are expected to conform to. The attitudes of professionals to drug users require further exploration, as there is clearly a gap in the research available in the UK.

As Nurses are usually in the front-line of treatment, such a gap is not acceptable. Most nursing authors agree that when Nurses define patients as bad, this perception is a problem in delivering effective care. It is likely that professionals may possess a significant amount of negative feeling, which may be conscious or unconscious.

Such negative feelings and attitudes may adversely affect patient care to the point of being counter-productive. It is hoped that the present study will fill some of the gaps in the research about the knowledge and attitudes of professionals and drug users, and their perceptions of service delivery.

C.H.A.P.T.E.R . . . 2

LITERATURE REVIEW

Stereotyping

According to Tajfel (9), stereotyping "is the general inclination to place a person into categories according to some easily and quickly identifiable characteristic such as age, sex, ethnic membership, nationality or occupation and then to attribute to him qualities believed to be typical of members of that category". Thus, stereotypes are initially based on differential perceptions of social groups.

People will differ naturally in many different ways, eg age and sex, but the danger inherent in stereotyping is that such differences will appear greater than they are, and that similarities between groups are minimised.

Doise found that when people are placed into different categories, such categories usually had positive or negative values attached (10). Such value labels tended to exaggerate differences between categories.

However, Tajfel (9) felt that stereotyping was a common, and necessary, process to facilitate everyday life. Stereotypes were used to predict social behaviour, and the expectations of such behaviour, and may condition reactions to it. People are assigned by society to different groups according to the labels they carry. Such labels were necessary for social interaction to occur.

According to this theory, stereotyping certain groups will allow greater interaction, ie through recognition of the specific characteristics of each group. As it would be impossible for any one individual to have personal experience of all other persons, a stereotype may reduce social discomfort by allowing us to "know" the supposed characteristics of the stereotyped group.

However, if the information is inaccurate, negative stereotyping may result. Thus, entire social groups can be labelled as undesirable due to a faulty perception based on wrong information.

Concept of Stigma

Every society has certain groups which are regarded as being deviant from the social norm. These "out-groups" suffer a degree of stigma based on the perceptions of their particular society (11). The extent of perceived deviance determined the degree of stigma felt (12). A study in 1983 found that respondents differentiated between different types of stigma (13). In particular, disabled people were regarded in a more positive light than other "deviants".

Social deviants were regarded as more offensive and threatening than the physically disabled. These findings suggest that the perceived disruption to social interaction, which the stigmatising condition causes, is crucial to the

degree of stigmatisation. It is this disruption which may explain why people differentiate between various types of stigma. Respondents feared being tainted through association with social deviants, eg ex-convicts and drug users. Although there was also social discomfort felt with the physically disabled, this was felt to result from ignorance as to how to cope with the situation. Such interaction did not carry the same association of crime and degeneracy that contact with social deviants did.

In the 1960's, "Labelling Theories" arose as part of the so-called counter-cultural revolt. Although this new theory accepted the concept of stigma, it rejected the "correctional perspective" which regarded deviant behaviour as a threat to the social order.

"Labelling Theory" focusses on the social processes which produced such deviance. This theory had 2 principal components; statements which concerned the nature of deviance, and statements which explained the development and stabilisation of deviant behaviour.

The first component was succinctly expressed by Becker (11) in his statement "Social groups create deviance by making the rules, whose infraction constituted deviance, and by applying these rules to particular people, label them as outsiders".

From this viewpoint, deviance is not a quality of the act a person commits, but rather the consequences of the application by others of rules and sanctions to the offender. The deviant is one to whom the label has been successfully applied, ie "Deviant behaviour is behaviour that people so label".

Again, according to Becker (11), this is a communal reaction. It is not a property inherent in certain forms of behaviour, but is conferred on these forms by the audience which, directly or indirectly, witnesses them. What counts as deviance is determined by the social situations of the actors involved. Rules and norms create the potential for deviance but not all rule breakers are regarded as deviant. The reaction of society is highly selective.

Goffman (12) postulated that labelling created and reinforced the sorts of behaviour to which the label was originally applied. Deviance is constituted by the meanings imputed by the audience to observable and reportable activities. Among his findings were that even ex-convicts and occasional homosexuals, carried the stigma of their offence long after the offensive behaviour had ceased. In other words, the stigma was strong enough to have very serious personal and professional consequences, even though the initial reason for the stigma had disappeared. Therefore, persons or groups which are labelled for their supposed current behaviour are being punished for displays of deviance. Epithets, ie "junkie, alky, pervert" are

actual weapons in the hands of powerful labellers. Such expressions tend to define, demean, or even destroy members of the labelled group, eg by inviting ostracism and isolation.

When taken out of the context of simple verbal abuse, terms such as "drug addict, alcoholic, psychopath" may give an official stamp to deviance. This stamp of stigma, whether publicly acknowledged or secretly held, can have lifelong consequences for the stigmatised person, according to Albrecht (13).

Types of Stigma

There are numerous groups in society which are categorised as being socially deviant. These include drug users, alcohol misusers, and gay men. All 3 groups are perceived as deviant to some degree.

Drug users are usually seen as being young, often leading chaotic lives, and indulging in criminal behaviour. Such perceptions, present even among professionals, form barriers to treatment (14). Alcohol misusers are usually regarded in the same light, although their behaviour is not usually regarded as being so disruptive (15). In the USA, Shiltz found widespread evidence of homophobia among politicians and professionals. Such attitudes predated the onset of AIDS (16).

Two American studies in the mid-1980's looked at attitudes of staff (17 and 18). The first examined the attitudes of Student Nurses towards drug users. The results suggested that respondents tended to have punitive attitudes, and that this tendency was reinforced by their training. The second study, among Drug Counsellors, indicated that treatment outcomes were affected by staff judgements. Perceptions of attractiveness, or otherwise, directly affected patient care.

However, a major British study in 1972 found that most hospital staff perceived drug users as being ill, and deserving of treatment. Such findings seem to contradict the findings of the few studies made into staff attitudes towards drug use and drug users. However, in practice, respondents drew a sharp distinction between "hard" and "soft" drug use (19).

Users of the former were widely regarded as dangerous, psychopathic, and non-conformist. Although the latter groups were also seen as non-conformist, they were seen as essentially harmless. No information is available in the study as to what was defined as "hard" or "soft" use. Currently, intravenous drug use is generally regarded, by professionals and the public alike, as "hard" use. Drug injecting is well-established in many Western countries, and is more common in Scotland than in the rest of the UK. The practice of injecting has led to a further stigmatisation of

drug users by professionals as injecting was widely regarded as "strange, horrible, and alien" (20).

Drug Use and HIV/AIDS

It is likely that the involvement of health care staff with intravenous drug users will increase, due to the spread of HIV/AIDS. Kennedy (21) describes the particular problems posed by such clients, and speculated that the public health implications of the twin epidemics, ie drug use and HIV/AIDS, would lead to much greater involvement of health care staff (Figure 2.1). Newcombe highlighted the association between drug use and HIV infection in Scotland (22) (Figure 2.2). In support of his findings, a recent report by a Health Board in Scotland indicated that intravenous drug users formed the vast majority of new HIV cases (23) (Figure 2.3), in Lothian.

Increased degree of stigmatisation is shown by a study by Pleck et al, in a major American AIDS in-patient facility (24). Most health care staff were found to have strongly negative views of drug users, whose lifestyle was seen as strange and threatening. Staff who avoided contact with patients in this category had the highest stress levels and vice-versa. This finding suggested to the authors that contact with stigmatised patients reduced fears and anxieties, which may, at least in part, be based on ignorance.

Miesenholder and La Charite, in another American study, suggested that fear of AIDS among health care staff was very real, and had completely overshadowed fears of drug users themselves. Intolerance of drug users had been integrated into a generalised AIDS phobia. The study showed a widespread fear of infection, which was manifested as avoidance, extreme precautions, and verbal expressions of fear (25).

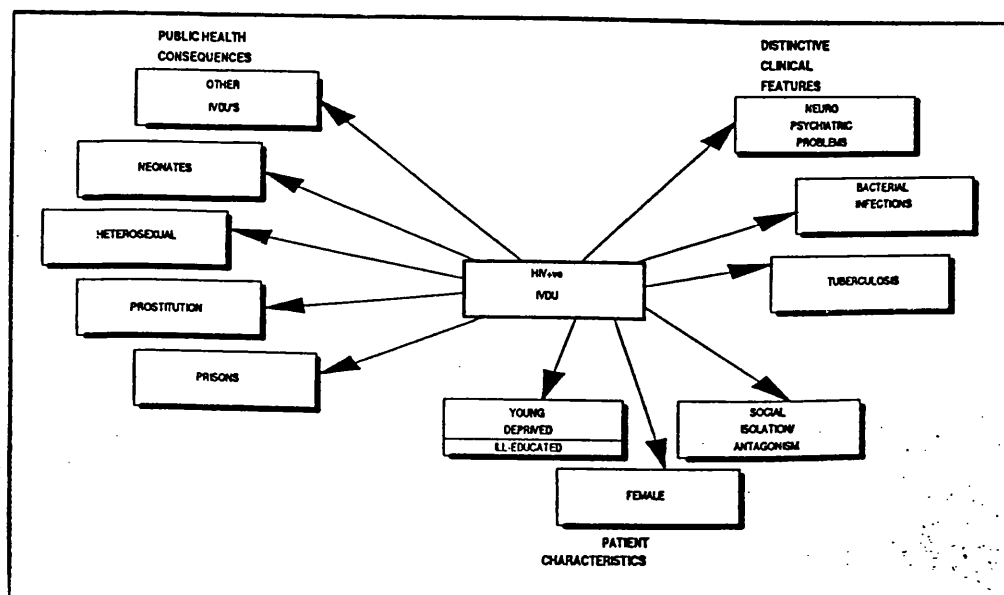


Figure 2:1 - Spread of HIV Infection through Intravenous Drug Use

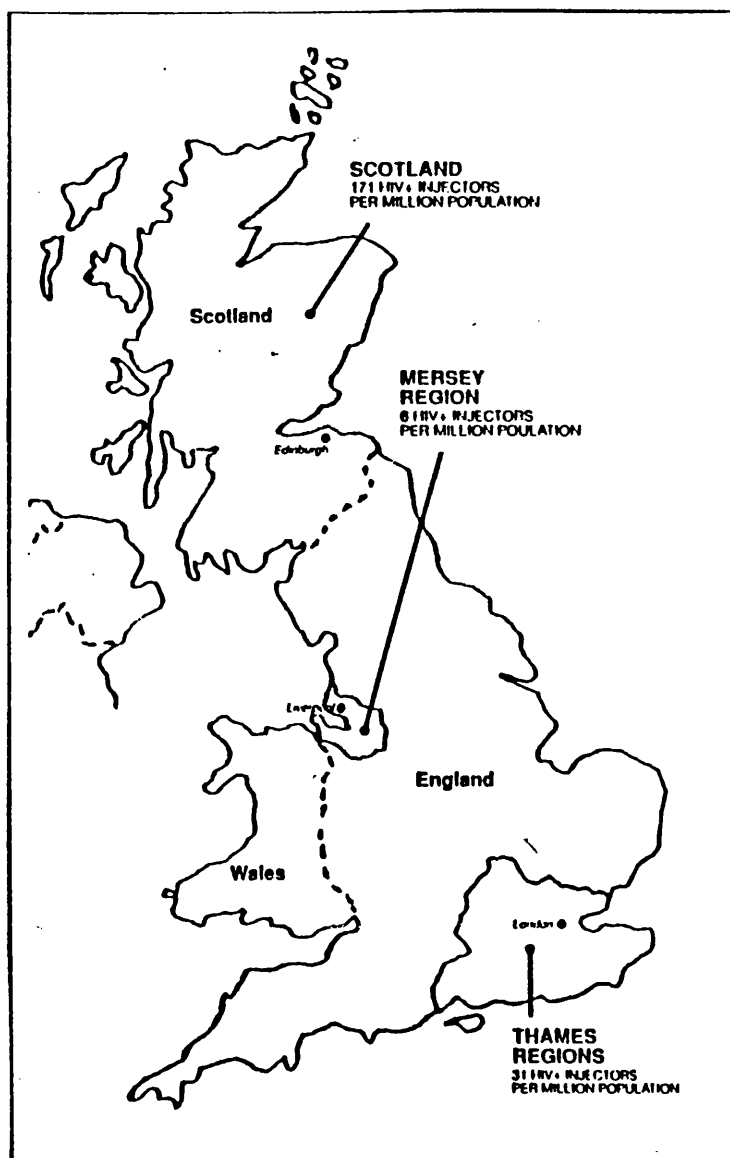


Figure 2:2 - HIV Rate Among Injectors in Three Major Areas of Drug Dependence

HIV Seropositivity Reports 1,149 In Lothian to 31/3/92

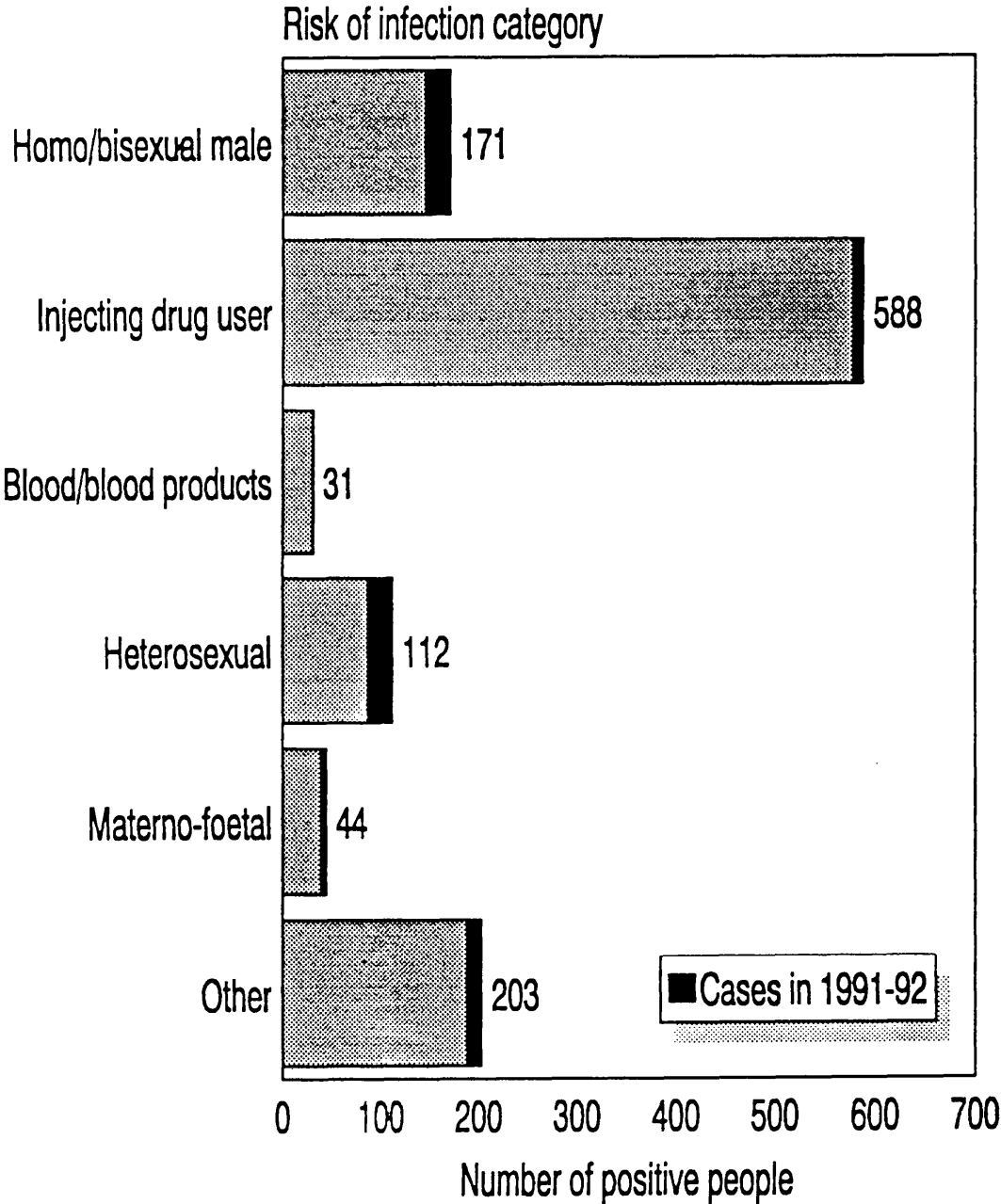


Figure 2:3 - HIV Seropositivity Reports 1,149
in Lothian to 31/3/92

Drug users, already suffering considerable prejudice, were, in addition, seen as a major risk to the general population. This perception further reinforced the negative stereotype which drug users tend to attract. The issue of drug use might well have declined in public concern had it not been for the discovery of AIDS.

Such popular fears may be well founded as intravenous drug users represent a major bridge to the heterosexual population. In a 1989 study, McKeganey showed that the majority of intravenous users continued to "lend" injecting equipment, even if they did not actually share needles. Moreover, the majority of respondents had non-using partners, and contraception was not widely practised (26).

The links between intravenous drug use and HIV/AIDS in Scotland were highlighted by a recent report from the Scottish Home & Health Department (27). This report predicted that 60% of all new cases of AIDS will be through the factor of intravenous drug use by 1993. In contrast, only 20% will be homosexual/bi-sexual men.

Thus, we have reached a situation where the 2 epidemics, ie drug use and HIV/AIDS, are inextricably intertwined, both in reality and in public perception. This may lead to an increase in stigmatisation of drug users.

Attitudes of Professionals

Some recent research suggests that the attitudes of professionals towards drug users may be negative (6). A postal survey of Community Nurses in Scotland indicated that 16% of respondents felt justified in refusing to care for HIV positive drug injectors, whereas only 6% would refuse to treat HIV positive haemophiliacs. The latter group were seen as innocent victims, and the former as causing their own health problems. Thus, drug users were being unfavourably compared with other groups of patients.

The authors of this report on Community Nurses in Scotland felt that the attitudes of professionals were very important in determining the standard of delivery of care. The findings of the study suggested that there was widespread fear, anxiety, and lack of confidence among the professionals involved. In particular, there was great discomfort in treating people whose supposed lifestyle had put them at risk, ie drug users and gay men. Such clients also were treated with a lack of confidentiality which may have prejudiced their desire to approach health care professionals.

Another study examined the attitudes and normative beliefs of a small sample of Nursing Students, as a predictor of their intentions to care for AIDS patients. Knowledge acquisition was found to significantly affect attitudes

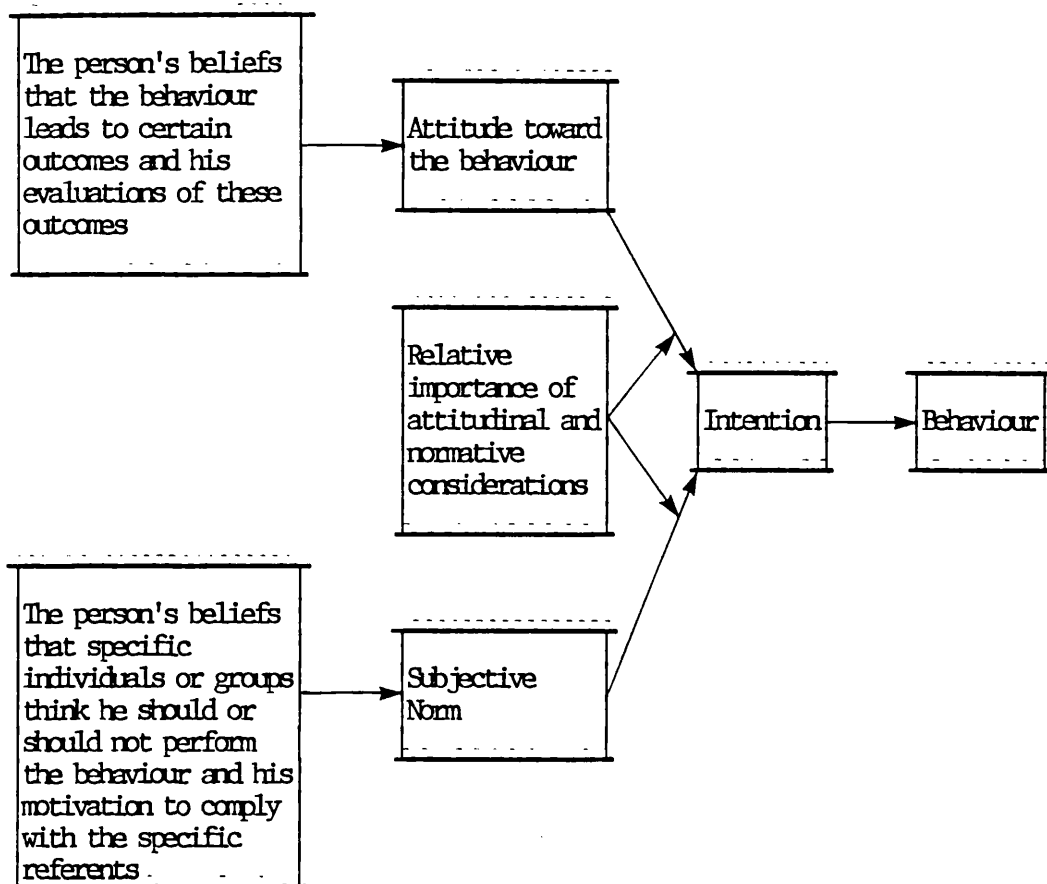
towards such patients. Attitudes were also found to affect care delivery (28).

The importance of subjective norms, ie the perceptions of the views of significant others, was stressed. Situational factors, in addition to a person's own attitude, were found to be accurate predictors of behaviour.

According to the Ajzen-Fishbein Theory of Reasoned Action (29), on which the study by Goldenberg & Laschinger was based, people's intentions to perform particular behaviours, eg caring for drug users, should be an accurate predictor of their behaviour. However, there are 2 major determinants of intentions to perform certain behaviours (see Figure 2:4).

The first is personal, and the second is the influence of the social environment. The personal factor is usually termed the attitude of individuals towards a particular behaviour. Measuring such attitudes, eg by using the MAD scale, will result in a single score which indicates an overall attitude, either positive or negative.

In the course of a person's life, his/her experiences lead to the formation of many different beliefs about various actions and events. These beliefs may be acquired in a number of ways, eg direct observation, indirectly, self-generated etc. Some beliefs may persist over time, some may be forgotten and new beliefs formed.



Note: Arrows indicate the direction of influence

Figure 2:4 - Summary Flow Chart of Fishbein's and Ajzen's Postulated Relationship between Beliefs, Attitudes, Intentions and Behaviour

Logically, having a positive attitude towards a behaviour should result in the performance of that behaviour. However, the social environment will also influence behaviour, usually expressed as subjective norms which are external to the individual.

This second determinant is made up of the opinions of significant others, the nature of the work situation, the extent of prior training etc. Clearly this factor is beyond

the control of an individual but may, nevertheless, influence his behaviour.

If the two determinants of behaviour are in harmony, then behaviour should be predictable, eg an Addiction Counsellor working in a Drug Project, is likely to have positive attitudes that are expressed in his behaviour. Therefore, according to the Ajzen-Fishbein Theory of Reasoned Action, this should result in efficient care delivery to drug users.

However, if the two components are not in harmony, then it is more difficult to predict behaviour, eg a General Nurse may have positive attitudes to drug users but may also be constrained by the nature of the working environment and/or the negative attitudes of her peers. This situation may result in a poor delivery of care to drug users, despite the presence of positive attitudes.

The behaviour of particular individuals will depend on the relative importance attached to each component, ie attitudes or subjective norms. In order to effect any desired change in behaviour, the relative importance of attitudes and normative beliefs must be ascertained.

The Measurement of Attitudes towards Drugs (MAD) Scale was developed mainly for research and clinical purposes. The scale was constructed by listing as many characteristic attitudes towards drugs as possible. These were gathered from a variety of sources, eg mass media, experts in

addictions field etc. The attitudes selected related to treatment, punishment, and the positive and negative attributes of drug users.⁽³⁰⁾

The scale went through several revisions, until the final version was reached. Only those items which proved to be good discriminators of attitude, and were reliable, were retained. The reliability of the scale was established by test-retest on 25 subjects. Table 2:1 shows the item reliabilities. The validity of the scale was measured using Multivariate Analysis of Variance. The subjects chosen for validation were from a wide variety of different backgrounds, and were expected to hold divergent views. Information was obtained on 106 subjects in 6 different groups, ie Social Work Students, Nuns, Police, Drug Hotline Volunteers, addicts in treatment, and Senior Citizens. Validity was tested by the scale's ability to discriminate between these groups, as shown in Table 2:2.

The MAD scale was used as a method of assessing attitudes towards drugs and drug users, among professionals and users themselves. In particular, it was found to be helpful where in-service training was required to modify existing attitudes, which were felt to be detrimental to the treatment process. Also, the scale was useful in assessing whether attitudes were significantly associated with respondent characteristics, eg age, sex, occupation etc.

It was shown to be highly reliable and valid. Test-retest reliability ranged from .91 to .44 by Pearson Product Moment Correlation. With regard to validity, only 2 of the 21 items did not show significant differences between groups. Moreover, the total mean scores for each occupational group were ranked in the expected direction, ie Social Workers had the most positive attitudes and Senior Citizens the least positive.

<u>Items</u>	<u>Correlation</u>
Drug users sexually promiscuous	0.912
Teen drugs are healthy experimentation	0.841
More would smoke marijuana if legal	0.839
Social workers should treat addicts	0.815
Not allowed in agency when high on drugs	0.800
Marijuana users have higher IQ	0.786
It is normal for teen to try drugs	0.785
Only disturbed would try drugs	0.782
Expel from agency if using again	0.750
Parent should react with anger if child on drugs	0.729
Addicts belong in jail	0.716
Drug users dress like hippies	0.705
Heroin dangerous because illegal	0.700
Addict is not hopeless	0.694
Marijuana leads to mental illness	0.678
Marijuana leads to heroin	0.644
Addicts can be rehabilitated	0.616
Addicts should be sterilized	0.596
Addiction like any physical handicap	0.507
LSD dangerous because illegal	0.475
Marijuana leads to other drugs	0.442

Table 2:1 - Test-Retest Item Reliabilities

Groups													
Item No	Social Workers		Nuns		Police		Volunteers		Addicts		Elderly		F. Ratio
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	
11	1.61	0.57	2.33	0.65	2.28	0.79	1.33	0.50	1.76	0.50	3.18	0.48	23.83 ^a
7	1.21	0.50	1.42	0.52	2.36	0.81	1.44	0.73	1.50	1.00	3.11	0.88	23.48 ^a
8	1.57	0.50	2.17	0.58	2.12	0.53	2.00	1.32	1.50	0.58	3.18	0.61	19.07 ^a
2	2.21	0.74	2.50	0.80	2.88	0.78	1.67	2.00	0.82	3.32	0.55	0.55	11.41 ^a
19	1.79	0.63	2.25	0.75	2.32	0.63	1.22	0.44	1.75	0.50	2.79	0.79	10.64 ^a
13	1.25	0.44	1.75	0.45	2.32	0.80	1.56	1.01	1.00	0.00	2.50	1.10	9.63 ^a
16	1.43	0.50	1.58	0.90	2.28	0.68	1.44	0.53	1.50	0.58	2.61	0.99	9.57 ^a
3	1.54	0.51	1.75	0.45	2.64	0.81	1.44	0.73	1.75	0.96	2.50	1.14	7.90 ^a
20	1.50	0.75	1.58	0.90	1.28	0.46	2.11	0.93	2.00	0.00	2.32	0.98	5.87 ^a
21	2.43	0.63	3.00	0.43	2.88	0.60	2.00	0.87	2.75	0.50	2.79	0.69	4.14 ^b
10	1.57	0.74	2.00	0.42	1.97	0.46	1.44	0.53	1.75	0.96	2.21	0.69	4.00 ^b
1	2.00	0.72	1.92	0.29	2.28	0.68	2.33	1.12	2.50	0.58	2.79	0.83	3.97 ^b
17	1.89	0.69	1.83	0.39	2.24	1.01	1.33	0.71	1.50	0.58	2.46	0.96	3.72 ^b
15	2.82	0.67	2.50	0.52	2.88	0.60	3.11	0.93	2.50	0.58	2.36	0.56	3.33 ^b
9	2.89	0.74	3.25	0.45	3.12	0.60	2.00	0.87	2.75	0.50	2.89	1.03	2.30 ^b
6	2.32	0.72	1.92	0.79	2.08	0.57	1.33	0.71	1.75	0.50	2.21	0.88	2.91 ^b
12	2.68	0.77	2.92	0.29	3.20	0.41	3.44	0.73	2.75	0.96	2.96	0.69	2.91 ^b
14	1.61	0.74	1.50	0.52	1.52	0.51	1.44	0.53	1.75	0.50	2.04	0.79	2.39 ^b
4	1.79	0.74	1.83	0.39	2.04	0.46	2.22	1.09	1.50	0.58	2.03	0.51	1.44
18	1.68	0.72	2.08	0.90	1.84	0.85	2.33	1.00	2.00	1.16	2.04	0.96	1.05

a P 0.001 by univariate F Ratio b P 0.01 by univariate
Note: Multivariate difference of P 0.001 using all 21 items

Table 2:2 - Multivariate Analysis of Variance Comparing Six Known Groups on the MAD Scale

Thus, the reliability of the MAD scale was established with the correlation of test and retest scores. Validity was established by comparing mean MAD scores for 6 groups.

Areas of Interaction between Professionals and Drug Users

Professionals and drug users interact in several areas, eg prisons, psychiatric services, medical-nursing services and social services. In the prisons the major group of professionals delivering care to drug users are the Prison Nurse Officers. All such staff are also qualified Nurses but, according to a recent report by the Scottish Prison Service (SPS) (31), they regard themselves basically as discipline officers with a nursing qualification.

The report stressed the role conflict such staff encounter as a result of their dual role. The professional isolation of such Nurses was also highlighted, ie their inability to keep up with professional development at all, much less specialist areas like drug use. While there are a number of Registered Mental Nurses employed by the SPS, whose counselling skills would be of particular value in this area, such staff are not utilised properly.

The problem of drug use within prisons is increasing according to a recent policy document issued by the SPS (32). This report estimated that 33% of prisoners had a history of serious drug use, and that the number had grown

significantly in recent years. Moreover, most drug users identified themselves to the authorities, so official figures may be underestimates.

A report in 1988 by Mersey Regional Health Authority highlighted the problems of preventing the spread of drug use and HIV infection in prisons (33). McBride and Inciardi found that the risks of HIV infection were higher in offenders than in non-offending drug users. This finding has clear and disturbing implications for prison staff, especially health care staff (34). A recent report by the Prison Reform Trust strongly condemned the English prison service for its poor response to the problems of drug use and HIV infection. In contrast, the Scottish Prison Service, and Saughton Prison in particular, was praised for a positive approach (35).

However, a more recent study found that 90% of drug users who had recently been in custody in Scotland had been offered no treatment whatsoever (36). This claim was made despite the fact that 84% of respondents contended that the prison authorities were aware of their problems with drugs.

Thus, the overall picture in British prisons is that little action seems to have been taken to deal with a growing problem. The limited evidence available suggests that drug users are not satisfied with the services provided. However, the most recent Home Office report recognises the problems of drug use, and proposes ways of dealing with it.

In particular, the importance of counselling and pre-release support for drug users was stressed, and the need for much closer links with community services, eg residential rehabilitation units (37). There was a recognition that prison is part of the community, and that drug use and HIV infection may in fact be exacerbated by prison conditions, leading to a further spread of infection on release.

General Medical/Nursing Services

The interaction between drug users and staff in general hospitals is usually involuntary on both sides. A recent American study showed that medical and nursing staff were intolerant of drug users, and that such intolerance is a significant predictor of resistance to working with AIDS patients (38). A British study in 1986, among health care staff, found similar attitudes to drug users (39).

Staff of all ages and both sexes were found to be judgemental in their attitudes towards overdosers, ie attempted suicides, who were regarded as mentally ill. Accidental overdosers were favourably regarded as innocent victims. Drug users who overdosed were heavily stigmatised, even those who attempt suicide are not as stigmatised as drug users. This finding is particularly disturbing since most drug users overdose accidentally.

Psychiatric Services

The research evidence of the experiences of drug users from psychiatric services is equally scant as far as staff attitudes are concerned. This is despite the fact that treatment of drug use falls within the remit of psychiatric services.

Drug users are not usually mentally ill, although they may well be admitted to psychiatric units due to lack of alternative facilities. Anecdotal evidence suggests that this has not been an appropriate setting for such clients or for the staff dealing with them who often lack confidence in their ability to help.

However, several authors have stressed the role of the Psychiatric Nurse as a specialist. Staff explained how his mobile team forged closer links with drug users who had shunned established psychiatric facilities which were not geared to their needs. As most drug users lead a chaotic lifestyle, they responded well to a flexible approach, which basically allowed the client to set the level of service required (40).

In Edinburgh, Egan described the problems facing a Community Psychiatric Nurse (CPN) in the "AIDS Capital of Europe". He had a numerous drug-using clientele, many of whom were HIV positive. The clinical and counselling skills of Registered Mental Nurses were particularly valued by drug users. The

author felt that Psychiatric Nurses were already adept at dealing with stigmatised groups, ie the mentally ill, and should be able to use such skills in dealing with drug users (41).

Social Services

The role of social care agencies in interacting with drug users has received little attention. In Scotland there was a rapid expansion of such agencies in the 1980's. By 1987 there were 73 agencies with 900 staff, over 50% being unpaid volunteers.

All such agencies report being under pressure, and especially suffering from a lack of access to primary health care. In particular, there was a lack of "crisis intervention centres", and "residential detoxification facilities". This finding suggests poor co-ordination between social care and health care agencies, to the detriment of drug users (42).

There seems to have been very little research carried out into the interaction between Social Workers and intravenous drug users. A recent report indicated that social work training was seriously deficient in equipping Social Workers to deal with people with drug and alcohol problems (43). These findings were supported by another recent report which examined the role of Social Service Departments in providing

services to drug users. Service provision was found to be minimal, and largely dependent on local circumstances, and in particular, on co-operation with health professionals (44).

Differences in professional roles were also highlighted in an earlier study by Lightfoot and Orford (45). They looked at a small sample of 24 Social Workers and 24 Community Psychiatric Nurses (CPNs) and compared their respective work situations in dealing with clients with alcohol problems.

The results suggested that situational constraints had a major influence on the development of therapeutic relationships with clients. Social Workers were found to be constrained by departmental policies on addiction problems. Generally, such problems were not felt, by management, to be within the remit of Social Workers. Very little support or guidance was given by management.

Alcohol related problems had to involve other "more acceptable" areas of case work to justify involvement. Such attitudes by senior staff limited the role of Social Workers. CPNs were generally found to have much more involvement and greater empathy with their clients.

These relationships were built up over time and required much effort and patience on the part of the professionals involved. However, this was regarded by managers as an

important part of the treatment process. Therefore, the role of CPNs in the alcohol field was seen as legitimate.

This was in sharp contrast to the role of Social Workers as the authors commented, "Here, in a nutshell, is the situationally constrained agent, constrained by time, by departmental policy and by absence of local back-up, or example - the response is, understandably, the adoption of negative attitudes to maintain self esteem."

Service Delivery/Views of Drug Users

An American study in 1991 found that the majority of drug users did not conform to the stereotype of the "hopeless junkie". On the contrary, most respondents regarded drug use as a legitimate career, offering an attractive lifestyle. Although this lifestyle was seen as deviant by society, there was no stigma attached to drug use within the peer group of respondents; instead, the lifestyle conferred status and meaning to daily life. The issue of crime was highlighted, the author demonstrating that drug use can cause crime, and vice-versa. Most respondents had ambivalent attitudes to the provision of services to stop using drugs. Although health care was valued, particularly in a crisis, motivation to stop using drugs was low, and drug users were selective in seeking help from particular professionals (46).

In an Edinburgh study, Morrison & Plant found that only 40% of respondents had made contact with a drug agency. Many drug users who suffered adverse consequences from drug use did not necessarily seek help. The severity of problems was assessed by the user, and pragmatic decisions made based on their perceptions of particular agencies.

The authors felt that this finding was disturbing in view of the high rate of HIV infection among intravenous drug users in Edinburgh. In future, services would have to be "user friendly", and flexible enough to respond to individual needs (47). In the West of Scotland a 1993 report indicated that in a drug agency, 98% of clients were satisfied with services provided, especially positive staff attitudes, thus emphasising the need for effective service delivery (48).

The importance of service provision being attractive to drug users is also stressed by a very recent (1992) report. This examined the success of professionals in being "user friendly" towards intravenous drug users. A number of major studies were reviewed and several factors identified as important in attracting clients (49).

The first was the severity of the drug user's current habit, the second, the personal and environmental characteristics, and thirdly, the availability of services and policies sympathetic to the drug user's perceived needs. Thus, drug users will seek help based on their perceptions of the ability of professionals to respond to their problems in a

desired way, which, in turn, is likely to be influenced by the attitudes of professionals.

Hartnoll felt that the key issues for professionals to be effective in delivering care were, firstly, to regard drug users' views about services and their drug use as important in delivering effective care, and secondly, to examine how staff deal with new demands. Drug users should be regarded not as "problem patients", but as people with problems.

Recent Studies (Focussing on Knowledge and Attitudes)

A number of recent studies have been carried out which examined the knowledge and attitudes of professionals in relation to HIV/AIDS. Although these studies were not specifically aimed at intravenous drug users, this client group was identified strongly with HIV/AIDS.

An unusual, and most illuminating, study was carried out in Florida in 1990. This compared the knowledge and attitudes towards HIV positive clients, of Mental Health and Substance Abuse staff. Results showed that one-third of all respondents were unaware of the neuropsychological effects of HIV infection. Also, Mental Health staff showed greater reluctance to work with HIV infected clients than Substance Abuse staff.

The authors postulated that Substance Abuse staff were already dealing with HIV positive clients and had gained confidence in the process. Further analysis demonstrated that the reluctance of Mental Health staff was due to several factors:-

- (1) Fear of contagion (despite knowledge of transmission routes).
- (2) Discomfort in working with the terminally ill, especially as they were young.
- (3) Discomfort with drug users due to their supposed lifestyle (50).

The second study examined the relationship between knowledge and attitudes and degree of contact with patients at risk of HIV/AIDS. Respondents were composed of Nurses, Psychology Students, and Design Students, using a standardised questionnaire. No relationship was found between knowledge and attitudes, but Nurses were found to have the greatest knowledge base and the least positive attitude.

The main finding of this study was the relationship between attitudes and degree of contact with patients. Direct contact with people who were HIV positive was likely to lead to more positive attitudes, and a greater knowledge base (51). Neither of these studies looked specifically at attitudes to drug users.

In the second study, only one group (Nurses) were practitioners, the other two groups being Students. All 3 groups had low levels of contact with people they considered to be in "high risk categories", eg intravenous drug users. Nurses had the lowest degree of contact. No minimum criteria were specified for contact.

The third study was a major, quantitative survey which examined the attitudes of hospital Nurses in the South of England to patients with HIV infection or AIDS. No minimum criteria were set for contact with patients. No relationship was found between knowledge and attitudes, but the knowledge base of many respondents was inadequate.

Negative attitudes were often shown to patients with HIV infection or AIDS. In particular, 37% of respondents felt that they could opt out of caring for such patients. Some qualitative analysis of data suggested that respondents needed to explore their own feelings and attitudes in order to deliver effective care (52).

Finally, a fourth study by Dworkin (53) examined the relationship between the attitudes, knowledge, professional background, experience, and demographic characteristics, and the emotional reactions of professionals to people with HIV/AIDS. The study focussed on experienced, rather than expressed, emotion as a factor in explaining the behaviour of professionals.

A large sample was surveyed from 3 professional groups, ie Nurses, Doctors, and Social Workers. Unusually, this study included both health care and social care staff, although the number of Social Workers was very small.

The findings suggested that the nature of interaction with patients determined the emotional reactions of respondents. Nurses tended to have the greatest degree of intimate contact with patients, and to be most concerned about such contact. The authors felt that attitudes and beliefs alone could not adequately explain levels of concern. The nature of the professional role, and the degree of autonomy a person had in carrying out this role, were significant factors in the reactions of professionals to people with HIV/AIDS.

Present Study

The present study examines the knowledge and attitudes of a range of professionals towards people who carry the stigma of HIV/AIDS. However, the approach of the present study differs from that of recent studies in several respects:-

- (a) This study also examines the knowledge and attitudes of drug users. None of the recent studies attempt this.

- (b) The present study stipulates minimum criteria for contact with members of a stigmatised group. No other recent study required this.
- (c) The present study will examine any relationship between the knowledge and attitudes of professionals, and drug users, and their perceptions of service delivery. No such correlation was established in the other recent studies.
- (d) The present study directly compares the views of professionals and drug users about the qualities needed in professionals. No other recent study attempted this.

In conclusion, the usefulness of previous studies is limited on several counts. First, none of them was as comprehensive as the present study, ie looking at knowledge, attitudes, and perceptions of service delivery, of both professionals and drug users. Second, the present study had a more representative sample of professionals, ie a majority of the eligible population, than any prior study. Third, the attitude survey used in the present study proved able to discriminate between professionals, in terms of subject variables, to a greater extent than previous studies. Finally, the attitude survey was also able to detect the correlation between attitudes to drug use and drug users and therapeutic relationships between professionals and clients. This was not the case for any other study documented, and

indicates the value of the instrument which, being valid and reliable, is able to tap the perceptions of clients and professionals.

C H A P T E R 3

METHODOLOGY

Aims

- (1) To identify the relationship between knowledge and attitudes.
- (2) To identify professionals' knowledge, attitudes, and intentions in providing service delivery, to intravenous drug users.
- (3) To ascertain the relationship between professionals' knowledge and attitudes, and the provision of service delivery to drug users.
- (4) To identify drug users' knowledge, attitudes, and perceptions of service delivery by professionals.
- (5) To ascertain the relationship between drug users' knowledge and attitudes, and their perceptions of service delivery.
- (6) To ascertain the relationship between knowledge and attitudes, and demographic characteristics.

Knowledge and Attitudes

Measuring knowledge and attitudes are central to the aims of the study. The knowledge base of respondents can be tested by administering tests based on the commonly available information.

While it is possible to gain an accurate insight into the knowledge base of respondents, attitudes are not so easy to measure. Only the words and actions of individuals indicate their attitudes. Thus, attitudes can only be inferred. People's behaviour is not always consistent with the inferred attitude. When people are asked about matters they regard as non-threatening, it may be possible to accurately measure attitudes, as the individual has no reason to hide anything. This may not be so in an area as contentious as drug use. Measuring attitudes in this area may be difficult due to peer pressure, ambivalence, inconsistency, lack of self-awareness, and finally, a desire to please the researcher.

Attitudes are based on beliefs that may include stereotypes, eg about drugs and drug users. Also, people may have attitudes which they express publicly and express different attitudes in private.

There are several components of attitudes, including the following:-

- (1) Descriptive, eg drug users are unkempt.
- (2) Evaluative, eg drug users are criminals.
- (3) Prescriptive, eg drug users should be shot.

In examining how attitudes arise, it is essential to assess the possible sources. There may be many sources, but they include the following:-

- (1) The media, eg television, press.
- (2) Educational establishments, eg schools, colleges.
- (3) Significant others, eg friends, relatives.
- (4) Personal experiences.

Thus, a person's perceptions of drug users may derive from several sources. An individual's attitudes to drug use and drug users may depend on which source is dominant. This is illustrated by Figure 3:1 overleaf.

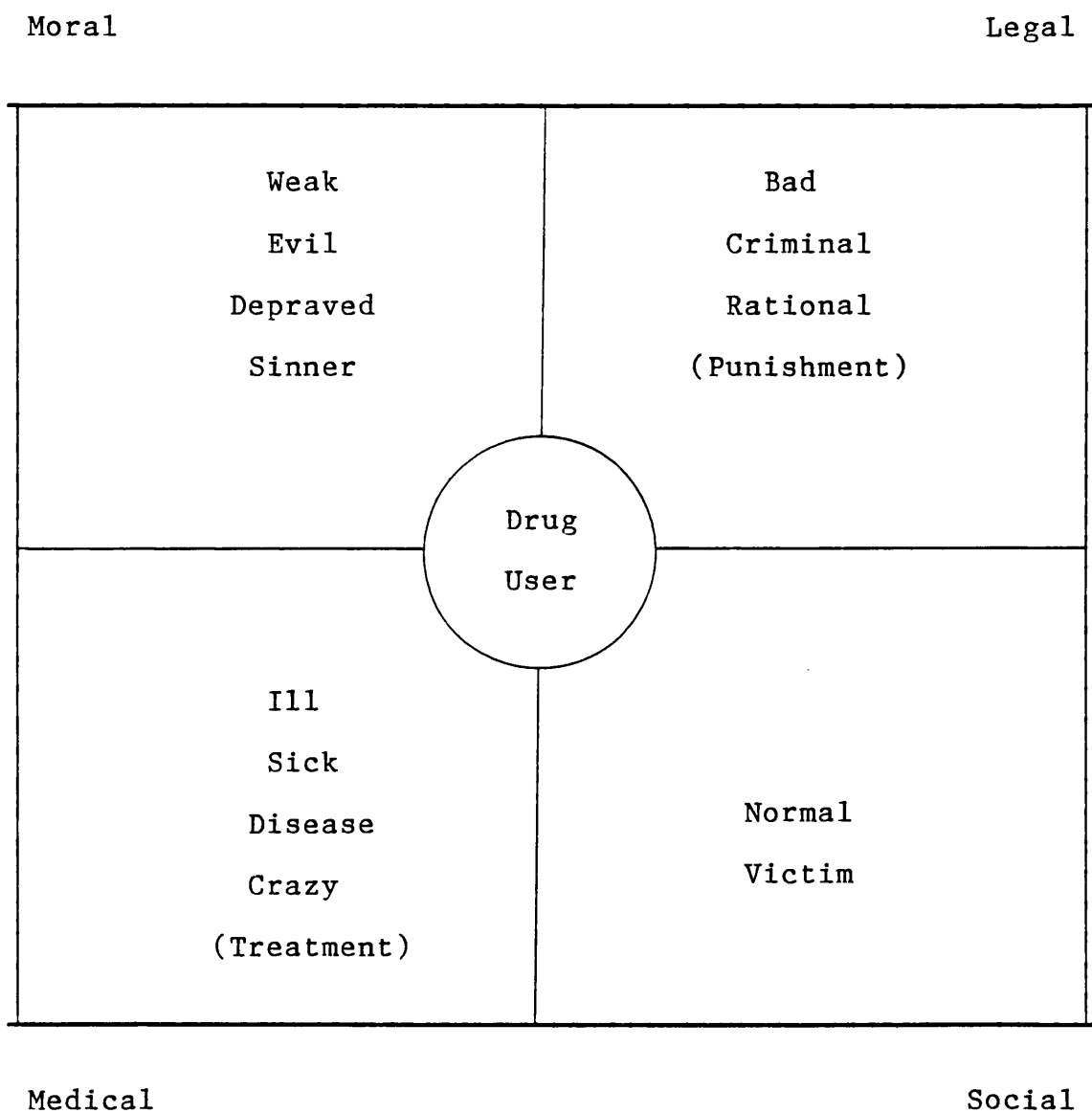


Figure 3:1 - Perceptions of Illegal Drug Users

The present study attempted to measure attitudes to drug use and drug users with the following factors being borne in mind:-

- (1) Reliance on inference, since it is not possible to measure attitudes directly.
- (2) The fact that people's beliefs, behaviour, and expressed feelings may not always match, even when they reflect a single attitude.
- (3) Attitudes may change over time, and possibly over a short period. If attitudes are volatile, one interview will not be enough for accuracy.

Methods of Data Collection

Three possible methods were considered to obtain the data required. These were examination of records, postal questionnaires, and interview schedules. All of these methods had advantages and disadvantages.

Records have several advantages, eg no additional time is needed to compile them. Secondly, records were gathered for different purposes to those of the researcher. Therefore, records may be regarded as objective.

The disadvantages of records are, firstly, they are frequently incomplete. Secondly, much time may need to be spent examining unfamiliar records.

For this study, records have particular disadvantages, ie it is unlikely that the data needed about knowledge, attitudes, and perceptions of service delivery, would be contained in the records available, ie personnel files and treatment notes.

Postal questionnaires have several advantages, ie anonymity, simultaneous delivery to all potential respondents, time for respondents to complete at their leisure, and finally, cheapness.

The disadvantages of postal questionnaires are, firstly, they are rigid and inflexible, eg if a person has problems interpreting questions, there is no opportunity to clarify. Secondly, people may not be able to express their views adequately in writing. Thirdly, even when stamped-addressed envelopes are included, the response rate may be low, as the respondent has to motivate himself or herself to return the questionnaire.

For this study, postal questionnaires had one further disadvantage, ie it would be difficult to trace drug users due to their often chaotic lifestyles. Even if this method was effective in tracing drug users, their motivation, and

sometimes poor literacy, would make a high response rate unlikely.

Interview schedules have several advantages. Firstly, they are effective in obtaining data from people with literacy problems, which often applies to drug users. Secondly, the response rates of interviews are generally higher than postal questionnaires. Thirdly, face-to-face interviews are effective and flexible, eg questions can be clarified.

The main disadvantage of interview schedules are, firstly, they are very time-consuming and costly. Secondly, the interviewer may inadvertently influence the respondent.

Detailed consideration was given to each of these approaches and, as a consequence, interview schedules were the method selected from other possible alternatives, as being most likely to yield data that would allow the aims of the study to be met.

Development of Instruments

The instrument was developed through 6 exploratory stages. The first stage consisted of a series of discussions with my supervisors, focussing on the implications of drug use for service delivery. Notes were taken at these unstructured sessions, and from these notes, a number of open and closed questions were formulated around the topics discussed. The

structure of the instrument was decided in the course of these discussions, and the nature of the data required.

Two interview schedules were to be used, one for professionals, and one for drug users. Both would have the same basic structure, ie consisting of 3 main components, service delivery, attitude scale, and a knowledge base. In addition, each schedule would open by asking for personal details, eg age and sex, although no names would be asked for. Finally, at the end of the interview, every respondent would be given the opportunity to make any final comments.

The second stage consisted of a series of further discussions with my supervisors, and with statisticians and computing professionals. Advice on the structure of particular questions was given and it was agreed that the schedules were suitable for data entry, computer analysis, and statistical testing. Responses to each question were categorised and a coding frame agreed.

Stages 3, 4 and 5 consisted of designing each part of the schedule in detail. The first section, service delivery, was intended to provide data on two main aspects, ie the intentions of professionals to deliver care, and the perceptions of drug users about such delivery. In both cases, the questions would follow a pattern, ie;-

- (1) Be clear, concise, and unambiguous.
- (2) Use only clearly defined terms.
- (3) Avoid leading statements.
- (4) Ask simple, information-gathering questions first.
- (5) Leave long, sensitive, or difficult, questions to the end.
- (6) Follow a logical progression, flowing smoothly from one topic to another.

The first draft of the professional's schedule contained 14 questions, 4 of which were "open response". Several topics were explored ,ie concept of professional role, concerns about HIV/AIDS, and specific care delivery to drug users. A similar procedure was followed with drug users. The first draft consisted of 13 questions, only one of which was "open response". The same topics were explored as in the professional schedule. Further discussions followed with my supervisors and a number of ambiguous questions were removed, or altered.

Stage 4 consisted of designing an attitude scale to be administered to both professionals and drug users. Such a measure would facilitate the comparison between the two groups. Although an extensive literature search was

undertaken, it proved impossible to find an existing measure which covered the desired topics, and could be administered to both groups.

However, it was decided to modify an existing American scale, which had been used in measuring the attitudes of professionals and drug users to drug use. This was a "Likert-type" scale, developed in 1973 (30). It was considered appropriate for use as it appeared to be both reliable and valid, although requiring some modification, eg to include statements about HIV/AIDS.

Content validity for the current scale should be adequate as it has been developed from a highly successful scale. However, in addition, a number of researchers experienced in the drugs field were also approached informally for advice on content validity. All agreed with the scoring and weighting of the items.

Non-differential items were excluded in the following way. The researchers, who acted as judges, indicated any items they felt were unclear or irrelevant, or statements which were too similar to each other. On the basis of such judgements, 8 of the original 40 statements were eliminated.

For the current scale, Cronbachs Alpha Co-efficient for Internal Consistency showed an overall reliability co-efficient of .82. Thus, the reliability was over .80 generally regarded as highly reliable. In addition, the

Standardised Item Alpha was .84. Individual items were found to correlate well with each other, as a measure under study. However, there were 3 items which reduced reliability. Had items 14 and 17 been removed, then reliability would increase to .83. The deletion of item 20 would increase reliability to .84. As the scale was still highly reliable, it was decided to retain these items, especially as one of them was an original statement.

For the current scale, the criteria for selecting statements were that they should relate to one of the characteristic attitudes being measured, eg punishment. The characteristics of the original scale were retained, and 15 of the original 21 statements, or approximations to them, were used in the current scale. Several statements relating to one particular attitude were always included, eg "Drug users should be sterilised", and "Drug users should be handled through jail". Such statements might elicit punitive attitudes to drug users. The scale contained 32 statements, all of the items being scored from 1 - 5, in terms of a Likert-type format. In the majority of items, 1 represented "strongly agree", while 5 represented "strongly disagree". For a minority of items, the scoring was reversed, with a lower score representing a more positive attitude to drug use and drug users.

Thus, for the current scale, the possible range of scores was from a minimum score of 32 to a possible maximum of 160. The former would represent a strongly positive attitude,

focussing on rehabilitation, while the latter would indicate a strongly negative attitude, focussing on punishment.

Further investigations may be needed as it is not known which of the attitudinal factors is most important. However, the fact that the attitudes of drug users were also measured by the scale should provide evidence of the attitudinal "fit" required between clients and professionals for effective treatment.

Stage 5 consisted of designing a knowledge base, which would be administered to both professionals and drug users. This section contained 16 statements about drug use and HIV/AIDS. Ten of the statements were drawn from a study of Scottish Community Nurses carried out in 1989. These statements dealt with HIV/AIDS, but were considered highly relevant to a study about drug users as their behaviour makes them a high-risk group for HIV/AIDS. The items were also considered the most up-to-date available (6). The remaining 6 statements were drawn from the author's own knowledge and experience, and from discussions with colleagues. Items which were answered correctly were given a score of 1, while items answered incorrectly, or where the respondent was unclear, scored 0. Following further discussions with my supervisors, all of the statements were retained. It was also considered suitable that this section should be for self-completion, in order to avoid embarrassment to the respondent, ie if the knowledge were inadequate.

The sixth and final stage of developmental work was the piloting of the instruments. This took place with a sample of 17 respondents, 12 professionals and 5 drug users. No major changes were necessary in the instrument, although the comments of respondents revealed several ambiguous questions or statements, which were amended or removed. Further details of these changes are contained in a later chapter.

However, the Pilot Study was successful in testing the instrument.

Data Collection:

Access to Sample

The initial steps involved contact with the Health, Social Work, and Prison Services. As personal interviews were to be used, it was necessary to limit the area of fieldwork to within two hours travelling distance, for practical reasons.

Therefore, requests were made in writing, to 9 Chief Area Nursing Officers, 4 Directors of Social Work, and 5 Prison Governors. All were asked to facilitate access to staff who met the criteria already stated, ie regular and frequent contact with intravenous drug users. In addition, all of the health care staff had to be qualified Nurses. This was not possible in the case of social care staff, ie there is no recognised qualification for Addiction Counsellors.

However, the Social Workers who were eligible to participate had to be qualified.

The Prison Governors, and the Directors of Social Work were also asked for permission to approach drug users in their care. The same request was made to 2 Consultants. The criteria for drug users were that they be current or recent intravenous users. Users who were in prison must have been convicted of a recent drug offence. Exclusion categories were clients who were primarily alcohol dependent, tranquilliser dependent, or using drugs as part of a psychiatric illness.

The response to these requests for access varied. One Chief Area Nursing Officer (CANO) declined access for no stated reason. Another CANO declined on the grounds that the study would take up too much staff time, and might prejudice staff/client relationships. A further 2 CANOs claimed that they had no nursing staff who met the criteria! However, 5 CANOs agreed to allow access, provided they were given feedback. In the case of one Health Board, the Psychiatric Nurses refused to participate at a later stage.

Four of the Prison Governors agreed to allow access to Prison Nurse Officers. One referred the request to Prison HQ and no response was ever received. Two Governors agreed to allow access to users. One declined on the grounds that another similar study was already being carried out in the

prison. The other Governor claimed that the users in his care were over-researched.

Only one Director of Social Work agreed to allow access to professionals and users. Feedback was requested. One Director never replied to the request. Another declined on the grounds that his staff were over-researched, and that users were already participating in a current study. Finally, one Director claimed that neither staff nor clients met the criteria in his area.

One of the Consultants agreed to allow access to his patients, after approval was granted by the local Ethical Committee. The other declined as his patients were over-researched.

In short, 4 Health Boards, 4 Prisons, and one Regional Social Work Department agreed to participate. Geographically, this covered all of West/Central Scotland. At this stage no sampling technique had been finally determined, but initial information from management indicated that there were only around 300 professionals who met the criteria.

Therefore, it seemed possible that a "census" was feasible, ie seeing the entire study population. The adoption of this method would greatly enhance the validity and reliability of the study, and it was decided to attempt a "census". In the case of users, there was no data available on the numbers

within the whole study area. Therefore, it was decided to aim for a figure of 100 users, ie enough to justify statistical testing.

Problems Encountered in Sampling Professional Population

The response rates for professionals are shown in Table 3:1. Respondents were seen at three different types of location, ie NHS, Social Work, and Prisons. There were very great variations in response rates according to employing authority, but the overall response rate was 67%.

<u>Location</u>	<u>Target Population</u>	<u>Number Seen</u>	<u>%</u>
Prisons	58	52	90
Social Work	95	75	79
NHS	219	121	55
Total	372	248	67

Table 3:1 - Population of Professionals

Prison Nursing Staff had the highest response rate (90%). Fifty-two of a possible 58 staff were seen, so a census was almost achieved. The small group who were not seen remained unavailable despite repeated requests, and visits, by the author.

Social care staff also had a high response rate (79%). These professionals were comprised of two occupational groups, ie Social Workers and Addiction Counsellors. The latter group had a very high response rate (86%). Only 9 staff were not seen, and they were almost all employed in a residential rehabilitation unit, which was closed for renovation. Consequently, the staff had been widely dispersed and were difficult to trace before the deadline.

Only 31 Social Workers were identified as meeting the criteria, of whom 20 were seen (64%). There had been an unfortunate delay, caused by correspondence to management going missing in the post. Had this not occurred, it may have been possible to include all potential respondents, as all indicated a willingness to participate.

The response rate for NHS Nurses was the lowest (55%). This poor response rate seems to have been due principally to 2 factors. Firstly, the number of General Nurses who met the criteria was a gross underestimate. According to information supplied by Nurse Managers, around 150 staff met the criteria, whereas 219 staff were identified in practice. This population was well in excess of the estimate. Secondly, the chief underestimate occurred in Accident and Emergency Departments. Staff in these departments had a very low response rate (30%) as they were apparently too busy to be seen.

There were differences between the response rates of General Nurses and Mental Health Nurses. General Nurses formed a population of 177, of whom 82 were seen (46%). Forty-two Mental Health Nurses were identified as meeting the criteria, of whom 39 were seen (93%).

Interview Procedure

Once permission had been granted by senior management, it was necessary to approach middle and junior management to facilitate access to potential respondents. Numerous initial meetings were held, at which the purpose of the study was explained. These were very time-consuming, but led to the development of trust. In some instances, there were meetings with potential respondents themselves, at which apprehensions about the study were alleviated, eg issues surrounding confidentiality. Sometimes, during such meetings, it became apparent that the professionals did not meet the access criteria, eg their client's primary problem was alcohol. Since such categories had already been excluded in correspondence with management, it appeared that some managers were unaware of the nature of the clientele with whom their staff actually worked!

There were many initial doubts expressed by potential respondents about the value of the proposed study, and anxiety about whether they would be identified. After giving assurances of confidentiality and anonymity, no-one

actually refused to participate. However, there were a considerable number of missed or forgotten appointments, and sickness and holidays also caused delays.

Once consent had been given, respondents were seen at their workplace in a room provided by management. This was always in an area where they could not be overheard and respondents were always seen alone. In order to put respondents at their ease, the aims of the study were briefly explained prior to interview. Any questions asked were answered, and confidentiality and anonymity stressed.

The interview formally commenced by asking respondents for demographic details, eg age, grade, work area etc. One respondent was very reluctant to give her age, but in most cases this question offered an opportunity for humour, and to put the respondent at his, or her, ease. At this point, respondents were asked a series of questions about service delivery to drug users. There were 13 questions, all of them closed. Respondents were shown a card containing a number of possible responses. The selected response was then entered on to the interview schedule by the author. There were also 2 "open response" questions, and the verbatim response was entered on to the schedule.

The next stage consisted of completing an attitude survey containing 30 positive and negative statements about drugs and HIV/AIDS. The author read out each statement in sequence, and again showed the respondent a card with a

number of possible responses. Such responses ranged from "strongly agree" to "strongly disagree" on a 5 point scale. The selected response was entered on to the interview schedule by the author.

The third part of the schedule was for self-completion. Each respondent was given a sheet containing 16 statements about drug use and HIV/AIDS. Respondents were asked to tick whether they felt that the statements were either true or false, or whether they felt uncertain.

The fourth and final part of the interview consisted of asking each respondent if they had any further comments about the schedule itself, or about the issues raised. If comments were made, they were entered verbatim on to the schedule by the author.

Finally, respondents were thanked for their participation. Initially, interviews lasted 40 minutes to an hour. However, as the author gained in confidence and expertise, this was reduced to around 30 minutes.

Problems Encountered in Sampling Drug Users

There were a number of problems in accessing drug users. Such clients tend to lead a disorganised lifestyle, and are difficult to trace in any event. Asking clients to participate in research also raises some difficulties, eg

they may be suspicious of the reasons for the research, and especially of what happens to the information gathered.

Drug users are often wary of authority figures, and if a researcher is seen as such, it may be difficult to persuade respondents to participate. A process of building trust is needed, either by the researcher personally, or with the help of trusted others, eg former users.

Not all of the problems arise from drug users themselves. In many cases, there may be competition from other researchers. They may be able to offer greater inducements, eg financial.

Staff who are actively working with drug users may also cause problems, eg they may be concerned that their clients are over-researched, or that clients may complain about them. Thus, the research may be seen as monitoring job performance. Reassurances about confidentiality and anonymity are necessary to counter this fear.

Even if staff are willing to help, they may be "too" helpful, eg by selecting "good" clients who may not be representative.

Interview Procedure

In the circumstances, the research method adopted was to approach staff in drug agencies, NHS addiction units, and prisons, and ask them to contact clients. Staff were not asked to select respondents in order to prevent staff bias, but simply to inform clients of the nature of the research, and ask for their co-operation. There were 9 separate locations widely scattered throughout West/Central Scotland. Thus, the respondents may be representative of drug users in this area. Six to 12 respondents were drawn from each location. The actual response rate is shown in Table 3:2.

<u>Location</u>	<u>Target Population</u>	<u>Number Seen</u>	<u>%</u>
Drug Agency	50	33	66
NHS Units	25	11	44
Prisons	25	25	100
Total	100	69	69

Table 3:2 - Population of Drug Users

The author arrived at each location at a time when most potential respondents were likely to be there, eg following a clinic or a group meeting. Obviously, this procedure was not relevant in the case of drug users in prison. Such respondents were seen at their convenience, and at times which suited the prison authorities. Otherwise the

procedure followed was identical to that for professionals, with one important exception. Each respondent was given an information sheet containing details of the study, and of the researcher (Appendix A). The interview schedule was administered in the same sequence. The first section again focussed on service delivery, but from the user's viewpoint. There were also 13 closed questions, but only one "open response" question. This was the only question which was identical to professionals and users alike, ie "What makes a good drugs worker?".

Effectiveness of the Method Employed

The method adopted fell well short of a random sample but it seemed eminently practical given the resources available. One possible alternative, which was actively considered, would have been to spend several weeks or months in one location. Respondents could have been contacted independently of the staff employed there which would remove staff bias. This method would also have reduced travelling time, but it would have been very time-consuming, less representative, and have no guarantee of a greater numerical response. Another possibility would have been for the author to actively seek out drug users at street level. However, time constraints, and the personal danger involved, ruled out this approach.

The overall response rate of drug users was 69%. Very few users were seen in NHS Addiction Units, partly due to the scarcity of such units, but due also to the difficulty of gaining ethical permission. Nearly 50% of respondents were seen at drug agencies, but it must be stressed that the location was largely a matter of chance. Most respondents were in contact with all three types of location in sequence, or even simultaneously.

Data Handling and Analysis

This study formally began on 1 October 1989, and fieldwork commenced on 16th April 1990 and was concluded on 30th January 1991. Names and addresses of respondents were never asked for by the author. Instead, each respondent was given a unique identification number. When the data had been collected, they were entered on to the mainframe computer of the University of Glasgow in March/April 1991 by the Computing Services Department.

Two statistical packages were used, SPSS-x and MINITAB. The bulk of the analysis was by SPSS-x. At a later stage, SPSS-pc was also employed. Cross-tabulations, means tables analysis, and the ANOVA procedure were performed, using Chi Square tests with Yates Continuity Correction. Pearsons Correlations were performed, and also "Tukey" tests.

Note: Percentages may not equate precisely to 100% due to the effects of "rounding" for missing values by the SPSS system.

Note: Not every respondent answered every question in Section 1 (Service Delivery) and some did not complete Section 2 at all (Attitude Scale). Therefore, totals will vary slightly.

Note: "Don't Knows" have been excluded from all tables in order to simplify such comparisons.

C H A P T E R . . . 4

PILOT STUDY

Purpose

The purpose of the Pilot Study is to establish an acceptable procedure to gain access, and to test the instruments used. No survey of any kind should be carried out without pre-testing the data collection methods. Questionnaires, no matter how carefully designed, will often contain ambiguous questions, or terms that are not properly explained, and a Pilot Study should reveal these defects.

A small sample of the study population is selected for the Pilot Study, and data collected and briefly analysed. The results are then carefully examined for errors and omissions. The Pilot Study should be able to answer the following question:-

- (1) Will the study aims be met?
- (2) Are the results consistent with similar surveys of this population?
- (3) Are the results what was expected?
- (4) Has the data been correctly and consistently recorded?
- (5) Have some questions been consistently missed out or misinterpreted?

Mistakes are rectified by making the necessary changes to instructions, questions etc. If there are a large number of changes, it may be decided to carry out a second Pilot Study. Every effort should be made at this stage to ensure that the main study goes as smoothly as possible, and successfully achieves its aims.

The Pilot Study may also be used to determine the categories for closed questions on the main study questionnaire/schedule. By asking open-ended questions and examining the response to these questions, it may be possible to design a set of responses for the same (closed) questions on the main questionnaire.

Population and Sample

The target group for the Pilot Study consisted of health and social care professionals who were in regular and frequent contact with intravenous drug users, ie at least once per week. A group of intravenous drug users who also met this criteria were used as subjects in the Pilot Study. As both groups were to be asked about their views on service delivery, this minimum criteria for contact was necessary. It was decided to aim for a sample of around 20 subjects, ie enough to test access, and to test the instrument.

Instrument

The instrument used was then in its fifth draft, and consisted of 3 distinct sections. The first section asked respondents about various aspects of their work with intravenous drug users, experience and training about HIV related work, and their beliefs regarding health education and counselling, and other aspects of their service delivery.

The second section consisted of a Likert type attitude scale containing 32 positive and negative statements about drug use. This was developed from the American "MAD" scale on which it was based. This scale had been adapted and updated as the drug scene had changed considerably since the original scale was developed in 1973 (30). The current scale had a 5 point scale, ranging from "strongly agree" to "strongly disagree". A lower score indicated a more positive attitude to drug use. Possible scores ranged from 32 to 160.

The third part of the schedule consisted of a 16 point knowledge base about drug abuse and HIV/AIDS. Respondents were asked to indicate whether a statement was "true, false or uncertain". This part of the schedule was partly based on the Tierney & Bond report in 1989 about Scottish Community Nurses (6). The interview schedule concludes by asking respondents if they had any further comments.

Access

Negotiations were conducted with various employers to gain access to a suitable site for the Pilot Study. Such permission was impossible to obtain until agreement to participate in the main study was granted. This caused a delay.

The subjects selected for the Pilot Study had to have similar characteristics to those in the main study, ie a mixture of health care and social care staff, and intravenous drug users in contact with such staff. The only agency which seemed to meet all the criteria was an AIDS Counselling Clinic.

The major disadvantage of this site was the small number of staff, a total of 12 professionals. However, this was considered sufficient to carry out the Pilot Study. Therefore, an approach was made to the AIDS Co-Ordinator who responded positively to the request, although he did express doubts about the participation of patients, as he felt they were over-researched.

A meeting was arranged with the entire staff team at which the reasons for the study, and the methods to be used, were clarified. Confidentiality and anonymity were stressed. The entire team agreed to participate, but expressed doubts about approaching clients as they felt that other

researchers had already been granted access on too many occasions, and their clients were over-researched.

This was clearly not an ideal situation, as it meant seeking access to drug users at a separate site. However, access to professionals was agreed, and they were seen at the Counselling Clinic over the next 2 weeks.

Shortly thereafter, an approach was made to detached drug workers in North Glasgow, already known to the author. They agreed to facilitate access to their clients, provided confidentiality and anonymity were guaranteed.

An arrangement was made to see 10 drug users at a local community centre. In practice, only 5 clients appeared, fairly typical behaviour for drug users. Although this was a very small number, it was considered sufficient to test the instrument.

Data Collection

Professionals were seen at times which suited them, over 2 weeks in February and March. Clients were seen in a single day in late March. All respondents completed an interview schedule.

Data Analysis

As the number of respondents was only 17, the analysis was done by hand with the aid of a calculator.

Results:

Comments by Professionals

The Pilot Study demonstrated that very few changes were necessary to the instrument. Principal findings were as follows:-

Section 1 (Service Delivery) contained 3 questions which were unclear or ambiguous - 4(2), 13 and 14. Minor amendments were carried out.

Question 7, ie "What makes a good client?" was felt by respondents to be unethical and vague. Therefore, it was changed from an open to a closed question focussing on the positive features of clients.

Section 2 (Attitude Scale) contained 3 items which respondents felt to be unclear or ambiguous - 1, 13 and 20. Minor amendments were carried out. Items 19 and 31 were consistently misinterpreted, and were omitted from the final scale.

The term "drug abuse", which was used throughout the schedule, was considered judgemental by respondents. The neutral term "drug user" was substituted.

Comments by Clients

Section 1 (Service Delivery) contained 4 questions which were unclear or ambiguous - 6, 14, 15 and 16. Minor amendments were carried out. Question 13 was felt to be ambiguous and unnecessary. Therefore, it was merged with another more structured question on the same topic, ie HIV/AIDS.

Section 3 (Knowledge Base) contained 5 items which were not understood by respondents - 5, 7, 8, 10 and 11. These items were re-written in "street language".

Main Findings (Professionals)

A number of conclusions can be drawn from the Pilot Study:-

- (1) The mean attitude score was 77.8 out of a possible 160, suggesting an overall positive attitude to drug users. However, four respondents had negative attitudes, suggesting that, even in a dedicated team orientated to HIV/AIDS work, there was some reluctance to work with drug users.

It should be noted that, at the time of the Pilot Study, the majority of patients encountered were homosexual/bisexual men, although the number of drug users was growing. Therefore, even in this team, some staff might have been relatively unfamiliar with drug users.

There did not appear to be any significant differences between health care staff whose mean attitude score was 78, and social care staff whose mean score was 77.3. Males appeared to have more negative attitudes than females, scoring 80 compared to a mean of 77.4 for females. However, there were only 2 males in an already very small sample. Age appeared to be a significant factor. People under 35 had a mean score of 75.8, compared to 82.3 for people who were 35 plus. Thus, attitudes seem to be less positive with advancing age.

- (2) All respondents appeared to be well informed about drug use and HIV/AIDS. The mean knowledge score was 12 out of a possible 16. Males scored 13 compared to 11.6 for females. Health care staff had a mean of 11.8 compared to 12.7 for social care staff. People under 35 had a mean of 13.5 compared with 11.6 for people who were 35 plus. The differences did not appear significant.

Main Findings (Clients)

All 5 respondents had a negative attitude score, ie 89. This suggested that they viewed drug abuse negatively. The only female respondent appeared to have a more positive attitude, ie 79. Ages ranged from 21 to 26 and it was not possible to draw distinctions due to the small numbers.

The mean knowledge score was 7.2, suggesting an inadequate knowledge base. Some of the statements in this section were incomprehensible to clients, and were rewritten in "street language" for the main study.

Discussion

The Pilot Study was useful in carrying out the tasks expected, ie gaining access and testing the instrument. Access to professionals was relatively easy to gain, while access to clients proved difficult. This pattern was repeated in the main study.

Both professionals and clients were very helpful in testing the instrument. The schedule was then in its fifth draft, and very few changes were necessary.

The Pilot Study was also roughly representative of the population in the main study, in terms of the age and sex profiles of both professionals and clients.

C.H.A.P.T.E.R. . . 5

DESCRIPTIVE PROFILE (PROFESSIONALS)

MAIN STUDY

Characteristics of Professionals:

Subject Variables

The age and sex profile of all respondents is shown by Table 5:1. Range of ages was from 21 to 62, and the mean age was 34.9 years. The sample was youthful, 40% of respondents being under 30. Females formed a clear majority of the sample, but just over 40% were males.

The employment profile, as shown by Table 5:2, demonstrates the preponderance of 3 major employers, 84% of the sample being employed by these employers. The remainder of the sample (16%) were employed by 3 small, predominantly rural Health Boards.

There was very great variation in terms of work area, 19 separate work areas being identified (Table 5:3). Prisons represented the work area of fully 25% of respondents, this site including several occupational groups. This illustrates the central role of prisons in making contact with drug users.

Drug Projects are the next work area of importance in terms of numbers of staff. Nearly 16% of professionals are employed in this type of work, almost all of them being Addiction Counsellors. They are a specialist group, and their contact with drug users is usually voluntary (on both sides).

The role played by staff in Accident and Emergency units is important. They are the third largest group of professionals 12.1%). All staff in these units are General Nurses, and their contact with drug users is not to treat their primary problem, but some associated physical condition, eg abscesses. This contact is likely to increase if drug use escalates.

All of the other work areas each represented less than 10% of respondents. There were 5 occupational groups represented in the sample (Table 5:4). Only 2 of these groups could be described as specialist, ie Addiction Counsellors and Mental Health Nurses. These 2 groups represented 37.9% of the sample. Thus, the majority of staff were non-specialist and their contact with drug users was involuntary (on both sides).

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Age</u>		
< 30	101	40.7
30 to 39	72	29.0
40 to 49	48	19.4
> 50	27	10.9
		<hr/>
		100
<u>Sex</u>		
Male	101	40.7
Female	147	59.3
		<hr/>
		100

Table 5:1 - Age & Sex Profile of Professionals

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
Health Board 1	83	33.5
Health Board 2	22	8.9
Health Board 3	9	3.6
Health Board 4	7	2.8
Prisons	53	21.4
Regional Social Work Dept	74	29.8
		100

Table 5:2 - Employment Profile

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
Accident and Emergency	29	11.7
Acute Admission (Psychiatric)	6	2.4
AIDS Ward	10	4.0
Addiction Unit	20	8.1
Area Team (Social Work)	9	3.6
Community Nursing	4	1.6
Community Psychiatric	9	3.6
Detached Drug Work	7	2.8
Day Hospital	1	0.4
Drug Project	39	15.7
Genito/Urinary	2	0.8
Infection Control	1	0.4
Infectious Diseases Ward	17	6.9
Infectious Diseases Out		
Patient Clinic	2	0.8
Medical Ward	14	5.6
Needle Exchange	4	1.6
Prison	63	25.4
Residential Rehab	8	3.2
Surgical Ward	4	1.6

Table 5:3 - Work Area Profile

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Occupation</u>		
Addiction Counsellor	55	22.2
General Nurse	82	33.1
Mental Health Nurse	39	15.7
Prison Nurse Officer	52	21.0
Social Worker	20	8.1

Table 5:4 - Occupational Profile

The 5 occupations can be further broken down into 2 occupational groups, ie health care and social care.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Occupational Group</u>		
Health Care	173	69.7
Social Care	75	30.3
		<hr/>
		100

Table 5:4(1) - Occupational Group Profile

Characteristics of Professionals in terms of Service Delivery:

Referral of Clients

There was no dominant source of client referral (Table 5:5). Drug users in prison were obviously not referred specifically for their drug problems. Therefore, they have

been included in the category of "Other", ie unspecified. This may be responsible for the importance of this, the second largest single source of referral.

Self-referral forms the largest category, being the usual method of referral in the case of drug agencies.

Referral by Social Workers is the third category in terms of numbers. This may be due to the social and legal problems which many drug users have, leading to social work intervention. Other counselling agencies are the fourth most common source of client referral. This may be due to good communications between such agencies. Referrals from families and the courts were very few. Less than 10% of referrals were from these combined sources.

Treatment Model Used

No single treatment model was dominant (Table 5:6). Nearly 40% of respondents claimed that they tailored treatment to the needs of individual clients, ie "client centred". Treating drug use as a "Social Problem" was favoured by nearly 30% of the sample. Over 20% regarded drug users as "risk takers". Very few respondents (6.9%) regarded drug use as an illness, ie the "Disease Model". Thus, drug users are regarded as being responsible for their behaviour, and may not merit the sympathy which is normally engendered by the "Sick Role".

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Source of Client Referral</u>		
Courts	13	5.2
Social Worker	46	18.5
Other Counselling Agency	32	12.9
Family/Friends	9	3.6
Self-Referral	95	38.3
Other	53	21.4

Table 5:5 - Breakdown of Client Referral

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Treatment Model Used</u>		
Social Problem	74	29.8
Risk Taking	50	20.2
Disease	17	6.9
Personality Disorder	10	4.0
Client Centred	97	39.1
		100

Table 5:6 - Breakdown of Treatment Model Used

Bereavement Counselling

Bereavement is increasingly common among the friends and families of drug users as the health risks of drug use increase, eg HIV/AIDS. However, only a minority of the sample gave bereavement counselling, although it was a large minority as shown in Table 5:7. It is likely that the need for such counselling will increase, and it is encouraging that a large number of respondents are already delivering such care.

Health Education Counselling

A majority of respondents claimed to give health education counselling (Table 5:7) This is an encouraging sign, since most professionals are non-specialist, and the provision of such counselling is vital for drug users, in view of the spread of HIV infection.

<u>Characteristic</u>	<u>Number (n = 245)</u>	<u>%</u>
Bereavement Counselling	92	37.6
Health Education Counselling	154	62.9

Table 5:7 - Percentage of Professionals Giving Counselling*

(* These categories are not mutually exclusive)

Management Support

The nature and degree of management support provided in caring for drug users is highly unsatisfactory (Tables 5:8 and 5:9). More than 50% of the sample felt they received most support, not from managers, but from their own peer group. The degree of support received from management was also strongly criticised by a majority of respondents. Almost 40% of the sample felt that they received very little support, whilst another 24% felt that they received inadequate support from management.

Job Satisfaction

The issue of job satisfaction felt in caring for drug users, is one which aroused strong feelings among respondents (Table 5:10). Only a small minority of respondents were mostly, or completely, satisfied in terms of job satisfaction. A very substantial minority (48%) were very dissatisfied or not very satisfied. Thus, among professionals, there appears to be widespread discontent in terms of job satisfaction.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Most Supportive Level of Management</u>		
Peer Support	132	53.2
Immediate Superior	87	35.1
Line Manager	27	10.9
Senior Management	2	0.8
		<hr/> 100

Table 5:8 - Views of Professionals
About Management Support (Level)

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Management Support Given</u>		
Very Little	94	37.9
Inadequate	60	24.2
Adequate	60	24.2
Considerable	23	9.3
Total	11	4.4
		100

Table 5:9 - Views of Professionals
About Management Support (Degree)

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Job Satisfaction</u>		
Very Dissatisfied	34	13.7
Not Very Satisfied	86	34.7
Fairly Satisfied	62	25.0
Mostly Satisfied	62	25.0
Completely Satisfied	4	1.6
		100

Table 5:10 - Views of Professionals
About Job Satisfaction

Knowledge of Clients with HIV/AIDS

The majority of professionals were not aware of whether or not their clients were HIV positive or had full-blown AIDS (Table 5.11). Since their clients are presenting with drug or drug-related problems, this may seem a surprising finding.

However, the issue of HIV/AIDS is an emotive one for clients and professionals alike. Drug users may be reluctant to raise the issue of their HIV status due to fears of rejection or breach of confidentiality. Similarly, professionals may have their own fears and prejudices about HIV/AIDS and avoid the issue, which may also be seen by professionals as a barrier to effective treatment for the presenting problem, eg in Accident and Emergency Departments. Finally, the majority of professionals sampled are non-specialist and the nature of contact is likely to be brief. Thus, it is unlikely that the question of HIV status would be raised by the professionals involved.

Positive Features in Clients Who Want to Stop

There was great variation in the views of respondents as to the nature of positive features, which would help a client to stop using drugs (Table 5:12). Nearly 80% of respondents felt that someone who had self-motivation, and admitted a problem existed, should be able to stop using drugs. Only a minority of respondents felt that co-operation on the part of a client was a positive feature, ie likely to help them stop using drugs. This may suggest a rather judgemental approach by professionals. Drug users were clearly seen as having a self-inflicted problem which they should make an effort to eliminate with or without professional help. However, on a more positive note, very few respondents were in favour of pressuring drug users to stop.

Referral to Other Professionals

There were very great variations in the rates of referral by professionals to other professionals. A majority of respondents referred drug users to Social Workers, whilst only a minority made referrals to Community Psychiatric Nurses or to STD clinics.

This disparity may be due to the fact that drug users tend to have many social and legal problems which require social work intervention. The comparatively low profile of the health professionals may be due to poor communications between professionals. Nevertheless, it is disturbing that the rate of referral is so low, given the many health problems of drug users (Table 5:13).

Support Given to Families and Friends of Drug Users

A majority of respondents gave counselling/support to the families of drug users. The degree of counselling/support given to the friends of drug users was far lower (Table 5:14). There are several possible reasons for this disparity. Families of drug users are not normally drug users, and may be regarded as victims, ie deserving of sympathy. Such a judgemental view may not offer similar sympathy to the friends of drug users who may be users themselves or regarded as such. However, friends may also be less accessible to professionals than families and not

regarded as having the same rights. Friends may also be less motivated to seek counselling and support.

<u>Characteristic</u>	<u>Number (n = 233)</u>	<u>%</u>
Knowledge of Clients with HIV/AIDS	77	33.0
No Knowledge	156	67.0
		100

Table 5:11 - Percentage of Professionals with HIV+ Clients

<u>Characteristic</u>	<u>Number (n = 246)</u>	<u>%</u>
Self-Motivation	192	78.0
Co-Operation	88	35.8
Admits Problem Exists	194	78.9
Under Pressure	31	12.6

Table 5:12 - Views of Professionals
About Factors Motivating Drug Users to Stop*

(* These categories are not mutually exclusive)

<u>Characteristic</u>	<u>Number</u>	<u>%</u>
Referral to CPN (n = 243)	63	25.9
Referral to STD Clinic (n = 243)	74	30.5
Referral to Social Worker (n = 246)	170	69.1

Table 5:13 - Percentage of Professionals Who Refer
Drug Users to Other Professionals*

(* These categories are not mutually exclusive)

<u>Characteristic</u>	<u>Number</u>	<u>%</u>
Support/Counselling to Families (n = 245)	148	60.4
Support/Counselling to Friends (n = 246)	108	43.9

Table 5:14 - Percentage of Professionals Who Give
Counselling/Support to Families and Friends*

(* These categories are not mutually exclusive)

Concerns about HIV/AIDS

This question revealed widespread concerns about HIV/AIDS (Table 5:15). Availability of resources and lack of in-service education were matters of concern to almost 60% of respondents. Professional support was felt to be lacking by nearly 50% of respondents.

Over 30% were concerned about lack of experience with HIV infected clients, whilst over 20% of respondents were concerned by their lack of knowledge.

These findings are disturbing as they appear to indicate that many professionals, whether specialist or non-specialist, have very great concerns about the risks from HIV/AIDS.

What Makes a "Good" Drugs Worker

This question revealed a high degree of unanimity (Table 5:16). Over 90% of respondents felt that personal qualities and professional skills were important. A good knowledge base was rated important, but still by less than 50% of the sample. Very few respondents valued having specific job training or being an ex-user.

Employing ex-users is still regarded as contentious and risky, and there is not yet a specific job training available in the drugs field. A combination of skills and personal qualities is clearly seen by most respondents as useful.

Previous Experience Relevant

In spite of the fact that most respondents were non-specialist, a clear majority felt that they had some or highly relevant experience.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>% Quite or Very Concerned</u>
Personal Risk of HIV	39	15.7
Risk of Passing on HIV to Own Family	45	18.1
Lack of Experience with HIV Infected Clients	86	34.7
Lack of Personal Knowledge about HIV Infection	56	22.6
Lack of Professional Support	114	46.0
Lack of In-Service Training	148	59.7
Reluctance to Discuss Safer Sex	12	4.8
Availability of Resources	146	58.9

Table 5:15 - Percentage of Professionals
Concerned about Risks from HIV/AIDS*

(* These categories are not mutually exclusive)

<u>Characteristic</u>	<u>Number</u>	<u>%</u>
<u>Factors Contributing to being a "Good" Drugs Worker</u>		
Personal Qualities (n = 248)	225	90.7
Professional Skills (n = 248)	235	94.8
Training (n = 247)	20	8.1
Knowledge Base (n = 247)	109	44.1
"Ex-User" (n = 246)	14	5.7

Table 5:16 - Views of Professionals about
"Good" Drugs Worker*

(* These categories are not mutually exclusive)

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Previous Work Experience Relevant</u>		
Not At All	91	36.7
Some Relevant	115	46.4
Highly Relevant	42	16.9
		<hr/>
		100

Table 5:17 - Percentage of Professionals
with Previous Relevant Work Experience

Effectiveness of Work with Drug Users

Less than 35% of respondents felt that their work with drug users was effective. A slightly higher figure felt that they were definitely ineffective. The remainder claimed not to have any idea of their effectiveness, or otherwise. These findings seem to show a pessimistic outlook by most respondents, but it is difficult even for specialist staff to estimate their effectiveness in this area (Table 5:18).

Reasons for Effectiveness

Nearly 50% of respondents stressed that the underlying nature of the problem was the reason for the effectiveness, or lack of effectiveness (Table 5:19). Available resources, professional skills, and follow-up were all rated as about equally important. Only a small minority of respondents regarded personal qualities as important.

Such findings may suggest that most professionals regard drug users as a particularly difficult group to treat. Also, the personal qualities of professionals needed to build up long-standing personal relationships with drug users may be under considerable strain in these circumstances.

Professional Future

When professionals were asked about their probable future involvement with drug users, no single category appeared dominant (Table 5:20). Almost 30% of respondents opted for "other", ie unspecified reasons. The next largest category felt that they would be working with drug users, but with more success. Thus, only a minority of respondents were optimistic about their future professional involvement.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Effectiveness of Work</u>		
Very Ineffective	32	12.9
Ineffective	63	25.4
Don't Know	68	27.4
Quite Effective	80	32.3
Very Effective	5	2.0
		<u>100</u>

Table 5:18 - Views of Professionals
About Effectiveness at Work

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>
<u>Reasons for Effectiveness</u>		
Personal Qualities	38	15.6
Available Resources	82	33.7
Underlying Nature of Problem	116	47.7
Professional Skills	88	36.2
Follow-up	86	35.4

Table 5:19 - Views of Professionals
About Reasons for Effectiveness*

(* These categories are not mutually exclusive)

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>
<u>Professional Future (in 5 years)</u>		
More Success	61	24.6
Less Direct Involvement	48	19.4
Present Situation	48	19.4
Less Satisfaction	5	2.0
Giving Up	12	4.8
Other	74	29.8
		<hr/>
		100

Table 5:20 - Views of Professionals about Future Involvement
with Drug Users

C-H-A-P-T-E-R--6

DESCRIPTIVE-PROFILE-(DRUG-USERS)

Characteristics of Drug Users:

Subject Variables

The age and sex profile of respondents is shown in Table 6:1 overleaf. The age range was from 16 to 41 years, with the mean age being 25.5 years.

Only 20% of the sample were female, and since the ratio of female to male drug users is generally accepted to be 1:3, ie 33%, they would seem to be under-represented. One possible reason for this discrepancy is that access to male drug users in prison was granted, but not to female users in prison.

Attitudes to drug use appeared to become more negative with increasing age. Drug users over the age of 25 seemed to have strongly negative attitudes to drug use. This finding may indicate that continued use of drugs leads to harmful consequences, eg prison, health complications, and problems with relationships.

Female respondents appeared to have marginally more positive attitudes to drug use than male respondents. However, it is difficult to draw any firm conclusions due to the small number of female respondents.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>%</u>
<u>Age</u>		
< 25	30	43.4
> 25	39	56.6
		<hr/> 100
<u>Sex</u>		
Male	55	79.7
Female	14	20.3
		<hr/> 100

Table 6:1 - Age and Sex Profile of Drug Users

Background to Drug Use

There did not appear to be any single factor which was dominant in contributing to drug use. Almost 50% of the sample opted for "other" unspecified reasons for starting to use drugs. Peer pressure and a poor environment were also highly rated. Very few respondents mentioned parents and/or siblings as contributing factors (Table 6:2).

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Claiming Yes</u>
<u>Reasons</u>		
Parents have problems with substance abuse	7	10.1
Parental separation	12	17.4
Siblings have drug problems	5	7.2
Peer pressure	18	26.1
Poor environment	19	27.5
Other	31	44.9

Table 6:2 - Background Problems of Drug Users*

(* These categories are not mutually exclusive)

Motivation to Stop Using Drugs

The majority of respondents did appear motivated to stop, although just over 26% felt able to stop without support. A further 40% felt that they could stop using, but only with support. Over 30% expressed doubts about their ability or motivation to stop using. Thus, it appears that most respondents are poorly motivated to stop using without support (Table 6:3).

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>%</u>
<u>Response</u>		
Not at all	3	4.3
Not very much	5	7.2
Would like to stop, but feel it is too difficult	15	21.7
Determined to stop with support	28	40.6
Determined to stop, with or without support	18	26.1

Table 6:3 - Motivation to Stop Using Drugs

Factors Helpful to Stopping Drug Use

Over 40% of respondents valued "Supportive Services", and a "Supportive Partner". Just over 30% of respondents valued drug maintenance. Perhaps surprisingly, very few respondents valued "Peer Pressure" as a helpful factor in stopping.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Claiming Helpful</u>
<u>Reasons</u>		
Nothing can help	1	1.4
Drug Maintenance	21	30.4
Peer Pressure	3	4.3
Supportive Services	30	43.5
Supportive Partner	30	43.5
Other	23	33.3

Table 6:4 - Helpful Factors in Stopping Drugs*

(* These categories are not mutually exclusive)

Death Through Drug Use

A very high proportion of respondents claimed to know at least one person who had died through drug use (72.5%). Almost 50% of respondents claimed to be aware of 2 to 5 persons who had suffered drug-related deaths.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Claiming</u>
<u>Response</u>		
> 10	3	4.3
6 - 10	6	8.7
2 - 5	33	47.8
1	8	11.6
None at all	19	27.5

Table 6:5 - Close "Others" Who Have Died Through Drug Misuse

Reasons for Involvement with Agency

There did not appear to be any dominant reason for respondents to become involved with drug agencies. However, the category of "Other" reasons includes users seen in prisons. Clearly, drug users in prison did not voluntarily choose to become involved with the professionals encountered there, eg prison nurses.

The next largest categories were "Self-Referral" and "Peer Pressure". This would seem to contradict the findings shown by Table 6:4. It is difficult to interpret these findings, since some of the "Self-Referrals" may have been under pressure, eg from the Courts (Table 6:6).

<u>Characteristic</u>	<u>Number (n = 68)</u>	<u>% of Sample</u>
<u>Reasons</u>		
Chance	1	1.5
Family Pressure	7	10.3
Another Official Agency	5	7.4
Peer Pressure	10	14.7
Self-Referral	12	17.6
Other	35	51.5

Table 6:6 - Reasons for Involvement with Agencies

Relationships with Professionals

Most respondents claimed to have satisfactory relationships with the professionals involved with them (83.8%). Therefore, it appears that most respondents were able to form good working relationships with professionals, which were conducive to the treatment process (Table 6:7).

<u>Characteristic</u>	<u>Number (n = 68)</u>	<u>% of Sample</u>
<u>Response</u>		
Badly	5	7.4
Indifferently	6	8.8
Adequately	19	27.9
Get on well	23	33.8
Get on very well	15	22.1
		<u>100</u>

Table 6:7 - Relations with Staff

Factors which make a "Good" Drugs Worker

Most respondents valued "Professional Skills" (65.2%). The next most valued factor was the "Personal Qualities" of professionals (58%). Just over 30% of respondents felt that the professionals involved should be ex-users themselves. Only 20% of respondents valued having a sound "Knowledge Base" and less than 5% valued a specific drug training. These findings indicate that drug users would like a greater involvement for ex-users.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>%</u>
<u>Reasons</u>		
Personal Qualities	40	58.0
Professional Skills	45	65.2
Training	3	4.3
Good Knowledge Base	14	20.3
Being an Ex-User	21	30.4

Table 6:8 - Reasons which make a "Good" Drugs Worker*

(* These categories are not mutually exclusive)

Knowledge of People with HIV Infection or AIDS

Almost 50% of respondents claimed to know someone who was HIV positive, and a further 20% claimed to know someone with full-blown AIDS. These high proportions are difficult to explain given the low rate of HIV infection and AIDS among drug users in the West of Scotland. This finding may reflect the age range of the sample, or the close nature of the drug using network. Another possible explanation is that the official estimates of HIV/AIDS are a gross underestimate.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Who Know</u>
<u>Knowledge</u>		
Knowledge of HIV Positive Person	32	46.4
Knowledge of Person with AIDS	14	20.3

Table 6:9 - Knowledge of People who are HIV Positive
or have AIDS*

(* These categories are not mutually exclusive)

Concerns about the Risks of HIV/AIDS

The high proportion of respondents who have personal knowledge of people with HIV infection or AIDS, may be reflected in the concerns about the risks from HIV/AIDS. More than 70% of respondents were concerned about, "Risks of Personal Infection" and "Risks of Passing On Infection". However, less than 40% of respondents were concerned about normal contact with people with HIV infection or AIDS. Less than 20% had any other concerns about HIV/AIDS. Thus, it appears that most respondents had realistic apprehensions about the transmission of the HIV virus (Table 6:10).

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Quite or Very Concerned</u>
<u>Concerns</u>		
Risk of Personal Infection	49	71.0
Risk of Passing On Infection	52	75.4
Contact with People who are HIV Positive	27	39.1
Other Aspects of HIV/AIDS	12	17.3

Table 6:10 - Concern About Risks from HIV/AIDS*

(* These categories are not mutually exclusive)

Treatment by Professionals

The treatment received by different professionals yielded some interesting results. Almost 70% of drug users had been seen by a Drug Counsellor, as might be expected. However, almost 60% of respondents had also seen a Social Worker, suggesting that drug use may have many associated social problems.

Health professionals were under-represented in terms of contact with drug users. Just over 30% of respondents had seen a CPN while only 15% had attended a STD clinic. Perhaps more surprisingly, only 10% of respondents claimed to have received "Health Education Counselling".

Thus, social care staff appear to be much more successful than health care staff in making contact with drug users. This finding may be explained by the nature of service provision. Specialist services are almost entirely staffed by social care staff, so they might be expected to have more extensive contact with drug users (Table 6:11 overleaf).

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Treated</u>
<u>Professional</u>		
CPN	21	30.4
STD Clinic	11	15.9
Health Education Counsellor	7	10.1
Social Worker	41	59.4
Drug Counsellor	48	69.6

Table 6:11 - Treatment by Professionals*

(* These categories are not mutually exclusive)

Satisfaction with Care Provided

While a majority of respondents expressed satisfaction with care provided, over 40% of respondents did not despite the evidence about good relationships with individual professionals, as shown in Table 6.7.

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>% Satisfied</u>
<u>Response</u>		
Not at all satisfied	17	24.6
Not very satisfied	11	15.9
Fairly satisfied	16	23.2
Mostly satisfied	12	17.4
Completely satisfied	13	18.8

Table 6:12 - Satisfaction with Care Provided

Degree of Felt Stigma

Over 60% of respondents felt fairly, or very, stigmatised by their drug use. Only 17% of respondents felt no stigma at all. Thus, the majority of respondents felt stigmatised to some degree.

Such perceptions may, or may not, be accurate, but they are likely to affect the willingness of drug users to approach professionals. Access to health and social care may therefore be diminished (Table 6:13).

<u>Characteristic</u>	<u>Number (n = 69)</u>	<u>%</u>
<u>Response</u>		
Not at all	12	17.4
Slight	8	11.6
Not very	3	4.3
Fairly	18	26.1
Very	28	40.6
		<u>100</u>

Table 6:13 - Degree of Felt Stigma

Predictions of Future Drug Use

When asked to predict their future drug use (within 5 years), almost 50% of respondents felt that they would be totally drug-free. Another 36% predicted that they would have reduced their level of drug use. Only 2.9% of respondents felt that they would continue to use at their current level, and only 1.4% of respondents predicted that their drug use would dramatically increase. Perhaps more realistically, 13% of drug users were unable to make any prediction about their future behaviour.

<u>Characteristic</u>	<u>Number (n. = 69)</u>	<u>%</u>
<u>Predictions</u>		
Become totally drug free	32	46.4
Reduce level of drug use	25	36.2
Continue at present level	2	2.9
Increase drug use dramatically	1	1.4
Other	9	13.0

Table 6:14 - Predictions of Future Drug Career

C.H.A.P.T.E.R . . . 7

RESULTS

(Analysis of Relationships between Variables,
focussing on the Knowledge and Attitudes of Professionals)

The main study is concerned with describing the characteristics of professionals and drug users, exploring the relationship between knowledge and attitudes, and the extent to which knowledge and attitudes affect service delivery in the case of professionals. No significant relationship was found between the knowledge and attitudes of drug users, and age and sex; or their perceptions of service delivery (P greater than 0.05).

The structure of this Chapter is as follows:-

Section A - Identifying the relationship between knowledge and attitudes of professionals, and of drug users.

Section B - Identifying the relationship between knowledge and attitudes and subject variables, ie age, sex occupation, and work area.

Section C - Identifying the relationship between knowledge and attitudes of professionals, and the nature of their contact with drug users.

Section D - Identifying the relationship between the knowledge and attitudes of professionals, and their concerns about HIV/AIDS.

Section E - Identifying the relationship between the knowledge and attitudes of professionals, and specific care delivery to drug users.

Section F - Identifying the relationship between the knowledge and attitudes of professionals, and issues relating to their role with drug users.

Section G - Identifying the relationship between the views of professionals and drug users about specific qualities of professionals.

SECTION - A

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES

(Professionals and Drug Users)

It is necessary to examine the possible relationship between knowledge and attitudes, as this will have implications for the findings of this study. If a significant association is found, such a finding may suggest that the provision of additional resources, eg training/information, would enhance positive attitudes towards drug use and drug users. However, if no such relationship is found as indicated by the literature review, then knowledge and attitudes should be treated as distinctly separate areas.

Relationship between Attitudes and Knowledge of Professionals

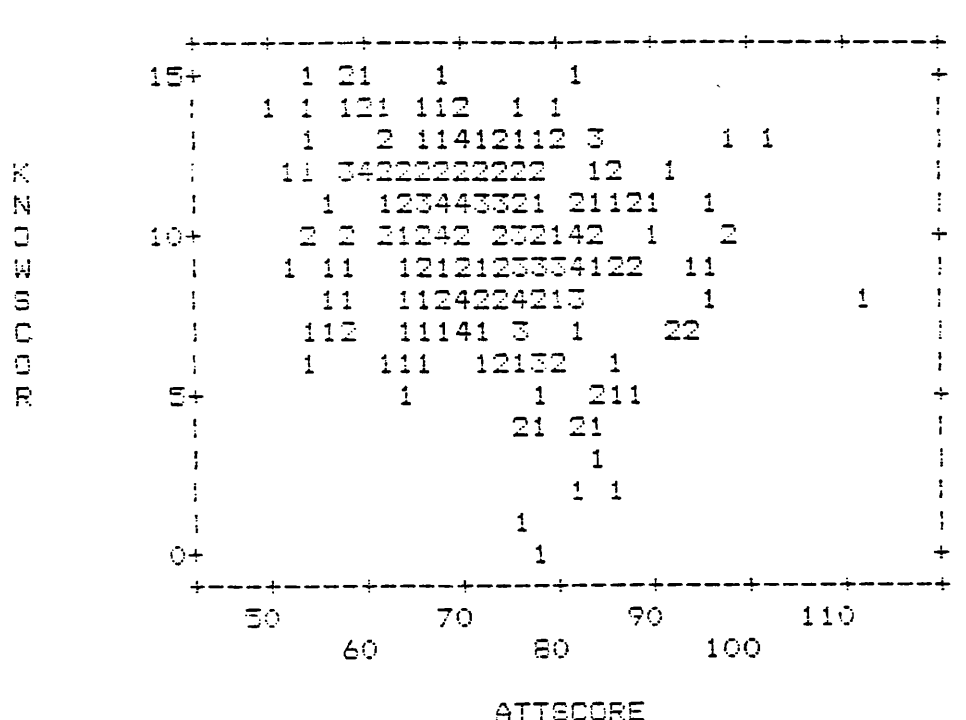
Pearson's Correlation was performed between the standardised means for attitude and knowledge scores as shown in Figure 7:1. The results demonstrate that a correlation does exist, but it is a negative one. Higher values for attitude scores are associated with lower values for knowledge scores. As a higher attitude score indicates a negative attitude towards drug users, this appears to suggest that an inadequate knowledge base may lead to less positive attitudes to drug use, and drug users.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>Mean</u>
Attitude Score	243	72.8
Knowledge Score	243	9.7

Table 7:1 - Knowledge and Attitudes of Professionals

The range of possible attitude scores is 30 - 150, so the mean score shown in Table 7:1 represents a marginally positive attitude. The range of knowledge scores is 1 - 16, so the mean score shown represents an adequate knowledge base.

The scattergram shown in Figure 7:1 below shows the association between the knowledge and attitude means of professionals. It is apparent that there is a very slight tendency for higher knowledge scores to be associated with lower attitude scores.



$r = -.2410$ $\text{Sig} = 0.0001$ ($P < 0.001$)

Figure 7:1 - Plot of Knowscore with Attscore (Professionals)

Relationship between the Attitudes and Knowledge of Drug Users

Pearson's Correlation was performed between the standardised means for attitude and knowledge scores, as shown in Figure 7:2. The results demonstrate that a correlation does exist, but it is a negative one. Higher values for attitude scores are associated with lower values for knowledge scores. As a

higher attitude score indicates a negative attitude towards drug users, this finding suggests that an inadequate knowledge base may be related to less positive attitudes to drug use and drug users.

<u>Characteristic</u>	<u>Number (n = 68)</u>	<u>Mean</u>
Attitude Score	68	80.1
Knowledge Score	68	6.5

Table 7:2 - Knowledge and Attitudes of Drug Users

The range of possible attitude scores is 30 - 150, so the mean score shown in Table 7:2 represents a negative attitude. The range of knowledge scores is 1 - 16, so the mean score shown represents a grossly inadequate knowledge base.

The scattergram shown in Figure 7:2 overleaf shows the association between the knowledge and attitude means of drug users. No apparent (significant) relationship is shown. However, there is a very slight tendency for higher knowledge scores to be associated with lower attitude scores.

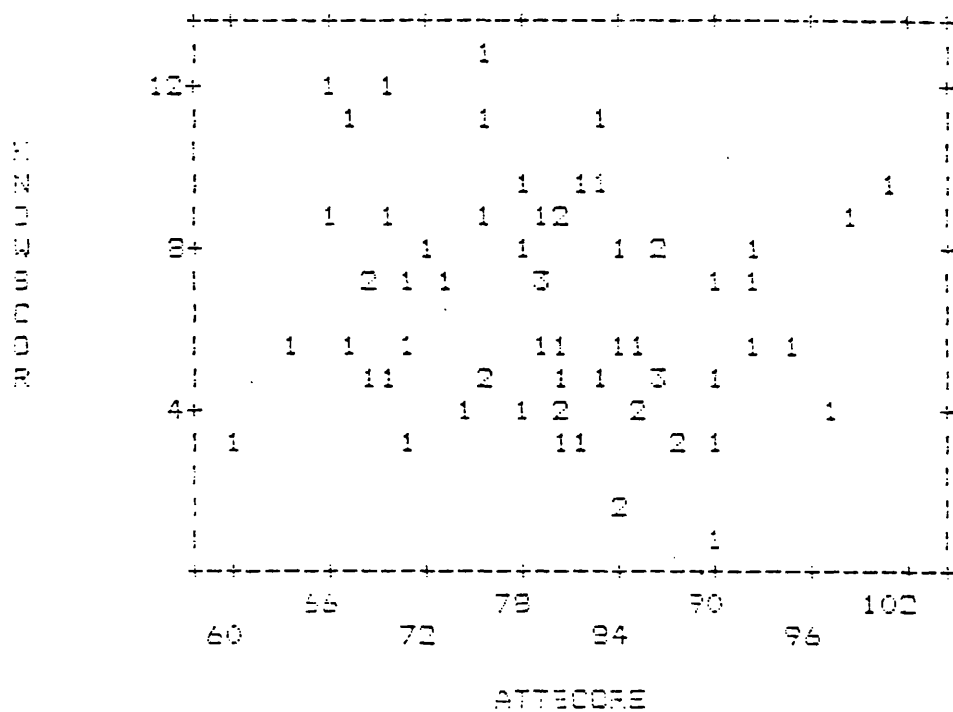


Figure 7:2 - Plot of Knowscore with Attscore (Drug Users)

SECTION - B

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES AND SUBJECT VARIABLES

It is necessary to examine the relationship between knowledge and attitudes and subject variables, eg age. The literature review indicates that knowledge and attitudes are likely to be significantly associated with subject variables. Therefore, if such a significant relationship is found in this study, it may suggest that certain groups who may display an inadequate knowledge base, or non-therapeutic attitudes, could be targeted. Differences may be highlighted and the possible reasons for such differences explored.

Relationship between the Characteristics of Professionals
in terms of Age-Group, Sex, Occupation, and Work Area
and their Knowledge Base about Drug Use and HIV/AIDS:

Relationship between Knowledge Base and Age-Group

Table 7:3 shows the distribution of mean knowledge scores by age-group. It is clear that there is no consistent pattern shown. Knowledge about drug use and HIV/AIDS does appear to vary according to age-group, but not in a linear path. This finding is statistically significant ($P < 0.05$), but not easily interpreted.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>	<u>Mean Score</u>
<u>Age-Group</u>			
< 30	101	40.7	9.6
30 - 39	72	29.0	10.5
40 - 49	48	19.4	9.5
> 50	27	10.9	8.6
		100	

One-Way Analysis of Variance
Sig = 0.0181 F = 3.4132 ($P < 0.05$)

Table 7:3 - Knowledge and Age-Group of Professionals

Table 7:3 describes a significant difference between related scores, but does not indicate where this difference lies. Further analysis using TUKEY tests allowed comparisons between pairs of means while preserving an overall

significance level of 0.05. The results of this analysis are shown in Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) > 50	8.6
(2) 40 - 49	9.5
(3) < 30	9.6
(4) 30 - 39	10.5

Note: Group 4 differs from Group 1 at the 0.05 level.

Table 7:3(1) - Further Exploration of Data
Employing Tukey Test

Note: A more detailed explanation of the working of Tukey Tests can be found in Bryman and Cramer, Page 148 (54).

Relationship between Knowledge Base and Work Area

Table 7:4 shows the distribution of knowledge scores between work areas. As there were 19 separate work areas, it was necessary to combine several categories in order to perform valid statistical comparisons, ie due to the very small numbers in some work areas. However there were a small number of respondents who could not logically be included in larger categories, and they were excluded from the calculation.

There are variations in the knowledge base of professionals, according to work area, and these are statistically significant ($P < 0.01$). It does seem that there is some sort of consistent pattern to the distribution of knowledge

scores. Staff in Accident and Emergency Departments and Medical/Surgical wards have the lowest scores, as might be expected of non-specialist staff whose contact with drug users is involuntary. Staff working in the community are the best informed, although not all were specialist staff.

<u>Characteristic</u>	<u>Number (n = 233)</u>	<u>%</u>	<u>Mean Score</u>
<u>Work Area</u>			
Accident and Emergency	29	12.4	8.5
Addiction Unit	20	8.6	10.0
Community Work	25	10.7	11.0
Drug Agency	47	20.2	10.2
Infectious Diseases	31	13.3	10.8
Medical/Surgical	18	7.7	8.6
Prisons	63	27.0	9.6

One-Way Analysis of Variance
 Sig = 0.0023 F = 3.5366 (P < 0.01)

Table 7:4 - Knowledge and Work Area of Professionals

Table 7:4(1) employs a TUKEY test for the same reasons as those outlined in Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) Accident/Emergency	8.5
(2) Medical/Surgical	8.6
(3) Prisons	9.6
(4) Addiction Unit	10.0
(5) Drug Agency	10.2
(6) Infectious Diseases	10.8
(7) Community Work	11.0

Note: Groups 6 and 7 are significantly different at the 0.05 level but only from Group 1.

Table 7:4(1) - Further Exploration of Data
Employing Tukey Test

No relationship was found between the knowledge base of respondents and sex ($P > 0.05$) and occupation. There does seem to be a significant relationship between the knowledge base of professionals and subject variables, but only in the case of age-group and work area.

Relationship between the Characteristics of Professionals in terms of Age-Group, Sex, Occupation and Work Area and their Attitudes to Drug Use:

Relationship between Attitudes and Age Group

Table 7:5 shows the distribution of mean attitude scores by age-group. It is clear that there is no consistent pattern shown. Attitudes to drug use do not appear to vary systematically according to age-group. This finding is statistically significant ($P < 0.001$), but not easily interpreted.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean Score</u>
<u>Age-Group</u>			
< 30	100	41.2	73.0
30 - 39	71	29.3	69.4
40 - 49	47	19.3	73.3
> 50	25	10.3	80.9

One-Way Analysis of Variance
 Sig = 0.0001 F = 7.7392 ($P < 0.001$)

Table 7:5 - Attitudes and Age Group of Professionals

Table 7:5(1) employs a TUKEY test for the same reasons as those outlined for Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) 30 - 39	69.4
(2) < 30	73.0
(3) 40 - 49	73.3
(4) > 50	80.9

Note: Group 4 is significantly different from Groups 1, 2 and 3 at the 0.05 level.

Table 7:5(1) - Further Exploration of Data
Employing Tukey Test

Relationship between Attitudes and Drug Use and Occupation

Do attitudes to drug use vary systematically according to occupation? Table 7:6 overleaf shows the distribution of mean scores by occupation. It is clear that there is a consistent pattern shown. Addiction Counsellors, a specialist group, have the lowest scores, representing the most positive attitude. Prison Nurse Officers, who combine a disciplinary role with a caring one, have the highest scores, representing the least positive attitudes. The result is statistically significant ($P < 0.0001$). It is noticeable that this pattern is true for all of the occupations.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Occupation</u>			
Addiction Counsellor	54	22.2	63.5
Mental Health Nurse	38	15.6	68.7
Social Worker	19	7.8	69.5
General Nurse	81	33.0	76.9
Prison Nurse Officer	51	21.0	80.4

One-Way Analysis of Variance
Sig = 0.0000 F = 32.0198 (P < 0.0001)

Table 7:6 - Attitudes and Occupational Group

Relationship between Attitudes to Drug Use and Work Area

Do attitudes to drug use vary systematically according to the work area of professionals? Table 7:7 shows the distribution of mean scores, and it appears that there is considerable variation among professionals, and there seems to be a pattern. The result is statistically significant (P < 0.0001). Due to the small numbers in some categories, it was necessary to combine several categories to facilitate statistical comparison.

Staff in drug agencies have the lowest scores, representing the most positive attitudes, as might be expected. However, staff in Accident and Emergency Departments have identical scores to staff working in Infectious Diseases Units (ID Units), both negative. As the staff in ID Units include Nurses from an AIDS unit, who might be expected to be sympathetic to drug users, this finding is difficult to explain.

Staff in Medical/Surgical units have the highest scores, representing the least positive attitudes to drug users. This may be due to the involuntary nature of their contact with drug users. Staff in such units are marginally more negative in their attitudes to drug users than staff in prisons.

<u>Characteristic</u>	<u>Number (n = 229)</u>	<u>%</u>	<u>Mean</u>
<u>Work Area</u>			
Drug Agency	46	20.0	62.7
Community	24	10.5	67.2
Addiction Unit	19	8.3	69.3
Accident and Emergency	29	12.6	76.7
Infectious Diseases	31	13.5	76.7
Prisons	62	27.0	78.6
Medical/Surgical	18	7.9	78.7

One-Way Analysis of Variance
 Sig = 0.0000 F = 19.7679 (P < 0.0001)

Table 7:7 - Attitudes and Work Area

No significant relationship was found between attitudes to drug use and sex ($P > 0.05$). However, 3 of the 4 subject variables were significantly associated with attitudes to drug use, ie age, occupation and work area.

Table 7:7(1) employs a TUKEY test for the same reasons as those outlined in Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) Drug Agency	62.7
(2) Community	67.2
(3) Addiction Unit	69.3
(4) Accident/Emergency	76.7
(5) Infectious Diseases	76.7
(6) Prisons	78.6
(7) Medical/Surgical	78.7

Note: Groups 4 and 5 are significantly different from Groups 1 and 2. Groups 6 and 7 are significantly different from Groups 1, 2 and 3 at the 0.05 level.

Table 7:7(1) - Further Exploration of Data
Employing Tukey Test

SECTION C

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES AND THE NATURE OF CONTACT BETWEEN PROFESSIONALS AND DRUG USERS

The literature review suggests that the nature of interaction between professionals and drug users is likely to influence treatment outcome. In particular, negative attitudes by professionals are associated with involuntary contact with drug users. Therefore, the present study will examine any possible relationship between the nature of contact and knowledge and attitudes. If a significant relationship is found, it may suggest that the nature of interaction needs to be re-examined.

Relationship between Knowledge and Attitudes and the Treatment Model Used, Knowledge of Clients with HIV Infection or AIDS and Previous Relevant Experience with Drug Users

No significant relationship was found between knowledge base about drug use and HIV/AIDS, and treatment model used ($P > 0.05$). Nor was there any association with previous relevant experience with drug users ($P > 0.05$). Perhaps more surprisingly, there was no significant association between knowledge base and awareness of clients with HIV infection or AIDS ($P > 0.05$).

Does a Relationship exist between Professionals Having Previous Relevant Work Experience of Drug Users and Attitudes to Drug Use?

Table 7:8 overleaf shows the distribution of mean scores. It is clear that there is variation in the mean scores, and the result is statistically significant ($P < 0.0001$).

Respondents who have previous relevant work experience with drug users have much lower attitude scores than respondents who do not have such experience.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Work Experience</u>			
No Relevant Experience	90	37.0	77.2
Some Relevant Experience	153	63.0	70.2
		<u>100</u>	

One-Way Analysis of Variance
 Sig = 0.0000 F = 26.2646 (P < 0.0001)

After adjusting for occupational group and age-group in a multi-way ANOVA F = 8.29 and P = 0.004 (P < 0.01)

Table 7:8 - Attitudes and Work Experience

Does a Relationship exist between the Perceptions of Professionals, ie Whether or not they have Personal Knowledge of Clients with HIV/AIDS and their Attitudes to Drug Use?

Table 7:9 overleaf shows the distribution of mean scores. It is clear that there are variations in mean scores, and that they are statistically significant (P < 0.001).

Respondents who are aware of having clients with HIV infection or AIDS also have higher attitude scores, ie more negative attitudes to drug use. This is disturbing since it indicates that clients who are most in need of care for health reasons are being cared for by professionals with the least empathy with such clients.

<u>Characteristic</u>	<u>Number (n = 228)</u>	<u>%</u>	<u>Mean</u>
<u>Knowledge of Clients with HIV/AIDS</u>			
Aware	76	33.3	76.2
Unaware	152	66.7	71.0
		<u>100</u>	

One-Way Analysis of Variance
Sig = 0.0005 F = 12.3412 (P < 0.001)

After adjusting for occupational group and age-group in a
multi-way ANOVA F = 1.93 and P = 0.16 (P > 0.05)

Table 7:9 - Attitudes and Knowledge of Clients
with HIV Infection

**Does a Relationship exist between the Treatment Model used
with Clients and the Attitudes of Professionals to Drug Use?**

Table 7:10 overleaf shows the distribution of mean scores. There are variations in the mean scores and the results are statistically significant (P < 0.05). No consistent pattern is apparent. However, respondents with the lowest attitude scores prefer the "Social Problems" model.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Treatment Model</u>			
Social Problem	82	33.7	70.2
Risk Taking	49	20.2	76.0
Disease	17	7.0	78.7
Client Centred	95	39.1	73.3
		100	

One-Way Analysis of Variance
 Sig = 0.0116 F = 3.7522 (P < 0.05)

After adjusting for occupational group and age-group in a
 multi-way ANOVA F = 2.45 and P = 0.047 (P < 0.05)

Table 7:10 - Attitudes and Treatment Model

Comment: It would appear that attitudes are significantly related to the nature of contact between professionals and drug users. This finding indicates that the nature of contact, eg voluntary or involuntary, may affect attitudes to drug use.

SECTION D

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES AND CONCERNS ABOUT HIV/AIDS

The knowledge base of professionals about drug use and HIV/AIDS, and their attitudes to drug use may or may not be related to concerns about HIV/AIDS. However, the literature review suggests that there is no apparent correlation between an adequate knowledge base and realistic concerns about HIV/AIDS. Negative attitudes towards drug users are also associated with fears of transmission of HIV infection, resulting in the further stigmatisation of drug users.

Therefore, this study will examine any possible relationship between knowledge and attitudes, and concerns about HIV/AIDS. If such a relationship is found, this will have implications for the future treatment of drug users.

**Does a Relationship exist between Concerns about HIV/AIDS
among Professionals and their Knowledge Base about Drug Use?**

Table 7:11 at the end of this section shows the distribution of mean scores. It appears that there are variations in scores and that they are statistically significant ($P < 0.001$ and $P < 0.0001$). Five of the 8 items of concern are significantly related to knowledge base.

**Does a Relationship exist between Concerns about HIV/AIDS
among Professionals and their Attitudes to Drug Use?**

Table 7:12 at the end of this section shows the distribution of mean scores. It appears that there are variations in mean scores, and that the results are statistically significant ($P < 0.005$, $P < 0.001$, and $P < 0.0001$). Three of the 8 items appear to be significantly associated with attitudes. These items of concern are "Personal risk", "Risk of passing on infection to one's own family", and "Availability of resources to treat clients".

Some respondents, albeit a small minority, have concerns about personal risk of HIV/AIDS, and also have much higher attitude scores.

Respondents who are concerned about the risk to their families are a minority of respondents, albeit a larger one (18.1%).

Respondents who are concerned about the availability of resources have lower attitude scores, ie more positive attitudes.

Comment: It would appear that knowledge and attitudes are significantly associated with concerns about HIV/AIDS. This is particularly so in the case of knowledge, but more positive attitudes to drug use are also associated with less concern about HIV/AIDS. This finding is encouraging as it suggests that if the knowledge of respondents were enhanced, this would lead to realistic concerns about HIV/AIDS. The findings about attitudes are less easy to interpret, but it would appear that changing attitudes does lead to realistic concern about HIV/AIDS. However, attitudes are also affected by the effects of occupational group and age-group.

<u>Characteristic</u>	<u>Concerned</u> <u>Mean (No)</u>	<u>Unconcerned</u> <u>Mean (No)</u>	<u>P</u>
<u>Concern (n = 248)</u>			
Risk of personal infection	8.5 (39)	9.9 (209)	0.0035
Risk of passing on infection to own family	8.3 (45)	10.0 (203)	0.0002
Lack of personal experience in dealing with HIV positive clients	8.4 (86)	10.4 (162)	0.0001
Lack of personal knowledge about HIV infection	8.4 (56)	10.1 (192)	0.0000
Lack of professional support networks	9.8 (114)	9.7 (134)	0.6959
Lack of in-service training	9.6 (148)	9.9 (100)	0.3426
Reluctance to discuss safer sex guidelines	7.8 (12)	9.8 (236)	0.0177
Availability of resources to treat HIV positive clients	9.7 (146)	9.8 (102)	0.7376

Table 7:11 - Knowledge Base and Concern About HIV/AIDS

<u>Characteristic</u>	<u>Concerned</u> <u>Mean (No)</u>	<u>Unconcerned</u> <u>Mean (No)</u>	<u>P</u>
<u>Concern (n = 243)</u>			
Risk of personal infection	79.3 (39)	71.6 (204)	0.0000
Risk of passing on infection to own family	77.2 (45)	71.8 (198)	0.0020
Lack of personal experience in dealing with HIV positive clients	73.9 (84)	72.2 (159)	0.2620
Lack of personal knowledge about HIV infection	73.0 (55)	72.7 (188)	0.8661
Lack of professional support networks	73.0 (111)	72.6 (132)	0.8027
Lack of in-service training	71.8 (145)	74.2 (98)	0.0856
Reluctance to discuss safer sex guidelines	71.8 (12)	72.9 (231)	0.7496
Availability of resources to treat HIV positive clients	71.3 (143)	74.9 (100)	0.0111

Table 7:12 - Attitudes and Concern About HIV/AIDS

After adjusting for occupational group and age-group in a multi-way ANOVA, the items which had shown a significant relationship with attitudes showed the following results:-

- (1) Risk of personal infection -
P=0.001 (P < 0.01)
- (2) Risk of passing on infection to own family
P=0.86 (P > 0.05)

- (3) Availability of resources to treat HIV positive clients -
P=0.000 (P < 0.001)

Note: Item 2 has been rendered non-significant by the ANOVA procedure.

SECTION E

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES AND SPECIFIC CARE DELIVERY

Professionals perform specific tasks for drug users, and their friends and families. It is necessary to examine whether there is any relationship between the knowledge and attitudes of professionals, and the performance of such tasks. The literature review suggests that an extensive knowledge base about drug use and HIV/AIDS does not result in effective care delivery to this stigmatised group and that, where attitudes are negative, there is a reluctance to deliver care. Therefore, this study will examine the relationship between knowledge and attitudes and care delivery. The findings should demonstrate the importance of knowledge and attitudes in delivering "hands on" care.

**Does a Relationship exist between giving Counselling
to Drug Users and the Knowledge Base of
Professionals about Drug Users?**

Table 7:13 shows the distribution of mean scores. It is clear that there are variations in the scores of respondents, and that they are statistically significant ($P < 0.05$ and $P < 0.001$).

Professionals who give bereavement counselling to drug users have significantly higher knowledge about drug use and HIV/AIDS.

Professionals who give health education counselling also have a higher knowledge base, and are probably similarly more aware of the health risks associated with drug use.

Professionals who give support and counselling to the families of drug users appear to have a higher knowledge base about drug use and HIV/AIDS.

Professionals who give support to the friends of drug users also have a higher knowledge base, although not to the same degree as the former group.

<u>Characteristic</u>	<u>Number</u>	<u>Mean (No)</u>	<u>Mean (No)</u>	<u>P</u>
<u>Counselling</u>		(Yes)	(No)	
Bereavement counselling to drug users	245	10.2 (92)	9.4 (153)	0.0412
Health education counselling to drug users	245	10.3 (154)	8.9 (91)	0.0001
Counselling/ support to families	245	10.4 (148)	8.8 (97)	0.0000
Counselling/ support to friends	246	10.4 (108)	9.3 (138)	0.0022

Table 7:13 - Knowledge and Counselling

Does a Relationship exist between Referral to Other Professionals and the Knowledge Base of Professionals about Drug Use?

Table 7:14 shows the distribution of mean scores. It is clear that there are variations in mean scores, and that they are statistically significant ($P < 0.0001$, $P < 0.01$, and $P < 0.05$).

Professionals who refer drug users to other professionals have a higher knowledge base about drug use and HIV/AIDS. This suggests that such respondents are more aware of the social and health problems attributed to drug use and HIV/AIDS.

<u>Characteristic</u>	<u>Number</u>	<u>Mean</u> (No)	<u>Mean</u> (No)	<u>P</u>
<u>Referral</u>		(Yes)	(No)	
Referred to Community Psychiatric Nurse	243	10.5 (63)	9.5 (180)	0.0162
Referred to Sexually Transmitted Diseases Clinic	243	11.0 (74)	9.1 (169)	0.0000
Referred to Social Worker	246	10.1 (170)	9.0 (76)	0.0060

Table 7:14 - Knowledge and Referral to Other Professionals

Does a Relationship exist between Professionals who give
Counselling to Drug Users and the Attitudes of
Professionals to Drug Use?

Table 7:15 shows the distribution of mean scores. It is clear that there are variations in mean scores, and that the results are statistically significant ($P < 0.001$, and $P < 0.0001$).

Respondents who give bereavement counselling to drug users had lower attitude scores, ie more positive attitudes.

Respondents who give Health Education counselling to drug users also have lower attitude scores, ie more positive attitudes.

Respondents who give counselling to the families of drug users have much lower attitude scores, ie more positive attitudes.

Respondents who give counselling and support to the friends of drug users also have lower attitude scores, ie more positive attitudes.

<u>Characteristic</u>	<u>Number</u>	<u>Mean</u> (<u>No</u>)	<u>Mean</u> (<u>No</u>)	<u>P</u>
<u>Counselling</u>		(Yes)	(No)	
Bereavement counselling to drug users	240	68.5 (89)	75.5 (151)	0.0000
Health education counselling to drug users	240	70.9 (150)	75.8 (90)	0.0007
Counselling/ support to families	240	69.0 (145)	78.6 (95)	0.0000
Counselling/ support to friends	241	68.0 (104)	76.4 (137)	0.0000

Table 7:15 - Attitudes and Counselling

After adjusting for occupational group and age-group in a multi-way ANOVA, the items in Table 7.15 showed the following results:-

- (1) Bereavement counselling to drug users -
P = 0.004 (P < 0.01)
- (2) Health education counselling to drug users -

$P = 0.003$ ($P < 0.01$)

(3) Counselling/support to families -

$P = 0.000$ ($P < 0.001$)

(4) Counselling/support to friends -

$P = 0.000$ ($P < 0.001$)

Note: All of the items remained significant after the ANOVA procedure.

Does a Relationship exist between Referring Drug Users to Other Professionals, and the Attitudes of Professionals to Drug Use?

Table 7.16 shows the distribution of mean scores. It is clear that there are variations in mean scores, and that the results are statistically significant ($P < 0.05$, $P < 0.001$, $P < 0.0001$).

Respondents who refer drug users to other professionals have consistently lower attitude scores, ie more positive attitudes to drug use.

<u>Characteristic</u>	<u>Number</u>	<u>Mean</u> (<u>No</u>)	<u>Mean</u> (<u>No</u>)	<u>P</u>
<u>Referral</u>		(Yes)	(No)	
Referred to Community Psychiatric Nurse	238	66.9 (62)	75.0 (176)	0.0000
Referred to Sexually Transmitted Diseases Clinic	238	69.1 (73)	74.4 (165)	0.0004
Referred to Social Worker	241	71.8 (167)	74.9 (74)	0.0434

Table 7:16 - Attitudes and Referral to Other Professionals

After adjusting for occupational group and age-group in a multi-way ANOVA, the items in Table 7.16 showed the following results:-

- (1) Referred to Community Psychiatric Nurse -
P = 0.000 (P < 0.001)
- (2) Referred to Sexually Transmitted Diseases Clinic -
P = 0.001 (P < 0.01)
- (3) Referred to Social Worker -
P = 0.057 (P < 0.05)

Comment: It would appear that knowledge and attitudes are significantly associated with specific care delivery to drug users. Every aspect of care delivery showed a significant relationship (P < 0.05, 0.001, 0.0001).

This finding suggests that knowledge and attitudes are directly related to care delivery. Therefore, enhancing knowledge and changing attitudes should result in improved care delivery. Adjusting for the effects of occupational group and age group does not significantly affect the results.

SECTION F

RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDES AND THE PERCEPTIONS OF PROFESSIONALS ABOUT THEIR ROLE WITH DRUG USERS

According to the literature review, it is likely that the perceptions of professionals about their role will be influenced by their knowledge and attitudes. Therefore, this study will examine whether any such relationship does exist, and, if so, the implications of such a relationship. It is likely that perceptions will be associated with knowledge and attitudes, and, consequently, perceptions may be altered if knowledge and attitudes change.

There are several aspects of professionals roles which will be critically examined, ie management support, job satisfaction, effectiveness and the reasons given for effectiveness, the factors which professionals believe motivate drug users to stop, and the qualities of a good drugs worker.

Finally, professionals were asked to predict their professional future in relation to drug use. All of these variables will be examined, and any relationship with knowledge and attitudes explored. If such a relationship is found, the importance, or otherwise, of knowledge and attitudes will be demonstrated.

Relationship between Knowledge Base and Management Support

Does a relationship exist between the nature, and degree of management support for professionals dealing with drug users, and the knowledge base of professionals? Table 7:17 shows the distribution of mean scores.

Respondents who feel that they receive inadequate support do have a higher knowledge than respondents who feel support is adequate. The difference is statistically significant ($P < 0.05$).

No relationship was found between knowledge and the most supportive level of management support ($P > 0.05$). Nor was there any significant relationship between attitudes and the amount, or level, of management support ($P > 0.05$).

No significant relationship was found between knowledge about drug use and HIV/AIDS, and the job satisfaction of professionals dealing with drug users ($P > 0.05$). However, there is evidence of a relationship between attitudes to drug use and job satisfaction.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>	<u>Mean</u>
<u>Support</u>			
Inadequate	154	62.0	10.0
Adequate	94	38.0	9.2
		<hr/>	
		100	

One-Way Analysis of Variance

Sig = 0.0238 F = 5.1755 (P < 0.05)

Table 7:17.- Knowledge and Management Support

Table 7:18 overleaf shows the distribution of mean scores. It is clear that there are variations in mean scores, and that they are statistically significant (P < 0.0001).

A consistent pattern is evident in the distribution of mean scores. Respondents with the highest attitude scores, representing the least positive attitudes to drug use, have the lowest level of job satisfaction. Conversely, respondents who express the highest levels of job

satisfaction have the lowest attitude scores, ie the most positive attitudes to drug users.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Satisfaction</u>			
Very Dissatisfied	34	14.0	78.8
Not Very Satisfied	86	35.4	76.2
Fairly Satisfied	60	24.7	68.9
Mostly Satisfied	63	25.9	68.7
		<hr/>	
		100	

One-Way Analysis of Variance

Sig = 0.0000 F = 13.8793 (P < 0.0001)

After adjusting for occupational group and age-group in a multi-way ANOVA, F = 19.90 and P = 0.004 (P < 0.01)

Table 7:18 - Attitudes and Job Satisfaction

Table 7:18(1) employs a TUKEY test for the same reasons as outlined in Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) Mostly Satisfied	68.7
(2) Fairly Satisfied	68.9
(3) Not Very Satisfied	76.2
(4) Very Dissatisfied	78.8

Groups 3 and 4 differ from Groups 1 and 2 at the 0.05 level

Table 7:18(1) - Further Exploration of Data
Employing Tukey Test

Does a Relationship exist between the Views of Professionals
about their Effectiveness/Ineffectiveness in dealing with
Drug Users and their Knowledge Base about Drug Use?

Table 7:19 shows the distribution of mean scores. A variation does exist in the mean scores of respondents, and it is statistically significant ($P < 0.05$). There appears to be a consistent pattern, ie respondents with the lowest scores feel they are ineffective, respondents who don't know have higher scores, and respondents who feel effective have the highest scores.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>	<u>Mean</u>
<u>Effectiveness</u>			
Ineffective	95	38.3	9.1
Don't Know	68	27.4	9.8
Effective	85	34.3	10.3

		100	

One-Way Analysis of Variance
Sig = 0.0208 F = 3.9356 (P < 0.05)

Table 7:19 - Knowledge and Effectiveness

Does a Relationship exist between the Views of Professionals about their Effectiveness/Ineffectiveness in Caring for Drug Users and their Attitudes to Drug Use?

Table 7:20 shows the distribution of mean scores. It is clear that there are variations in the mean scores, and the result is statistically significant (P < 0.0001).

A consistent pattern is apparent. Respondents with the lowest attitude scores, which represent the most positive attitudes, feel most effective in caring for drug users. Conversely, respondents with the highest scores feel least effective, and respondents who have intermediate scores claim not to know whether or not they are effective.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Effectiveness</u>			
Ineffective	95	39.0	77.1
Don't Know	66	27.2	72.2
Effective	82	33.7	68.2

One-Way Analysis of Variance
Sig = 0.0000 F = 17.2668 (P < 0.0001)

After adjusting for occupational group and age-group
in a multi-way ANOVA, F = 10.71 and P = 0.000 (P < 0.001)

Table 7:20 :- Attitudes and Effectiveness

Does a Relationship exist between the Reasons Professionals
give for Effectiveness/Ineffectiveness and their
Knowledge Base About Drug Use?

Table 7:21 shows the distribution of mean scores. It appears that there are variations in the mean scores of respondents. However, only 2 of the 5 reasons given seem to have a significant relationship with knowledge base (P < 0.05). The personal qualities of respondents appear to be associated with having an adequate knowledge base, although respondents who stress this factor have a lower knowledge base.

The issue of the "follow-up" of clients is also significantly associated with knowledge base, although respondents who stress this factor have a higher knowledge base.

<u>Characteristic</u>	<u>Agree</u> <u>Mean (No)</u>	<u>Disagree</u> <u>Mean (No)</u>	<u>P</u>
<u>Reason (n = 243)</u>			
Personal Qualities	8.9 (38)	9.9 (205)	0.0528
Available Resources	9.8 (82)	9.8 (161)	0.8635
Underlying Nature of Problem	9.9 (116)	9.6 (127)	0.4267
Professional Skills	10.1 (88)	9.5 (155)	0.1417
Follow-Up	10.2 (86)	9.5 (157)	0.0382

Table 7:21 - Knowledge and Reasons for Effectiveness

Does a Relationship exist between the Reasons Professionals give for Effectiveness/Ineffectiveness and their Attitudes to Drug Use?

Table 7:22 shows the distribution of mean scores. It is clear that there are variations in the mean scores, but only in 2 of the variables are the results statistically significant ($P < 0.0001$ and $P < 0.001$).

No consistent pattern appears. However, respondents who opt for "Professional Skills" and "Follow-Up" as important, have much lower attitude scores.

<u>Characteristic</u>	<u>Agree</u> <u>Mean (No)</u>	<u>Disagree</u> <u>Mean (No)</u>	<u>P</u>
<u>Reason (n = 238)</u>			
Personal Qualities	71.3 (36)	73.0 (202)	0.4000
Available Resources	71.8 (80)	73.2 (158)	0.3714
Underlying Nature of Problem	73.9 (113)	71.6 (125)	0.0944
Professional Skills	68.4 (84)	75.1 (154)	0.0060
Follow-Up	69.8 (83)	74.3 (155)	0.0022

After adjusting for occupational group and age-group
in a multi-way ANOVA,
Professional Skills, $P = 0.005$ ($P < 0.01$).
Follow-up, $P = 0.029$ ($P < 0.05$)

Table 7:22 - Attitudes and Reasons for Effectiveness

There is no relationship between the knowledge base of respondents and the factors that professionals consider important in motivating drug users to stop ($P > 0.05$). However, such a relationship does exist between the attitudes of professionals towards drug use, and the factors motivating drug users to stop.

Table 7:23 shows the distribution of mean scores. There is some variation in the mean scores, but only one variable is statistically significant ($P < 0.05$). Respondents who feel that "Self-Motivation" is an important factor in helping drug users to stop do have markedly lower attitude scores, ie more positive attitudes to drug use. No consistent pattern is discernible in the case of the other 3 variables.

<u>Characteristic</u>	<u>Agree</u> <u>Mean (No)</u>	<u>Disagree</u> <u>Mean (No)</u>	<u>P</u>
<u>Factor (n = 241)</u>			
Self-Motivation	71.9 (189)	75.9 (52)	0.0171
Co-Operation	73.5 (87)	72.4 (154)	0.4359
Admits Problem	72.4 (191)	74.1 (50)	0.3221
Under Pressure	71.0 (29)	73.0 (212)	0.3376

After adjusting for occupational group and age-group
in a multi-way ANOVA,
Self-Motivation, $P = 0.21$ ($P > 0.05$)

Table 7:23.- Attitudes and Factors Considered Important
in Motivating Drug Users to Stop

There is no significant relationship between the knowledge of respondents, and the qualities that professionals consider important in a drugs worker ($P > 0.05$). However, such a relationship does exist between the attitudes of respondents towards drug use and the qualities considered important in drugs workers.

Table 7:24 shows the distribution of mean scores. Although it is clear that there are variations in mean scores, only in 3 of the variables concerned are these statistically significant ($P < 0.05$).

No consistent pattern is discernible in the distribution of mean scores. Respondents with low attitude scores, representing positive attitudes to drug use, value personal qualities and professional skills highly. Such respondents are also in favour of training and a good knowledge base,

but not in favour of employing ex-users as drug workers. Therefore, it is difficult to interpret the results.

<u>Characteristic</u>	<u>Number</u>	<u>Agree</u> <u>Mean (No)</u>	<u>Disagree</u> <u>Mean (No)</u>	<u>P</u>
<u>Reason</u>				
Personal Qualities	243	72.3 (220)	77.2 (23)	0.0402
Professional Skills	243	72.4 (230)	79.1 (13)	0.0303
Training	242	70.4 (19)	73.1 (223)	0.3056
Knowledge Base	242	70.8 (106)	74.4 (136)	0.0089
Ex-User	241	76.6 (14)	72.6 (227)	0.1797

Table 7:24 - Attitudes and the Qualities of a Good Drugs Worker

After adjusting for occupational group and age-group in a multi-way ANOVA, the results in Table 7:24 which had been significant, were as follows:-

- (1) Personal Qualities -
P = 0.354 (P > 0.05)
- (2) Professional Skills -
P = 0.184 (P > 0.05)
- (3) Knowledge Base -
P = 0.054 (P < 0.05)

Does a Relationship exist between Professionals' Views
on their Future Involvement with Drug Users
and their Knowledge Base about Drug Use?

Table 7:25 shows the distribution of mean scores, and it is clear that there are variations in scores which are statistically significant ($P < 0.05$). However, no consistent pattern is discernible. Respondents who visualise no change in their professional situation have the lowest scores.

<u>Characteristic</u>	<u>Number (n = 248)</u>	<u>%</u>	<u>Mean</u>
<u>Prediction</u>			
More Success	61	24.6	9.8
Less Direct Involvement	48	19.3	10.7
Present Situation	48	19.3	8.9
Other	91	36.7	9.6

One-Way Analysis of Variance
Sig = 0.0158 F = 3.5194 ($P < 0.05$)

Table 7:25 - Knowledge and Future Predictions

Table 7:25(1) employs a TUKEY test for the same reasons as outlined in Table 7:3(1).

<u>Group</u>	<u>Score</u>
(1) Present Situation	8.9
(2) Other	9.6
(3) More Success	9.8
(4) Less Direct Involvement	10.7

Note: Group 4 differs from Group 1 at the 0.05 level.

Table 7:25(1) - Further Exploration of Data
Employing Tukey Test

Does a Relationship exist between Professionals' Views
on their Future Involvement with Drug Users and their
Attitudes to Drug Use?

Table 7:26 shows the distribution of mean scores. It is clear that there are variations in the mean scores, and the result is statistically significant ($P < 0.001$).

No consistent pattern is evident, but it is noticeable that respondents who foresee less involvement with drug users have the lowest attitude scores, and thus the most positive attitudes. This finding is difficult to interpret. Respondents with the highest scores do not see their current situation changing.

<u>Characteristic</u>	<u>Number (n = 243)</u>	<u>%</u>	<u>Mean</u>
<u>Prediction</u>			
More Success	60	24.7	73.6
Less Direct Involvement	47	19.3	68.2
Present Situation	46	18.9	76.6
Other	90	37.0	72.7

One-Way Analysis of Variance
 Sig = 0.0016 F = 5.2284 (P < 0.01)

After adjusting for occupational group and age-group
 in a multi-way ANOVA, F = 2.20, P = 0.000 (P < 0.001)

Table 7:26 - Attitudes and Future Predictions

Comment: It would appear that knowledge and attitudes are significantly related to the perceptions of professionals about their role with drug users. There appeared to be a stronger association with attitudes (6 of 8 variables) than with knowledge (4 of 8 variables). Therefore, it would appear that altering knowledge, and especially, attitudes, is likely to change the views of professionals.

Adjusting for the effects of occupational group and age-group does appear to affect attitudes to some extent. Two of the 8 variables, ie the qualities of a "good" drugs worker, and the factors motivating drug users to stop, are affected by the effects of occupational group and age group.

SECTION-G

RELATIONSHIP-BETWEEN-THE-VIEWS-OF-PROFESSIONALS AND-DRUG-USERS-ABOUT-DRUG-USE-AND-HIV-INFECTION

It is likely that there will be a wide divergence between the views of professionals and drug users. This study will examine whether any relationship between the views of both groups does exist. This will allow the viewpoint of professionals and drug users to be compared and contrasted.

One question was administered to both professionals and drug users. This allows a direct comparison of their views. This was an "Open Response" question, ie "What makes a good drugs worker?".

Does a Relationship exist between the Views of Professionals and Drug Users about the Qualities which make a Good Drugs Worker?

Table 7:27 shows the distribution of mean scores. It is clear that there are significant differences in the views of professionals and drug users ($P < 0.001$). This finding is true for 4 of the 5 qualities described. Over 90% of professionals valued their professional skills, but only 65% of drug users valued such skills.

Almost 95% of professionals valued their personal qualities, compared to less than 60% of drug users who shared this view.

The possession of a good knowledge base is valued by 44% of professionals, but by only 21% of drug users.

Less than 10% of professionals valued having a specific job training in drug work, compared with less than 5% of drug users. Thus, both groups placed a low value on this quality, but there was a disparity in the proportions involved.

The issue of employing ex-users as drugs workers was the one which most differentiated professionals and drug users. Less than 6% of professionals valued this quality, compared to over 30% of drug users.

<u>Characteristic</u>	<u>Professionals</u>		<u>Drug Users</u>		<u>X</u>	<u>P</u>
		<u>%</u>	<u>(n = 69)</u>	<u>%</u>		
<u>Qualities of Drugs Worker</u>						
Personal Qualities (n=248)	225	(90.7)	40	(58.0)	42.2	0.001
Professional Skills (n=248)	235	(94.8)	45	(65.2)	45.7	0.001
Knowledge Base (n=247)	109	(44.1)	14	(20.3)	12.9	0.001
Training (n=247)	20	(8.1)	3	(4.3)	1.1	0.290
Ex-User (n=246)	14	(5.7)	21	(30.4)	33.4	0.001

Table 7:27 - Comparison of Views of Professionals and Drug Users about the Qualities of a "Good" Drugs Worker*

(* These categories are not mutually exclusive)

C H A P T E R . . . 8

DISCUSSION

SUMMARY

This study demonstrated that an important determinant of care delivery to clients is the knowledge and attitudes of the professionals delivering such care. The evidence of this study suggests that the knowledge base of professionals is relatively low and that attitudes are a mixture of professional and judgemental views. Unfortunately, the majority of professionals expressed judgemental attitudes towards drug use and drug users.

The degree of interaction between professionals and drug users is shown to be disappointing. A lack of empathy or effective care delivery is shown, although there are wide divergences between the views and performance of professionals.

The demographic characteristics of professionals, ie age group and occupational group, were found to be major factors influencing the process of interaction between professionals and drug users, especially occupational group.

INTRODUCTION

This study is the first major study in the West of Scotland to explore the perceptions of professionals and drug users towards each other. Also, in addition, it examines their knowledge of, and attitudes to, drug use. A major question

raised by this study is the extent to which knowledge and attitudes, of both groups, affected service delivery to drug users.

According to Kelly, the way in which clients are regarded by professionals is highly relevant to the treatment outcome (7). Moreover, he found that it was the perceptions of professionals which were decisive, rather than any qualities which clients actually possessed.

Consequently, any desired change in the behaviour of clients, eg drug stopping, was likely to be influenced by the attitudes of professionals, including the degree of interest, warmth, understanding and respect shown by professionals. The interview schedule used in this study attempted to elicit the extent to which these qualities were shown by professionals.

The study revealed significant occupational differences among professionals in terms of their attitudes. Two specialist groups, Addiction Counsellors and Mental Health Nurses, showed the most positive attitudes to drug users. Two non-specialist groups, General Nurses and Prison Nurse Officers, showed the most negative attitudes to drug users.

Another non-specialist group, ie Social Workers, occupied a middle position. They were not as positive as the specialist groups, but were less negative than the other non-specialist groups.

These occupational differences are similar to those found by Ross, who explained them in terms of the nature and degree of professionals' interaction with drug users (30). She found that positive attitudes were related to an adequate knowledge base, as was also found in the present study. People with liberal and tolerant attitudes were likely to deliver effective services to drug users.

The effectiveness of care delivery appeared to be linked to several factors. These were as follows:-

- (1) Role adequacy, ie how professionals viewed their own competence.
- (2) Role legitimacy, ie whether work with drug users was regarded, by themselves and others, as part of their professional role.
- (3) Role support, ie whether management and peers gave support to professionals.
- (4) Degree of therapeutic commitment on the part of professionals, ie motivation to work with drug users.
- (5) Situational constraints, ie barriers to care delivery caused by circumstances surrounding care delivery.

Perceptions of Professionals

Perceptions of professionals are shown to reflect the stereotyping of drug users. The reasons for such stereotyping are discussed, in particular, the importance of situational constraints and occupational background. The relationship between professionals and a stigmatised group are also explored.

It is evident from this study that the myth of the "drug addict" is still prevalent among professionals. An individual, even in crisis, is likely to be seen, not as an individual, but as a representative of a stereotyped group and regarded with suspicion due to his or her supposed deviant behaviour

Typical statements were as follows, "Prison Nurses are Officers first, and Nurses second. This affects their ability to nurse", and, "Prison attitudes are faulty, only superficial attention is paid to HIV".

Statements by professionals tend to illustrate the degree of stereotyping which drug users encounter. One Prison Nurse commented, "Drug users are personally weak and do not deserve sympathy". This statement reveals strong feelings of hostility; it is judgemental and punitive, and clearly not conducive to care delivery. Moreover, although this respondent was in frequent contact with individual drug

users, he did not differentiate between individuals; all drug users carried the same negative stereotype.

Although the statement expressed was one of the most extreme and value-laden, other statements from prison staff indicated negative feelings towards drug users. Statements such as, "Drug use often leads to violent behaviour" and, "Drug users are a problem insofar as smuggling drugs is concerned" indicate that drug users are seen as a threat or a nuisance, and, again, all drug users are so categorised.

Such stereotyping does not only occur in the prison environment. A Sister in a Casualty Department stated "Accident & Emergency does not offer appropriate facilities. Staff attitudes are terrible". However, in areas where interaction was seen as non-threatening, much more positive statements were expressed, as in the following statement from a Sister in an Infectious Diseases clinic:-

"Our attitudes are more sympathetic due to frequency of contact, other services are not appropriate".

Finally, a Project Leader in a Drug Project commented, "What professionals believe about drug users is critical. They are heavily stigmatised as scapegoats, and attitudes affect care".

The majority of comments indicated that drug users aroused feelings of fear, anxiety, hostility, and avoidance. Such

feelings probably result in negative attitudes towards drug users, who were already regarded as a stigmatised group, and expected to conform to their negative stereotype. The comments also revealed that situational factors influenced attitudes and intentions to deliver care. Occupational background and the nature of the working environment appeared to be important considerations in the expression of positive or negative comments.

The majority of professionals also appeared to be judgemental towards drug users. In order to stop using drugs, clients must first "admit they had a problem" (Table 5:12). Thus, drug users are regarded as deviant to some degree as their behaviour caused problems and was clearly self-inflicted. Less than 7% of professionals regarded drug users as being sick (Table 5:6). This client group were clearly seen as responsible for their fate, and must therefore motivate themselves to become "normal".

Staff working in general hospitals formed the largest single group (33%), and interacted with drug users in half the locations. Such contact was also involuntary. Drug users were generally regarded with suspicion, and sometimes fear and hostility. In the study, 4 respondents indicated their belief that drug users should be sterilised - all were general nurses!

However, such outright hostility was unusual. More commonly, complaints were expressed about lack of resources

and the fact that facilities were not appropriate to treat drug users. Typical comments were, "I have strong feelings that nurses should be involved in drug training" from a Senior Nurse in infection control.

Psychiatric Nurses were found to be closely involved in the treatment of drug users, but almost always in a specialist role. Thus, this group were shown to be highly motivated. However, staff were interacting with drug users in only 3 settings, ie Addiction Units, Acute Admission Wards and in the community. Such areas of client contact accounted for only 14% of all contacts (Table 5:3). Morale was generally high among this group as they had chosen to work with this client group. However, even among this group, there were widespread feelings of frustration due to lack of resources. A small number of Psychiatric Nurses were in involuntary contact with drug users, ie those working in a General Hospital Psychiatric Unit. This was not a situation which the staff were happy with as the setting was felt to be inappropriate. A Staff Nurse in the Unit made the following comment:-

"Treatment is the same as for alcohol patients, which is not appropriate".

However, although such professionals resented having to care for drug users, they did accept that this group was within their professional remit, unlike the majority of General Nurses or Prison Nurses. Therefore, although the nature of

interaction was felt by professionals to be unsatisfactory, due to the setting, the attitudes of the professionals and their occupational background were decisive in the delivery of care.

Social care staff were found to interact with drug users in 5 settings (Table 5:3). Morale among such staff was generally high although there were numerous complaints about lack of resources, and especially about lack of training. Typical comments were, "I feel that my knowledge base is grossly inadequate" from an Addiction Counsellor, and, "Training could be improved, eg in harm reduction techniques", from a detached Drugs Worker. Some concerns were also expressed about lack of status and professional skills as in the following statement from an Addiction Counsellor:-

"I believe strongly that there should be a recognised training for drug workers, like the Alcohol Studies Course".

The majority of social care staff were specialists, but a minority were Social Workers who had not specifically chosen to work with drug users. This group felt that their drug related training was especially lacking, supporting the findings of Harrison (43).

Importance of Occupational Group

The present study found that occupation, and especially occupational group, were significantly related to the attitudes of professionals, and to their service delivery to drug users. (These findings are described in detail in Appendix B and Appendix C).

It is apparent from this study that the occupation of respondents does influence attitudes (Table 7:6), and that both factors, ie attitudes and occupation, influence service delivery. For ease of comparison, the 5 occupations have been combined into 2 occupational groups, ie health care and social care staff. All health care staff were qualified Nurses and were mainly non-specialist. Most social care staff were unqualified, as no recognised qualification exists in drug work.

Situations of uncertainty, such as dealing with drug users, are likely to provoke strong emotional responses. This client group is generally regarded as demanding and this is not a new phenomenon. However, the evidence of this study suggests that more professionals are experiencing stressful contact with intravenous drug users for the first time.

The results (Chapter 7) indicated that there is a significant association between the attitudes of professionals to drug use and drug users and occupational group. The attitudes of professionals differed according to

their differing roles, socialisation, and the type and nature of their contact with drug users. Such differences may be explained by differences in job function, professional authority, and differing perceptions of their rights to make choices within their work functions. The health care professionals were mainly non-specialist and it is, therefore, perhaps not surprising that they exhibited much more negative attitudes, similar to those of the general population, towards drug users.

Unlike social care professionals, most had not specifically chosen to work with drug users. Nevertheless, the presence of such negative attitudes is disturbing and may be considered unethical. The fact that a small minority of respondents agreed that drug users should be sterilised demonstrates the existence of punitive attitudes, albeit only in a tiny percentage of respondents (2%).

Furthermore, the occupational background of professionals is likely to have an effect on emotional responses and attitudes. Therefore, the professionals involved are likely to manifest differences in attitudes due to their differing professional socialisation and the conditions in which they work with drug users. It is also probable that familiarity with drug users will reduce the fears and concerns of professionals, especially about HIV infection, and with increasing contact, health care staff may develop more positive attitudes.

It is the nature of the interaction which appears to be decisive and this is influenced by the voluntary or involuntary occupational roles of professionals. Social care staff are mainly specialist, but even the non-specialist staff, ie Social Workers, have positive attitudes to drug users. Thus, the occupational background and training proved decisive, although the nature of Social Workers' contacts with drug users is unlikely to be threatening or intimate. Their primary role is to offer support of a psychological nature and possibly to provide material help for the client. In other words, even though they are a non-specialist group, they are able to use their skills directly to help solve the emotional and financial problems of clients and thus gain satisfaction from the performance of their primary role. Although they are probably not solving the client's drug problems, they are enhancing his or her social and economic well-being.

However, the majority of health care staff are non-specialist and many had no expectation of delivering care, often of an intimate nature, to drug users. Nurses have the closest involvement in daily patient care, and may feel threatened by the degree of contact. This would accord with the theory of Kelly and May (7) described in Chapter 1. The authors postulated that Nurses did not like patients who did not validate their role by showing appreciation. The evidence of the study also suggests that most of the health care staff had considerably less autonomy and, consequently, more situational constraints than social care staff.

The combination of occupational group and attitudes to drug users, plus the nature of interaction, appear to be the decisive factors in the delivery of care to drug users. Social care staff generally have much more positive attitudes than health care staff (Table 7:6). In terms of service delivery, social care staff also appear to be more effective (Tables C:3, C:9, C:10, C:11, C:12, C:13, C:14 and C:18). The role played by occupational group in influencing service delivery will now be examined in detail.

The study found that professionals did provide counselling/support, but there were great variations in service delivery. The majority of professionals did not provide such counselling, but there were significant differences between social care and health care staff.

The finding suggests social care staff have more therapeutic relationships with drug users than health care staff, and 63% saw bereavement counselling as relevant to their role, compared to only 25% of health professionals.

As the medical complications of intravenous drug use, eg HIV/AIDS, are likely to increase, this suggests that there is a gap in service delivery which is likely to worsen unless efforts are made, ie through provision of facilities to encourage counselling, particularly among health professionals.

A majority of professionals did provide health education counselling. There was a higher percentage among social care staff (68%), compared to health care staff (60%), but the difference was not statistically significant.

The fact that most professionals did provide such counselling is encouraging, but there is clearly still a gap in service provision to a vulnerable group. The vast majority of social care professionals (92%) gave counselling/support to the families of drug users compared to only 47% of health care staff. This wide divergence may be explained by the fact that social care staff provide services geared to the whole family, whereas health care may be brief and transient, concerned only with drug users themselves.

There is a similar contrast, although less striking, in the provision of counselling to friends of drug users. Only 64% of social care staff counselled the friends of users, but among health care staff the percentage was markedly lower (35%). The difference was statistically significant.

This finding suggests that, although social care staff are much more likely to provide counselling, both groups of professionals need to improve service delivery. It may be surmised that friends of drug users may not be regarded as legitimate recipients of counselling, especially by health care staff, or they may simply be less receptive to such counselling.

The majority of professionals felt that they received inadequate support from management in dealing with drug users. However, there were marked differences between health care and social care staff. Among health care staff, 70% of respondents felt that support was inadequate, compared with 43% of social care staff.

This finding suggests that both groups are in need of much greater support, although the situation appears to be much more serious among health care staff. A similar finding was revealed in the job satisfaction of respondents, although a majority did express satisfaction in working with drug

users, no less than 48% were dissatisfied. Health care staff expressed a much higher level of dissatisfaction (57%) than social care staff (29%). The difference was statistically significant.

The implications of HIV/AIDS aroused concern among professionals. Certain aspects were particularly stressed, ie in-service training and availability of resources. The majority of respondents expressed concerns about these aspects of HIV/AIDS. This indicates the need for a greater input of information and training, and the allocation of more resources.

There were 8 items on the interview schedule relating to HIV/AIDS and there were marked differences between the concerns of health care and social care staff. Social care staff showed less concern in all but one item. The differences between social and health care staff was statistically significant in 2 of the items, ie risk of personal infection and risk of passing on infection to one's own family. The dichotomy may be considered surprising as health professionals should have a greater knowledge about the health risks of HIV/AIDS.

The only item in which social care staff showed a higher level of concern than health care staff was in the availability of resources. This may suggest that social care staff are more aware of the needs of drug users and, thus, of the need for greater resources.

The study found that only a minority of respondents are aware of the HIV status of the drug users they are in contact with. There is a wide divergence between the experiences of social care and health care staff. Perhaps, surprisingly, only 13% of social care staff were aware of their clients' HIV status, compared to 42% of health care staff.

A possible explanation of this dichotomy may be that health care staff have easier access to this information due to the nature of their role. Alternatively, health care staff may assume that intravenous drug users are HIV positive without any factual knowledge, due to their supposed risky behaviour, eg needle sharing.

There was evidence of poor communications between professionals, resulting in a low rate of referral to other professionals, except in case of referral to Social Workers. No significant differences were found between social care and health care staff, except in the case of referral to Community Psychiatric Nurses (CPNs). Social care staff were much more likely to refer clients to CPNs than health care staff.

This finding is encouraging as it suggests good communications between social and health care staff, resulting in enhanced service delivery to clients. However, it also suggests that communications between different types of Nurses, ie General, Prison and Psychiatric, were poor.

The qualities of a "good" drugs worker were felt by professionals to be professional skills, personal qualities and, to a lesser extent, previous specific training and a good knowledge base. Being an ex-user was not thought important by most professionals. One other item, "personal qualities", showed a significant difference between social care and health care staff. A higher proportion of social care staff (97%) than health care staff (88%) rated this highly. This may be due to the greater emphasis placed on interpersonal relationships in social work training.

Relevant work experience was claimed by most professionals, but especially by social care staff. The difference was significant. One possible explanation of this finding is that most social care staff were specialists and voluntarily gained previous experience with drug users. However, a majority of health care staff, mainly a non-specialist group, also claimed previous relevant experience (54%). This was an encouraging finding as it may indicate that Nurses are becoming more familiar with the problems caused by intravenous drug use.

Only a minority of professionals felt that their work with drug users was effective but a significantly higher percentage of social care staff felt effective (44%), compared with only 30% of health care staff. No single reason was given for effectiveness, and the two professional groups gave significantly different reasons.

Availability of resources, professional skills, and the importance of follow-up were all more highly valued by social care staff. However, the majority of professionals were not optimistic about future work with drug users - less than 25% envisaged more success in 5 years time.

Role Played by Knowledge and Attitudes

It is evident from the results of this study (Chapter 7) that knowledge and attitudes play a central role in

determining service delivery to drug users. As knowledge increases, attitudes appear to become more positive (Figure 7:1). However, the nature of this interaction is not at all clear. Although knowledge and attitudes do seem to influence aspects of service delivery and are themselves influenced by demographic factors, eg age-group, the specific role of each variable is difficult to determine.

Both knowledge and attitudes appear to have a significant relationship with age-group (Tables 7:3(1) and 7:5(1)). Respondents aged over 50 have the lowest knowledge base and also the least positive attitudes towards drug users. However, there was no clear linear pattern in the results. Professionals aged 30-39 had the highest knowledge base and also the most positive attitudes. People aged 20-29 and 40-49 had almost identical knowledge and attitude scores. It may have been reasonably expected that knowledge would increase with advancing age, ie due to seniority and experience, whilst the reverse occurred. This may be due to the age gap between older professionals and this young client group, ie such respondents find it difficult to empathise and are not motivated to improve their knowledge. Such increasing rigidity of views may also explain the negative attitudes held by this age-group.

The progressive position of people aged 30-39 is difficult to explain. This group may represent managers who are keen to enhance care delivery and feel the need to keep their knowledge up-to-date. Clearly, knowledge and attitudes are

influenced by age-group but the way in which the mechanism operates is not clear.

Another area in which both knowledge and attitudes play a significant role is the work area of respondents. However, again, there is no consistent pattern evident. It might be reasonably expected that respondents in specialist areas, eg Addiction Units, would have greater knowledge and more positive attitudes than respondents in non-specialist areas, eg Accident & Emergency Departments. Such expectations are only partially supported by the results (Tables 7:4(1) and 7:7(1)). Respondents working in Infectious Diseases and community staff had the greatest knowledge base. Although community staff were mainly specialist, nurses working in Infectious Diseases were not, ie they had not chosen to work with drug users, although some had volunteered to work in an AIDS ward. Respondents who worked in Accident & Emergency Units, Medical-Surgical Units and the Prisons had the lowest knowledge base, although still adequate. Thus, knowledge does seem to be related to the nature of interaction with clients. Community staff who have the greatest autonomy also have the greatest knowledge despite the fact that not all had chosen to work with drug users. This result is probably due to the need to keep up-to-date in order to perform their role effectively and the same motivation may be ascribed to infectious diseases staff.

Attitudes are also shown to be related to work area. As might reasonably be expected, respondents who work in

specialist areas have positive attitudes and vice versa. However, the pattern is not entirely linear.

Respondents working in the community, not all specialist staff, appear to have more positive attitudes than staff working in Hospital Addiction Units. Staff working in Accident & Emergency Units score identically with staff working in Infectious Diseases Units. This is despite the high knowledge base of the latter and the fact that some had volunteered to work in an AIDS Unit. People who worked in the prison service had significantly more negative attitudes than staff in specialist areas, as might reasonably be expected due to their work setting which is essentially punitive. However, Nurses working in Medical-Surgical Wards had marginally more negative attitudes. This finding is difficult to explain but possibly involuntary nature of contact with drug users, combined with length of stay, make these two settings unsatisfactory for positive interaction between professionals and drug users.

It is clear from the above findings that both knowledge and attitudes have a relationship with age-group and work area, ie demographic characteristics. However, it is also evident that they appear to act independently of each other, or at least no consistent relationship is evident. The relationship between knowledge and attitudes and aspects of service delivery suggests that one variable may be significant, even when the other is not significant.

No relationship was found between knowledge base and the job satisfaction of respondents, but a significant relationship was found between attitudes and job satisfaction (Table 7:18). Moreover, further exploration of the data indicated that a very clear linear association existed (Table 7:18(1)). Respondents who were very dissatisfied or not very satisfied had significantly more negative attitudes than respondents who were mostly or fairly satisfied. Therefore, it seemed likely that attitudes affect job satisfaction in the expected direction and without any complementary role being played by knowledge base.

Similarly, no relationship was found between attitudes and the degree of management support received by respondents, whereas a significant relationship was found between knowledge base and the degree of support (Table 7:17). Respondents who felt that support was inadequate had a greater knowledge, suggesting more awareness of the needs of drug users and, thus, of their own need for support. Again, as in the previous example, there appears to be no complementary role played by attitudes.

Therefore, it would seem that knowledge and attitudes have a complex relationship with each other, with the demographic characteristics of respondents, and with aspects of service delivery. The results (Chapter 7) suggest that both variables play a central role in the quality of care delivery, and that attitude but not knowledge is significantly related to occupation (Table 7:6).

Other Issues Raised by the Study

Some of the findings were best represented in the qualitative data which gives an insight into the concerns of both professionals and drug users. The principal concerns of professionals are with lack of resources and the presence of negative attitudes which inhibit care delivery. Comments suggest that professionals need to explore their own feelings and attitudes to drug use. When such issues have been explored, it is likely that care delivery will be enhanced.

It would appear that the most effective approach in working with drug users is a multi-faceted one. Such an approach may require a conceptual leap in an appreciation of drug issues, challenging former practices and beliefs. Thus, professionals working with drug users must accept complex responsibilities, eg sexuality and risky behaviour.

The changes in the nature of work practices caused by HIV/AIDS demand new skills as the majority of professionals are unaware of the HIV status of their clients (Table 5:11) and there is widespread concern about the risks from HIV/AIDS (Table 5:15). It is probable that the incidence of HIV infection among intravenous drug users will increase, so the anxieties of staff must be addressed, eg by developing effective training packages.

Working with a new client group, which appears to be the case for the majority of respondents, may be particularly de-skilling for many generic staff. This is likely to be especially so in working with a group as stigmatised as intravenous drug users. The dichotomy between the expectations of professionals and drug users is suggested in Chapters 5 and 6.

Gaps in service delivery are apparent, resulting in unfulfilled expectations by drug users (Chapter 6). This gap is particularly acute in the case of health care staff whose relationships with drug users are generally unsatisfactory, and who appear much less involved in a therapeutic relationship than social care staff.

The results of this study show that a positive relationship does appear to exist between occupational group and attitudes to drug use and drug users. There is evidence that increasing the knowledge base of professionals will result in more positive attitudes.

As occupational background appears to be decisive in the delivery of care, it is likely that much greater co-ordination between professionals will enhance such care delivery. Nurses, through their training and validating bodies, have already developed useful curricula in drug use and HIV/AIDS. Therefore, it should be possible to develop

joint training in these subjects between Nurses and social care staff. The study suggests that current training provision in dealing specifically with drug use and HIV/AIDS is grossly inadequate and often non-existent.

Therefore, training should be geared to the actual needs of practitioners and, in particular, to their work situation. Hopefully, such an approach would enhance role legitimacy and increase motivation to work with drug users.

The five factors mentioned in the introduction, ie role adequacy, role legitimacy, role support, therapeutic commitment and situational constraints, have all been shown to be the main variables which affect knowledge and attitudes; among professionals.

Each of these factors are also linked to the occupational group of professionals. It is apparent that health care staff did not generally have such deep levels of involvement with drug users as social care staff. This is chiefly due to the effects of role constraints which impede effective service delivery. It is likely that changes in basic training and the employment of more specialist staff within each occupational group will be necessary. Such staff could act as a catalyst to their peers, and overcome the effects of a constraining work environment.

C-H-A-P-T-E-R - - 9

CONCLUSIONS

This study has focussed on the knowledge and attitudes of professionals and drug users in the West of Scotland. The findings highlight a number of issues which are of concern:-

- (1) The knowledge and attitudes of professionals have been shown to be significantly related to their perceptions of service delivery to drug users. This finding suggests the importance of knowledge and attitudes in determining service delivery.
- (2) There are significant differences between professionals in their knowledge and attitudes. These are on grounds of age, occupation, and work area. Thus, it should be possible to target certain groups to achieve improvements in knowledge and attitudes.
- (3) No significant relationship was found between knowledge and attitudes of drug users and their perceptions of service delivery. This finding is disturbing as it indicates that improving knowledge and attitudes is unlikely to affect the perceptions of drug users.
- (4) No significant relationship was found between the knowledge and attitudes of drug users on grounds of age and sex. This finding indicates that the targeting of particular groups, eg female users, may not be effective.

- (5) The knowledge base of professionals needs strengthening to improve service delivery. The findings demonstrate the need for intensive education and training for professionals. In view of the strong association between intravenous drug use and HIV infection in Scotland, this finding is particularly disturbing. Due to the patterns of Scottish drug use, and the nature of HIV infection (leading to greater risk of spread into general population), regular updating of training is needed.
- (6) The attitudes of professionals towards drug use and drug users are often judgemental and professionally inappropriate. Given the likely increase in intravenous drug use, and consequently increased contact with professionals, this finding suggests the need to cultivate non-judgemental attitudes. The poor attitudes shown in this study should be further explored and appropriate means of intervention determined to enhance service delivery.
- (7) Communications between professionals were shown to be poor. This was particularly so between the different types of Nurses, ie General, Psychiatric and Prison Nurses. Different occupations were often unaware of services being offered by other groups. Working together should enhance service delivery.

- (8) All professionals, but particularly nursing staff, complained about lack of managerial support in dealing with drug users. The provision of such support is urgently required to improve the morale of staff, and reduce feelings of isolation.

- (9) There was a clear divergence between the views of professionals and drug users about the most effective means of service delivery. The reasons for this gap need to be explored by further research.

A . P . P . E . N . D . I . C . E . S

Appendix A - Documents Used in the Study

Appendix B - Knowledge and Attitudes of Professionals

Appendix C - Service Delivery

Appendix D - Attitudes of Professionals to Drug Abusers

A . P . P E N D I X . . . A

DOCUMENTS USED IN THE STUDY

APPENDIX A(1)

Interview Schedule (Professionals)

CONFIDENTIAL

ALL RESPONSES TREATED IN STRICTEST CONFIDENCE. NO
INDIVIDUAL WILL BE IDENTIFIED. THANK YOU FOR YOUR
CO-OPERATION.

- 1 Centre/Interview Location _____
- 2 Interview No _____
- 3 Date of Interview _____
- 4 Age _____
- 5 Sex _____ Male (1) Female (2) _____
- 6 Designation _____

SERVICE DELIVERY

1 Where are most of your clients referred from?

- | | | |
|---|--------------------------|-------|
| 1 | Courts | _____ |
| 2 | Social Worker | _____ |
| 3 | Other Counselling Agency | _____ |
| 4 | Family or Friends | _____ |
| 5 | Self | _____ |
| 6 | Other | _____ |

2 Do you treat drug users according to:

- | | | |
|---|----------------------------|-------|
| 1 | Social Problem Model | _____ |
| 2 | Risk Taking Model | _____ |
| 3 | Disease Model | _____ |
| 4 | Personality Disorder Model | _____ |
| 5 | Client Centred Model | _____ |

3 Does your work involve bereavement counselling with drug users?

Yes No Don't Know

4.1 What support do you receive from management in dealing with drug users?

Very Little/Inadequate/Adequate/Considerable/Total

4.2 What level of management is most supportive?

Peer Support/Immediate Supervisor/Line Manager/
Senior Management

5 How much satisfaction do you gain working with drug users?

- | | | |
|---|----------------------|-------|
| 1 | Very Dissatisfied | _____ |
| 2 | Not Very Satisfied | _____ |
| 3 | Fairly Satisfied | _____ |
| 4 | Mostly Satisfied | _____ |
| 5 | Completely Satisfied | _____ |

6 Do you knowingly deal with many clients with AIDS or who are HIV positive?

Yes No Don't Know

7 Which of the following do you regard as positive features in a client who wants to stop using drugs?

- | | | |
|---|-------------------------------------|-------|
| 1 | Self-Motivation | _____ |
| 2 | Someone who Co-Operates | _____ |
| 3 | Someone who Admits a Problem Exists | _____ |
| 4 | Someone who is under Pressure | _____ |

8 Have you ever referred a client to:

- | | | | | |
|---|---------------|-----|----|------------|
| 1 | CPN | Yes | No | Don't Know |
| 2 | STD | Yes | No | Don't Know |
| 3 | Social Worker | Yes | No | Don't Know |

9.1 Have you ever given a client health education counselling?

Yes No Don't Know

9.2 Have you ever given support and/or counselling to clients' families?

Yes No Don't Know

9.3 Have you ever given support and/or counselling to clients' friends?

Yes No Don't Know

10 In relation to HIV/AIDS, have you any of the following concerns:

i Risk of personal infection

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

ii Risk of passing on infection to own family

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

iii Lack of personal experience in dealing with HIV effects

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

iv Lack of personal knowledge

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

v Lack of professional support networks

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

vi Lack of in-service training

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

vii Reluctance to discuss safer sex guidelines

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

viii Availability of resources to treat HIV positive clients

Not at all Concerned	Not very Concerned	Fairly Concerned	Quite Concerned	Very Concerned
-------------------------	-----------------------	---------------------	--------------------	-------------------

- 11 What in your opinion makes a good drugs worker? _____
- 12 Did your previous work experience prepare you for working with drug users?
- 1 Not at All _____
- 2 Some Relevant Experience _____
- 3 Highly Relevant Experience _____
- 13 How effective do you feel your work is with this client group?
- 1 Very Ineffective _____
- 2 Ineffective _____
- 3 Don't Know _____
- 4 Quite Effective _____
- 5 Very Effective _____
- 14 Why do you feel you are effective/ineffective?
- 15 Where do you see yourself professionally in 5 years?
- 1 Still dealing with drug dependency but with more success _____
- 2 Still being involved but less directly so _____
- 3 Present situation _____
- 4 Giving up on this client group and working in another area altogether _____
- 5 Other _____

ATTITUDE SURVEY

Interviewer reads the following statements. Please tick subjects' response. Please answer all questions.

- | | | | | | | |
|---|---|-------------------|-------|---------------|----------|----------------------|
| 1 | Drug use can be treated successfully | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 2 | A drug using person who has had several relapses cannot be treated successfully | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 3 | Street pushers are the initial source of drugs for young people | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 4 | Angry confrontation is necessary in the treatment of drug users | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 5 | Drug users are usually unconventional in dress and appearance | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 6 | Any person who is receiving treatment in a residential setting should be discharged if discovered using illicit drugs | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 7 | Drug users can be rehabilitated | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |
| 8 | Only disturbed people would experiment with drugs | Strongly
Agree | Agree | Don't
Know | Disagree | Strongly
Disagree |

- | | | | | | | |
|----|---|----------------|-------|------------|----------|-------------------|
| 9 | Drug users should be sterilised | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 10 | Once someone is using drugs there is very little that can be done | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 11 | Drug use leads to mental illness | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 12 | Most drug users have higher than average intelligence | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 13 | Treatment of drug users should be through the prison system only | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 14 | For most purposes the drug user can best be helped by a Social Worker | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 15 | Parents should react with anger on discovering that their sons or daughters are using drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 16 | People who are "high" on drugs should not be allowed into a drug treatment agency | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 17 | Drug misuse is no different from any other physical illness | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |

- | | | | | | | |
|----|--|----------------|-------|------------|----------|-------------------|
| 18 | People who use drugs are sexually promiscuous | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 19 | It is normal for a teenager to experiment with illicit drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 20 | Drug users should only be cared for in specialised units | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 21 | People who use drugs are irresponsible | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 22 | Most female drug users prostitute to support their habit | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 23 | Drugs corrupt the young | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 24 | Pregnant drug users should have an abortion | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 25 | All drug users are criminals who prey on society | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 26 | Drug users will "grow out of it" | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |

- 27 HIV testing should be compulsory for all drug users
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 28 Health and social services staff should be able to refuse to work with drug users
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 29 All drug users are a threat to society as potential AIDS carriers
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 30 Drug users are not as deserving of care as other patients
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|

KNOWLEDGE

- | | | | | |
|---|---|------|-------|---------|
| 1 | All drug users smoke illicit drugs before starting injecting | True | False | Unclear |
| 2 | All drug users are knowledgeable about correct injection sites and techniques | True | False | Unclear |
| 3 | Drug injecting is the most common route in Scotland for drug users | True | False | Unclear |
| 4 | Street Heroin is the main drug of choice in Scotland | True | False | Unclear |
| 5 | Street Heroin contains many impurities | True | False | Unclear |
| 6 | Heroin addiction is much worse than alcoholism to withdraw from | True | False | Unclear |
| 7 | The HIV blood test in routine use detects the presence of antibodies to the virus that can cause AIDS | True | False | Unclear |
| 8 | After HIV infection it can take three months until antibodies can be detected in the blood | True | False | Unclear |
| 9 | Procedures for avoiding Hepatitis B infection are also appropriate for avoiding HIV infection | True | False | Unclear |

- | | | | | |
|----|---|------|-------|---------|
| 10 | Spills of HIV infected material can be inactivated by simple disinfectants such as household bleach | True | False | Unclear |
| 11 | The risk of acquiring HIV infection after a needlestick contaminated by HIV infected blood is less than 1% | True | False | Unclear |
| 12 | Newborn infants who initially test HIV positive may over time become HIV negative | True | False | Unclear |
| 13 | HIV can be transmitted in breast milk | True | False | Unclear |
| 14 | All blood intended for transfusion in the United Kingdom is tested for HIV antibodies | True | False | Unclear |
| 15 | Over 75% of people with HIV have developed AIDS within five years of becoming HIV positive | True | False | Unclear |
| 16 | Encephalopathy (disturbance of the brain) is more likely to occur in people who are HIV positive than people who are HIV negative | True | False | Unclear |

CONCLUSION

Is there anything you would like to add about this survey?

APPENDIX A(2)

Interview Schedule (Drug Users)

CONFIDENTIAL

ALL RESPONSES TREATED IN STRICTEST CONFIDENCE. NO
INDIVIDUAL WILL BE IDENTIFIED. THANK YOU FOR YOUR
CO-OPERATION.

1	Centre/Interview Location	_____
2	Interview No	_____
3	Date of Interview	_____
4	Age	_____
5	Sex	_____ Male (1) Female (2) _____
6	Designation	_____

CLIENTS PERCEPTION

1 Is there anything in your background that you feel contributed to your drug problem?

1 Parents have problems
with substance abuse

2 Parental separation

3 Siblings have drug problems

4 Peer pressure

5 Poor environment

6 Other

2 How much do you want to stop using drugs?

1 Not at all

2 Not very much

3 Would you like to stop but
feel it is too difficult

4 Determined to stop with support

5 Determined to stop, with or
without support

3 What would help you to stop using drugs?

1 Nothing can help

2 Drug maintenance

3 Peer pressure

4 Supportive services

5 Supportive partner

6 Other

4 How many people close to you have died as a result of drug abuse?

- 1 More than 10 _____
- 2 6 - 10 _____
- 3 2 - 5 _____
- 4 1 _____
- 5 None at all _____

5 How did you come to be involved with this agency?

- 1 Chance _____
- 2 Family Pressure _____
- 3 Another official agency _____
- 4 Peer pressure _____
- 5 Self-referral _____
- 6 Other _____

6 How did you get on with staff involved?

- 1 Badly _____
- 2 Indifferently _____
- 3 Adequately _____
- 4 Get on well _____
- 5 Get on very well _____

7 What in your opinion makes a "good" drugs worker?

8 Do you know anyone personally who:

- | | | | | |
|---|---------------------|-----|----|------------|
| 1 | is HIV positive | Yes | No | Don't Know |
| 2 | has full blown AIDS | Yes | No | Don't Know |

- 9 Have you ever been treated by:
- | | | | | |
|---|-----------------|-----|----|------------|
| 1 | CPN | Yes | No | Don't Know |
| 2 | STD Clinic | Yes | No | Don't Know |
| 3 | Social Worker | Yes | No | Don't Know |
| 4 | Drug Counsellor | Yes | No | Don't Know |
- 10
- 1 Has anyone close to you ever been given support and/or counselling by a drug agency?
- | | | | |
|--|-----|----|------------|
| | Yes | No | Don't Know |
|--|-----|----|------------|
- 2 Have you ever been given Health Education Counselling?
- | | | | |
|--|-----|----|------------|
| | Yes | No | Don't Know |
|--|-----|----|------------|
- 11 In relation to HIV infection and AIDS how concerned are you about:
- 1 Risk of personal infection
- | | | | | |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
| Not at all
Concerned | Not very
Concerned | Fairly
Concerned | Quite
Concerned | Very
Concerned |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
- 2 Risk of passing on infection
- | | | | | |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
| Not at all
Concerned | Not very
Concerned | Fairly
Concerned | Quite
Concerned | Very
Concerned |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
- 3 Contact with people who are HIV positive
- | | | | | |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
| Not at all
Concerned | Not very
Concerned | Fairly
Concerned | Quite
Concerned | Very
Concerned |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
- 4 Other aspects of HIV infection and AIDS
- | | | | | |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|
| Not at all
Concerned | Not very
Concerned | Fairly
Concerned | Quite
Concerned | Very
Concerned |
|-------------------------|-----------------------|---------------------|--------------------|-------------------|

12 How satisfied are you with the standard of care provided?

1 Not at all satisfied _____

2 Not very satisfied _____

3 Fairly satisfied _____

4 Mostly satisfied _____

5 Completely satisfied _____

13 Do you feel "looked down" upon by a society which doesn't really care about drug users?

1 Not at all _____

2 Slightly _____

3 Not very _____

4 Fairly _____

5 Very _____

14 What do you think will happen to you within the next five years?

1 Become totally drug free _____

2 Reduce level of drug use _____

3 Continue at present level _____

4 Increase drug use dramatically _____

5 Other _____

ATTITUDE SURVEY

Interviewer reads the following statements. Please tick subjects' response. Please answer all questions.

- | | | | | | | |
|---|---|----------------|-------|------------|----------|-------------------|
| 1 | Drug use can be treated successfully | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 2 | A drug using person who has had several relapses cannot be treated successfully | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 3 | Street pushers are the initial source of drugs for young people | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 4 | Angry confrontation is necessary in the treatment of drug users | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 5 | Drug users are usually unconventional in dress and appearance | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 6 | Any person who is receiving treatment in a residential setting should be discharged if discovered using illicit drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 7 | Drug users can be rehabilitated | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 8 | Only disturbed people would experiment with drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |

- | | | | | | | |
|----|---|----------------|-------|------------|----------|-------------------|
| 9 | Drug users should be sterilised | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 10 | Once someone is using drugs there is very little that can be done | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 11 | Drug use leads to mental illness | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 12 | Most drug users have higher than average intelligence | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 13 | Treatment of drug users should be through the prison system only | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 14 | For most purposes the drug user can best be helped by a Social Worker | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 15 | Parents should react with anger on discovering that their sons or daughters are using drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 16 | People who are "high" on drugs should not be allowed into a drug treatment agency | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 17 | Drug misuse is no different from any other physical illness | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |

- | | | | | | | |
|----|--|----------------|-------|------------|----------|-------------------|
| 18 | People who use drugs are sexually promiscuous | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 19 | It is normal for a teenager to experiment with illicit drugs | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 20 | Drug users should only be cared for in specialised units | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 21 | People who use drugs are irresponsible | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 22 | Most female drug users prostitute to support their habit | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 23 | Drugs corrupt the young | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 24 | Pregnant drug users should have an abortion | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 25 | All drug users are criminals who prey on society | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
| 26 | Drug users will "grow out of it" | Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |

- 27 HIV testing should be compulsory for all drug users
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 28 Health and social services staff should be able to refuse to work with drug users
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 29 All drug users are a threat to society as potential AIDS carriers
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|
- 30 Drug users are not as deserving of care as other patients
- | | | | | |
|----------------|-------|------------|----------|-------------------|
| Strongly Agree | Agree | Don't Know | Disagree | Strongly Disagree |
|----------------|-------|------------|----------|-------------------|

KNOWLEDGE

- | | | | | |
|---|---|------|-------|---------|
| 1 | All drug users smoke illicit drugs before starting injecting | True | False | Unclear |
| 2 | All drug users are knowledgeable about correct injection sites and techniques | True | False | Unclear |
| 3 | Drug injecting is the most common route in Scotland for drug users | True | False | Unclear |
| 4 | Street Heroin is the main drug of choice in Scotland | True | False | Unclear |
| 5 | Street Heroin is mainly "Bad Gear" | True | False | Unclear |
| 6 | Heroin addiction is much worse than alcoholism to withdraw from | True | False | Unclear |
| 7 | Testing for antibodies to the AIDS virus tells you whether someone has AIDS or not | True | False | Unclear |
| 8 | After HIV infection it can take three months until you know whether you are HIV positive or not | True | False | Unclear |
| 9 | Procedures for avoiding Hepatitis B infection are also appropriate for avoiding HIV infection | True | False | Unclear |

- | | | | | |
|----|---|------|-------|---------|
| 10 | The AIDS virus is easily destroyed by simple disinfectants such as household bleach | True | False | Unclear |
| | | | | |
| 11 | If you scratch yourself with an infected needle, the chance of catching HIV infection is less than one-in-a-hundred | True | False | Unclear |
| | | | | |
| 12 | Newborn infants who initially test HIV positive may over time become HIV negative | True | False | Unclear |
| | | | | |
| 13 | HIV can be transmitted in breast milk | True | False | Unclear |
| | | | | |
| 14 | All blood intended for transfusion in the United Kingdom is tested for HIV antibodies | True | False | Unclear |
| | | | | |
| 15 | Over 75% of people with HIV have developed AIDS within five years of becoming HIV positive | True | False | Unclear |
| | | | | |
| 16 | Encephalopathy (disturbance of the brain) is more likely to occur in people who are HIV positive than people who are HIV negative | True | False | Unclear |

CONCLUSION

Is there anything you would like to add about this survey?

APPENDIX A(3)

Information Sheet (Clients)

INFORMATION SHEET

Study of Problems Facing Drug Users

I am currently carrying out a study of the problems facing drug users. This is part of a "Nurse Research Fellowship" funded by the SHHD. Prior to commencing this study I was the Community Nurse at the "Possil Drug Project" in Glasgow.

The study aims to examine the services provided to drug users, their attitudes towards drug use, and, finally, their knowledge about drugs and HIV infection. This last part of the questionnaire is for self-completion.

The whole questionnaire will take about 30 minutes to complete. It will be confidential and anonymous. The only personal detail required is your age.

Participation in this study would be greatly appreciated. I hope that the research will lead to improvements in service provision.

Thank you for your help.

Jim Carroll
SHHD Research Fellow
Department of Nursing Studies
University of Glasgow
Glasgow

A P P E N D I X . . . B

KNOWLEDGE AND ATTITUDES OF PROFESSIONALS

(by Occupational Group)

<u>Statement</u>	<u>Correct</u>		<u>Incorrect</u>		<u>Unclear</u>	
(n = 75)	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<u>Item</u>						
1) All drug users smoke illicit drugs before starting injecting	67	(89)	2	(3)	6	(8)
2) All drug users are knowledgeable about correct injection sites and techniques	70	(93)	1	(1)	4	(5)
3) Drug injecting is the most common route in Scotland for drug users	15	(20)	45	(60)	15	(20)
4) Street Heroin is the main drug of choice in Scotland	52	(69)	13	(17)	10	(13)
5) Street Heroin contains many impurities	59	(79)	11	(15)	5	(7)
6) Heroin addiction is much worse than alcoholism to withdraw from	50	(67)	18	(24)	7	(9)

Note: This table demonstrates the accuracy of actual responses.

Table B:1 - Knowledge Base about Drug Use
and HIV/AIDS
(Social Care Staff)

<u>Statement</u>	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
(n = 75)	<u>No. (%)</u>	<u>No. (%)</u>	<u>No. (%)</u>
<u>Item</u>			
7) The HIV blood test in routine use detects the presence of antibodies to the virus that can cause AIDS	51 (68)	11 (15)	13 (17)
8) After HIV infection it can take three months until antibodies can be detected in the blood	59 (79)	11 (15)	5 (7)
9) Procedures for avoiding Hepatitis B infection are also appropriate for avoiding HIV infection	56 (75)	8 (11)	11 (15)
10) Spills of HIV infected material can be inactivated by simple disinfectants such as household bleach	50 (67)	13 (17)	12 (16)

Table B:1 (Continued) - Knowledge Base about Drug Use and HIV/AIDS
(Social Care Staff)

<u>Statement</u>	<u>Correct</u>		<u>Incorrect</u>		<u>Unclear</u>	
(n = 75)	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<u>Item</u>						
11) The risk of acquiring HIV infection after a needlestick contaminated by HIV infected blood, is less than 1%	26	(35)	29	(39)	20	(27)
12) Newborn infants who initially test HIV positive may, over time, become HIV negative	45	(60)	7	(9)	23	(31)
13) HIV can be transmitted in breast milk	44	(59)	12	(16)	19	(25)
14) All blood intended for transfusion in the UK is tested for HIV antibodies	64	(85)	4	(5)	7	(9)
15) Over 75% of people with HIV infection have developed AIDS within five years of becoming HIV positive	30	(40)	13	(17)	32	(43)

Table B:1 (Continued) - Knowledge Base about Drug Use and HIV/AIDS
(Social Care Staff)

<u>Statement</u>	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
	<u>No. (%)</u>	<u>No. (%)</u>	<u>No. (%)</u>
(n = 75)			

Item

16) Encephalopathy (Disturbance of the brain) is more likely to occur in people who are HIV positive than in people who are HIV negative	16 (21)	22 (29)	37 (49)
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Table B:1 (Continued) - Knowledge Base about Drug Use
and HIV/AIDS
(Social Care Staff)

<u>Statement</u> (n = 173)	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
	<u>No.</u> <u>(%)</u>	<u>No.</u> <u>(%)</u>	<u>No.</u> <u>(%)</u>
<u>Item</u>			
1) All drug users smoke illicit drugs before starting injecting	119 (69)	29 (17)	25 (14)
2) All drug users are knowledgeable about correct injection sites and techniques	124 (72)	39 (23)	10 (6)
3) Drug injecting is the most common route in Scotland for drug users	58 (33)	75 (43)	40 (23)
4) Street Heroin is the main drug of choice in Scotland	88 (51)	49 (28)	36 (21)
5) Street Heroin contains many impurities	140 (81)	16 (9)	17 (10)
6) Heroin addiction is much worse than alcoholism to withdraw from	76 (44)	63 (36)	34 (20)

Note: This table demonstrates the accuracy of actual responses.

Table B:2 - Knowledge Base about Drug Use
and HIV/AIDS
(Health Care Staff)

<u>Statement</u>	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
	<u>No. (%)</u>	<u>No. (%)</u>	<u>No. (%)</u>
(n = 173)			
<u>Item</u>			
7) The HIV blood test in routine use detects the presence of antibodies to the virus that can cause AIDS	119 (69)	26 (15)	28 (16)
8) After HIV infection it can take three months until antibodies can be detected in the blood	126 (73)	21 (12)	26 (15)
9) Procedures for avoiding Hepatitis B infection are also appropriate for avoiding HIV infection	147 (85)	18 (10)	8 (5)
10) Spills of HIV infected material can be inactivated by simple disinfectants such as household bleach	119 (69)	40 (23)	14 (8)

Table B:2. (Continued) - Knowledge Base about Drug Use and HIV/AIDS
(Health Care Staff)

<u>Statement</u>	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
	<u>No. (%)</u>	<u>No. (%)</u>	<u>No. (%)</u>
(n = 173)			
<u>Item</u>			
11) The risk of acquiring HIV infection after a needlestick contaminated by HIV infected blood, is less than 1%	93 (54)	36 (21)	44 (25)
12) Newborn infants who initially test HIV positive may, over time, become HIV negative	62 (36)	61 (35)	50 (29)
13) HIV can be transmitted in breast milk	102 (59)	25 (14)	46 (27)
14) All blood intended for transfusion in the UK is tested for HIV antibodies	153 (88)	9 (5)	11 (6)
15) Over 75% of people with HIV infection have developed AIDS within five years of becoming HIV positive	57 (33)	51 (29)	65 (38)

Table B:2 (Continued) - Knowledge Base about Drug Use and HIV/AIDS
(Health Care Staff)

<u>Statement</u>	<u>Correct</u>	<u>Incorrect</u>	<u>Unclear</u>
	<u>No.</u> <u>(%)</u>	<u>No.</u> <u>(%)</u>	<u>No.</u> <u>(%)</u>
(n = 173)			

Item

16) Encephalopathy (Disturbance of the brain) is more likely to occur in people who are HIV positive than in people who are HIV negative	74 (43)	51 (29)	48 (28)
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Table B:2 (Continued) - Knowledge Base about Drug Use
and HIV/AIDS
(Health Care Staff)

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<hr/>								
<u>Item</u>								
1) Drug use can be treated successfully	(n = 68)				(n = 153)			
	62	(91)	6	(7)	133	(87)	20	(13)
<hr/>								
2) A drug-using person who has had several relapses cannot be treated successfully	(n = 74)				(n = 151)			
	0	(0)	74	(100)	13	(9)	138	(91)
<hr/>								
3) Street "Pushers" are the initial source of drugs for young people	(n = 68)				(n = 149)			
	19	(28)	49	(72)	75	(50)	74	(50)
<hr/>								
4) Angry confrontation is necessary in the treatment of drug users	(n = 75)				(n = 154)			
	5	(7)	70	(93)	12	(8)	142	(92)
<hr/>								
5) Drug users are usually unconventional in dress and appearance	(n = 73)				(n = 168)			
	2	(3)	71	(97)	10	(15)	158	(85)

Note: "Don't Knows" have been excluded from this table, so totals will vary.

Table B:3 - Attitudes of Professionals
by Occupational Group

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<u>Item</u>								
6) Any person who is receiving treatment in a residential setting should be discharged if discovered using illicit drugs	(n = 57)				(n = 136)			
	9	(16)	48	(84)	47	(35)	89	(65)
7) Drug users can be rehabilitated	(n = 74)				(n = 166)			
	74	(100)	0	(0)	161	(97)	5	(3)
8) Only disturbed people would experiment with drugs	(n = 75)				(n = 163)			
	0	(0)	75	(100)	2	(1)	161	(99)
9) Drug users should be sterilised	(n = 74)				(n = 167)			
	0	(0)	74	(100)	4	(2)	163	(98)
10) Once someone is using drugs there is very little that can be done	(n = 75)				(n = 167)			
	1	(1)	74	(99)	4	(2)	163	(98)
11) Drug use leads to mental illness	(n = 67)				(n = 137)			
	10	(15)	57	(85)	60	(48)	77	(52)

Table B:3 (Continued) - Attitudes of Professionals
by Occupational Group

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<hr/>								
<u>Item</u>								
12) Most drug users have higher than average intelligence	(n = 49)				(n = 122)			
	6	(12)	43	(88)	15	(12)	107	(88)
<hr/>								
13) Treatment of drug users should be through the prison system only	(n = 75)				(n = 168)			
	0	(0)	75	(100)	5	(3)	163	(97)
<hr/>								
14) For most purposes, the drug user can best be treated by a Social Worker	(n = 70)				(n = 148)			
	6	(9)	64	(91)	29	(20)	119	(80)
<hr/>								
15) Parents should react with anger on discovering that their sons or daughters are using drugs	(n = 73)				(n = 150)			
	5	(7)	68	(93)	13	(9)	137	(91)
<hr/>								
16) People who are "high" on drugs should not be allowed into a drug treatment agency	(n = 63)				(n = 133)			
	15	(24)	48	(76)	37	(28)	96	(72)
<hr/>								

Table B:3 (Continued) - Attitudes of Professionals
by Occupational Group

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<u>Item</u>								
17) Drug misuse is no different from any other physical illness	(n = 69)				(n = 166)			
	11	(16)	58	(84)	48	(29)	118	(71)
18) People who use drugs are sexually promiscuous	(n = 73)				(n = 143)			
	1	(1)	72	(99)	18	(13)	125	(87)
19) It is normal for a teenager to experiment with illicit drugs	(n = 65)				(n = 158)			
	32	(49)	33	(51)	40	(25)	118	(75)
20) Drug users should only be cared for in specialised units	(n = 69)				(n = 150)			
	9	(13)	60	(87)	82	(55)	68	(45)
21) People who use drugs are irresponsible	(n = 72)				(n = 153)			
	9	(12)	63	(88)	62	(41)	91	(59)
22) Most female drug users prostitute to support their habit	(n = 63)				(n = 103)			
	5	(8)	58	(92)	56	(54)	47	(46)

Table B:3 (Continued) - Attitudes of Professionals
by Occupational Group

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>
<hr/>								
<u>Item</u>								
	(n = 68)				(n = 157)			
23) Drugs corrupt the young	16	(24)	52	(76)	119	(76)	38	(24)
<hr/>								
	(n = 72)				(n = 139)			
24) Pregnant drug users should have an abortion	0	(0)	72	(100)	14	(10)	125	(90)
<hr/>								
	(n = 75)				(n = 166)			
25) All drug users are criminals who prey on society	1	(1)	74	(99)	10	(6)	156	(94)
<hr/>								
	(n = 65)				(n = 145)			
26) Drug users will "grow out of it"	24	(37)	41	(63)	30	(21)	115	(79)
<hr/>								
	(n = 72)				(n = 163)			
27) HIV testing should be compulsory for all drug users	6	(8)	66	(92)	61	(37)	102	(63)
<hr/>								
	(n = 71)				(n = 160)			
28) Health and social services staff should be able to refuse to work with drug users	11	(15)	60	(85)	36	(22)	124	(78)
<hr/>								

Table B:3 (Continued) - Attitudes of Professionals by Occupational Group

<u>Characteristic</u>	<u>Social Care</u>				<u>Health Care</u>			
	<u>Agree</u>		<u>Disagree</u>		<u>Agree</u>		<u>Disagree</u>	
	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>	<u>No.</u>	<u>(%)</u>

Item

29) All drug users are a threat to society as potential AIDS carriers	(n = 69)				(n = 157)			
	5	(7)	64	(93)	67	(43)	90	(57)

30) Drug users are not as deserving of care as other patients	(n = 75)				(n = 167)			
	0	(0)	75	(100)	19	(11)	148	(89)

Table B:3 (Continued) - Attitudes of Professionals
by Occupational Group

A . P . P . E . N . D . I . X . . . C

SERVICE . DELIVERY

(by . Occupational . Group)

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Source of Referral</u>				
Social Worker	13	(17)	33	(19)
Other Counselling Agency	9	(12)	23	(13)
Self-Referral	44	(59)	51	(29)
Other	9	(12)	66	(38)

Table C:1 - Breakdown of Clients Source of Referral
by Occupational Group

Null Hypothesis: There is no association between the source of referral of clients and the occupational group of professionals.

$$x^2 = 23.6, DF = 3, P = 0.0000 (P < 0.0001)$$

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the source of client referral and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Treatment Model</u>				
Social Problem	29	(39)	55	(32)
Risk Taking	17	(23)	33	(19)
Disease	1	(1)	16	(9)
Client Centred	28	(37)	69	(40)
		<u>100</u>		<u>100</u>

Table C:2 - Breakdown of Model of Treatment
by Occupational Group

Null Hypothesis: There is no association between the model of treatment used and the occupational group of professionals.

$\chi^2 = 5.9$, DF = 3, P = 0.11 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between the treatment model used and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=74)</u>		<u>Health Care (n=171)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Counselling Given</u>				
Yes	47	(64)	45	(26)
No	27	(36)	126	(74)
		<u>100</u>		<u>100</u>

Table C:3.- Breakdown of Bereavement Counselling Given
by Occupational Group

Null Hypothesis: There is no association between giving bereavement counselling and the occupational group of professionals.

$\chi^2 = 28.9$, DF = 1, P = 0.0000 (P < 0.0001)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between giving bereavement counselling and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Support Received</u>				
Very Little	22	(29)	72	(42)
Inadequate	10	(13)	50	(29)
Adequate	35	(47)	48	(28)
Total	8	(10)	3	(2)

Table C:4 - Breakdown of Management Support
by Occupational Group

Null Hypothesis: There is no association between support received from management and the occupational group of professionals.

$\chi^2 = 22.3$, $DF = 3$, $P = 0.0001$ ($P < 0.001$)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between support given by management and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Most Supportive</u>				
Peer Support	35	(47)	97	(56)
Immediate Superior	32	(43)	55	(32)
Line Manager	6	(8)	21	(12)
Senior Management	2	(3)	0	(0)

Table C:5 - Breakdown of Level of Management Support
by Occupational Group

Null Hypothesis: There is no association between the level of management support and the occupational group of professionals.

$\chi^2 = 8.1$, $DF = 3$, $P = 0.0446$ ($P < 0.05$)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the level of management support and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Satisfaction</u>				
Very Dissatisfied	4	(5)	30	(17)
Not Very Satisfied	18	(24)	68	(39)
Fairly Satisfied	27	(36)	35	(20)
Mostly Satisfied	26	(35)	40	(23)

Table C:6 - Breakdown of Job Satisfaction
by Occupational Group

Null Hypothesis: There is no association between job satisfaction and the occupational group of professionals.

$$\chi^2 = 16.9, DF = 3, P = 0.0008 (P < 0.001)$$

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the degree of job satisfaction and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=71)</u>		<u>Health Care (n=162)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Knowledge of Clients</u>				
Yes	9	(13)	68	(42)
No	62	(87)	94	(58)
		<u>100</u>		<u>100</u>

Table C:7 - Breakdown of Knowledge of Clients with HIV/AIDS and Occupational Group

Null Hypothesis: There is no association between knowledge of clients with HIV/AIDS and the occupational group of professionals.

$\chi^2 = 17.9$, DF = 1, P = 0.0000 (P < 0.0001)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the knowledge of clients with HIV/AIDS and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Self-Motivation</u>				
Yes	64	(88)	128	(74)
No	9	(12)	45	(26)
		<u>100</u>		<u>100</u>

Table C:8(1) - Breakdown of Self-Motivation as a Factor which Professionals regard as Positive in Drug Users' Motivation to Stop by Occupational Group

Null Hypothesis: There is no association between regarding self-motivation as a factor in drug users' motivation to stop and the occupational group of professionals.

$$X^2 = 4.8, DF = 1, P = 0.0278 (P < 0.05)$$

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between regarding self-motivation as a factor in drug users' motivation to stop and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Co-Operation</u>				
Yes	23	(32)	65	(38)
No	50	(68)	108	(62)
		<u>100</u>		<u>100</u>

Table C:8(2) - Breakdown of Co-Operation as a Positive Factor in Drug Users' Motivation to Stop by Occupational Group

Null Hypothesis: There is no association between regarding co-operation as a factor in drug users' motivation to stop and the occupational group of professionals.

$\chi^2 = 5.8$, DF = 1, P = 0.4466 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between regarding co-operation as a factor in drug users' motivation to stop and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Admits Problem</u>				
Yes	61	(84)	133	(77)
No	12	(16)	40	(23)
		<u>---</u>		<u>---</u>
		100		100

Table C:8(3) - Breakdown of Regarding Admitting Problem as a
Positive Factor in Drug Users' Motivation to Stop
by Occupational Group

Null Hypothesis: There is no association between regarding admitting the problem as a positive factor in drug users' motivation to stop and the occupational group of professionals.

$$x^2 = 1, DF = 1, P = 0.3164 (P > 0.05)$$

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between regarding admitting problem as a positive factor in drug users' motivation to stop and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Under Pressure</u>				
Yes	12	(16)	19	(11)
No	61	(84)	154	(89)
		<u>100</u>		<u>100</u>

Table C:8(4) - Breakdown of regarding being Under Pressure as a Positive Factor in Drug Users' Motivation to Stop by Occupational Group

Null Hypothesis: There is no association between regarding being under pressure as a positive factor in drug users' motivation to stop and the occupational group of professionals.

$\chi^2 = 0.9$, DF = 1, P = 0.3332 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between regarding being under pressure as a positive factor in drug users' motivation to stop and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=72)</u>		<u>Health Care (n=171)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Referral to CPN</u>				
Yes	30	(42)	33	(19)
No	42	(58)	138	(81)
		<u>100</u>		<u>100</u>

Table C:9 - Breakdown of Referral of Clients
and Occupational Group

Null Hypothesis: There is no association between referring clients to Community Psychiatric Nurses and the occupational group of professionals.

$\chi^2 = 12$, DF = 1, P = 0.0005 (P < 0.001)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between referring clients to Community Psychiatric Nurses and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=170)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Referral to STD Clinic</u>				
Yes	27	(37)	47	(28)
No	46	(63)	123	(72)
		-----		-----
		100		100

Table C:10 - Breakdown of Referral of Clients to STD Clinics and Occupational Group

Null Hypothesis: There is no association between referring clients to Sexually Transmitted Disease clinics and the occupational group of professionals.

$$X^2 = 1.7, DF = 1, P = 0.1942 (P > 0.05)$$

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between referring clients to a Sexually Transmitted Disease clinic and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Referral to Social Worker</u>				
Yes	52	(71)	118	(68)
No	21	(29)	55	(32)
		<u>100</u>		<u>100</u>

Table C:11 - Breakdown of Referral of Clients
to Social Workers by Occupational Group

Null Hypothesis: There is no association between referring clients to Social Workers and the occupational group of professionals.

$\chi^2 = 0.1$, DF = 1, P = 0.7505 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between referring clients to Social Workers and occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=172)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Counselling</u>				
Yes	50	(69)	104	(61)
No	23	(31)	68	(39)
		<hr/>		<hr/>
		100		100

Table C:12 - Breakdown of Health Education Counselling
by Occupational Group

Null Hypothesis: There is probably no association between giving Health Education Counselling and the occupational group of professionals.

$\chi^2 = 1$, DF = 1, P = 0.2961 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between giving Health Education Counselling and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=172)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Support/Counselling</u>				
Yes	67	(92)	81	(47)
No	6	(8)	91	(53)
		<hr/>		<hr/>
		100		100

Table C:13 - Breakdown of Support/Counselling
given to Client's Families
by Occupational Group

Null Hypothesis: There is no association between giving support/counselling to client's families and the occupational group of professionals.

$\chi^2 = 40.9$, DF = 1, P = 0.0000 (P < 0.0001)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between giving support/counselling to client's families and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=73)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Support/Counselling</u>				
Yes	47	(64)	61	(35)
No	26	(36)	112	(65)
		<hr/>		<hr/>
		100		100

Table C:14 - Breakdown of Support/Counselling
given to Client's Friends
by Occupational Group

Null Hypothesis: There is no association between giving support/counselling to client's friends and the occupational group of professionals.

$\chi^2 = 16.5$, $DF = 1$, $P = 0.0000$ ($P < 0.0001$)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between giving support/counselling to client's friends and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Risk of Personal Infection</u>				
Not at All	35	(47)	50	(30)
Not Very	31	(41)	51	(29)
Fairly	6	(8)	36	(21)
Quite	1	(1)	18	(10)
Very	2	(3)	18	(10)
		<u>---</u>		<u>---</u>
		100		100

Table C:15(1) - Breakdown of Degree of Concern about Risk of Personal Infection with HIV/AIDS by Occupational Group

Null Hypothesis: There is no association between degree of concern about risk of personal infection with HIV/AIDS and the occupational group of professionals.

$\chi^2 = 21.6$, DF = 4, P = 0.002 (P < 0.01)

Conclusion: The hypothesis is rejected.

Comment: There probably is an association between degree of concern about risk of personal infection with HIV/AIDS and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Passing On Infection to Own Family</u>				
Not at All	51	(68)	81	(47)
Not Very	16	(21)	32	(18)
Fairly	5	(7)	18	(10)
Quite	1	(1)	13	(8)
Very	2	(3)	29	(17)
		<u>100</u>		<u>100</u>

Table C:15(2) - Breakdown of Degree of Concern about Passing On Infection to Own Family by Occupational Group

Null Hypothesis: There is no association between degree of concern about passing on HIV/AIDS to own family and the occupational group of professionals.

$\chi^2 = 17.3$, DF = 4, P = 0.0017 (P < 0.01)

Conclusion: The hypothesis is rejected.

Comment: There probably is an association between degree of concern about passing on HIV/AIDS to own family and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Lack of Personal Experience with HIV/AIDS</u>				
Not at All	15	(20)	41	(24)
Not Very	12	(16)	28	(16)
Fairly	26	(35)	40	(23)
Quite	13	(17)	37	(21)
Very	9	(12)	27	(16)
		<u>100</u>		<u>100</u>

Table C:15(3) - Breakdown of Degree of Concern about Lack of Personal Experience with HIV/AIDS by Occupational Group

Null Hypothesis: There is no association between degree of concern about lack of personal experience with HIV/AIDS and the occupational group of professionals.

$\chi^2 = 3.8$, DF = 4, P = 0.4289 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between degree of concern about lack of personal experience with HIV/AIDS and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Lack of Personal Knowledge About HIV/AIDS</u>				
Not at All	13	(17)	25	(14)
Not Very	24	(32)	47	(27)
Fairly	22	(29)	61	(35)
Quite	10	(13)	26	(15)
Very	6	(8)	14	(8)
		<u>100</u>		<u>100</u>

Table C:15(4) - Breakdown of Degree of Concern about Lack of Personal Knowledge about HIV/AIDS by Occupational Group

Null Hypothesis: There is no association between degree of concern about lack of personal knowledge about HIV/AIDS and the occupational group of professionals.

$\chi^2 = 1.4$, DF = 4, P = 0.8505 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between degree of concern about lack of personal knowledge about HIV/AIDS and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Lack of Professional Support Networks</u>				
Not at All	13	(17)	30	(17)
Not Very	15	(20)	20	(12)
Fairly	15	(20)	41	(24)
Quite	21	(28)	49	(28)
Very	11	(15)	33	(19)
		<u>100</u>		<u>100</u>

Table C:15(5) - Breakdown of Degree of Concern about Lack of Professional Support in Dealing with HIV/AIDS by Occupational Group

Null Hypothesis: There is no association between degree of concern about lack of professional support networks and the occupational group of professionals.

$\chi^2 = 3.5$, DF = 4, P = 0.4730 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between degree of concern about lack of professional support networks and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Lack of In-Service Training</u>				
Not at All	9	(12)	15	(9)
Not Very	3	(4)	17	(10)
Fairly	24	(32)	32	(18)
Quite	15	(20)	40	(23)
Very	24	(32)	69	(40)
		<u>100</u>		<u>100</u>

Table C:15(6) - Breakdown of Degree of Concern about Lack of In-Service Training by Occupational Group

Null Hypothesis: There is no association between the degree of concern about lack of in-service training and the occupational group of professionals.

$$x^2 = 8.1, DF = 4, P = 0.0872 (P > 0.05)$$

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between degree of concern about lack of in-service training and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Discussing Safer Sex Guidelines</u>				
Not at All	65	(87)	124	(72)
Not Very	6	(8)	25	(14)
Fairly	0	(0)	16	(9)
Quite	1	(1)	5	(3)
Very	3	(4)	3	(2)
		<u>100</u>		<u>100</u>

Table C:15(7) - Breakdown of Degree of Concern about Discussing Safer Sex Guidelines by Occupational Group

Null Hypothesis: There is no association between reluctance to discuss safer sex guidelines and the occupational group of professionals.

$\chi^2 = 11.9$, DF = 4, P = 0.0185 (P < 0.05)

Conclusion: The hypothesis is rejected.

Comment: There probably is an association between reluctance to discuss safer sex guidelines and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Degree of Concern about Availability of Resources to Treat HIV/AIDS</u>				
Not at All	5	(7)	19	(11)
Not Very	5	(7)	12	(7)
Fairly	17	(23)	44	(25)
Quite	21	(28)	55	(32)
Very	27	(36)	43	(25)
				<u>100</u>

Table C:15(8) - Breakdown of Degree of Concern about Available Resources by Occupational Group

Null Hypothesis: There is no association between degree of concern about availability of resources to treat HIV/AIDS and the occupational group of professionals.

$$x^2 = 3.7, DF = 4, P = 0.4448 (P > 0.05)$$

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between degree of concern about availability of resources to treat HIV/AIDS and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Personal Qualities</u>				
Yes	73	(97)	152	(88)
No	2	(3)	21	(12)
		<u>100</u>		<u>100</u>

Table C:16(1) - Breakdown of Views of Professionals about
the Value of Personal Qualities in Drugs Workers
by Occupational Group

Null Hypothesis: There is no association between the value placed on personal qualities in drugs workers and the occupational group of professionals.

$$x^2 = 4.6, DF = 1, P = 0.0337 (P < 0.05)$$

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the value placed on personal qualities in drugs workers and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Professional Skills</u>				
Yes	74	(99)	161	(93)
No	1	(1)	12	(7)
		<u>100</u>		<u>100</u>

Table C:16(2) - Breakdown of Views of Professionals about
the Value of Professional Skills in Drugs Workers
by Occupational Group

Null Hypothesis: There is no association between the value placed on professional skills in drugs workers and the occupational group of professionals.

$\chi^2 = 2.3$, $DF = 1$, $P = 0.1315$ ($P > 0.05$)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between the value placed on professional skills in drugs workers and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=172)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Previous Training</u>				
Yes	4	(5)	16	(9)
No	71	(95)	156	(91)
		<u>100</u>		<u>100</u>

Table C:16(3) - Breakdown of Views of Professionals about
the Value of Previous Training in Drugs Workers
by Occupational Group

Null Hypothesis: There is no association between the value placed on previous training in drugs workers and the occupational group of professionals.

$\chi^2 = 0.6$, DF = 1, P = 0.2930 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between the value placed on previous training in drugs workers and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=172)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Knowledge Base</u>				
Yes	39	(52)	70	(41)
No	36	(48)	102	(59)
		<u>100</u>		<u>100</u>

Table C:16(4) - Breakdown of Views of Professionals about the Value of a "Good" Knowledge Base about Drug Use and HIV/AIDS by Occupational Group

Null Hypothesis: There is no association between the value placed on knowledge base among drugs workers and the occupational group of professionals.

$\chi^2 = 2.3$, DF = 1, P = 0.1322 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between the value placed on knowledge base among drugs workers and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care</u>	<u>(n=75)</u>	<u>Health Care</u>	<u>(n=171)</u>
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Ex-User</u>				
Yes	0	(0)	14	(8)
No	75	(100)	157	(92)
		<u>100</u>		<u>100</u>

Table C:16(5) - Breakdown of Views of Professionals about the Value of Employing Former Drug Users as Drugs Workers by Occupational Group

Null Hypothesis: There is no association between the value placed on employing ex-users as drugs workers and the occupational group of professionals.

$\chi^2 = 5.1$, DF = 1, P = 0.0243 (P < 0.05)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between the value placed on employing ex-users as drugs workers and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Relevant Experience</u>				
None	11	(15)	80	(46)
Some	64	(85)	93	(54)
		<u>100</u>		<u>100</u>

Table C:17 - Breakdown of Previous Relevant Work Experience
by Occupational Group

Null Hypothesis: There is no association between having previous relevant work experience and the occupational group of professionals.

$$\chi^2 = 21.1, DF = 1, P = 0.0000 (P < 0.0001)$$

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between having previous relevant work experience and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Effectiveness</u>				
Ineffective	14	(19)	81	(47)
Don't Know	28	(37)	40	(23)
Effective	33	(44)	52	(30)
		<hr/>		<hr/>
		100		100

Table C:18 - Breakdown of Effectiveness
by Occupational Group

Null Hypothesis: There is no association between effectiveness and the occupational group of professionals.

$\chi^2 = 17.6$, $DF = 2$, $P = 0.0001$ ($P < 0.001$)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=168)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Personal Qualities</u>				
Yes	13	(17)	25	(16)
No	62	(83)	143	(84)
		<u>100</u>		<u>100</u>

Table C:19(1) - Breakdown of Personal Qualities as a Reason for Effectiveness by Occupational Group

Null Hypothesis: There is no association between regarding personal qualities as a reason for effectiveness and the occupational group of professionals.

$\chi^2 = 0.9$, DF = 1, P = 0.7680 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between regarding personal qualities as a reason for effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care</u> (n=75)		<u>Health Care</u> (n=168)	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Available Resources</u>				
Yes	16	(21)	66	(39)
No	59	(79)	102	(61)
		<hr/>		<hr/>
		100		100

Table C:19(2) - Breakdown of Availability of Resources as a Reason for Effectiveness by Occupational Group

Null Hypothesis: There is no association between regarding available resources as a reason for effectiveness and the occupational group of professionals.

$$\chi^2 = 6.7, DF = 1, P = 0.0097 (P < 0.01)$$

Conclusion: The hypothesis is rejected.

Comment: There probably is an association between regarding available resources as a reason for effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=168)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Underlying Nature of Problem</u>				
Yes	38	(51)	78	(46)
No	37	(49)	90	(54)
		<u>100</u>		<u>100</u>

Table C:19(3) - Breakdown of Underlying Nature of Problem as a Reason for Effectiveness by Occupational Group

Null Hypothesis: There is no association between regarding the underlying nature of the problem as a reason for effectiveness and the occupational group of professionals.

$\chi^2 = 0.2$, DF = 1, P = 0.6370 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between regarding the underlying nature of the problem as a reason for effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=168)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Professional Skills</u>				
Yes	41	(55)	47	(28)
No	34	(45)	121	(72)
		<hr/>		<hr/>
		100		100

Table C:19(4) - Breakdown of Professional Skills as a Reason for Effectiveness by Occupational Group

Null Hypothesis: There is no association between regarding professional skills as a reason for effectiveness and the occupational group of professionals.

$\chi^2 = 14.9$, DF = 1, P = 0.0001 (P < 0.001)

Conclusion: The hypothesis is rejected.

Comment: There is probably an association between regarding professional skills as a reason for effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care</u> (n=75) <u>Number</u>	<u>%</u>	<u>Health Care</u> (n=168) <u>Number</u>	<u>%</u>
<u>Follow-Up</u>				
Yes	36	(48)	50	(30)
No	39	(52)	118	(70)
		<u>100</u>		<u>100</u>

Table C:19(5) - Breakdown of Follow-Up as a Reason for Effectiveness by Occupational Group

Null Hypothesis: There is no association between regarding follow-up as a reason for effectiveness and the occupational group of professionals.

$$X^2 = 6.8, DF = 1, P = 0.0093 (P < 0.01)$$

Conclusion: The hypothesis is rejected.

Comment: There probably is an association between regarding follow-up as a reason for effectiveness and the occupational group of professionals.

<u>Characteristic</u>	<u>Social Care (n=75)</u>		<u>Health Care (n=173)</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
<u>Prediction</u>				
More Success	15	(20)	46	(27)
Less Direct Involvement	20	(27)	28	(16)
Present Situation	10	(13)	38	(22)
Other	30	(40)	61	(35)
		<u>100</u>		<u>100</u>

Table C:20 - Breakdown of Professionals Future Predictions by Occupational Group

Null Hypothesis: There is no association between professionals predictions of future involvement with drug users and the occupational group of professionals.

$\chi^2 = 6.2$, DF = 3, P = 0.1010 (P > 0.05)

Conclusion: The hypothesis is accepted.

Comment: There is probably no association between professionals' predictions of future involvement with drug users and the occupational group of professionals.

A-P-P-E-N-D-I-X---D

"ATTITUDES-OF-PROFESSIONALS-TO-DRUG-ABUSERS"

Jim-Carroll-BA-RMN-(CPN-Possil-Drug-Project)

Paper presented at the Addictions Forum
"National Members Meeting"
held at Yorkshire Health, The Queen Building,
Park Parade, Harrogate
on 29th and 30th March 1993

(First presented at the Mental Health Nursing Conference,
"Working in Wider Communities",
held at the University of Stirling
on 10th June 1992)

INTRODUCTION

This paper presents some preliminary findings from an interview study which examined the experiences of 248 professionals working with intravenous drug abusers in West/Central Scotland. Practise settings studies include specialist areas (Hospital Addiction Units and Drug Projects), and non-specialist areas (Infectious Diseases Wards, Medical/Surgical Wards, Accident and Emergency Departments, Prison, Social Work Departments, and Community Work).

The study covered a variety of professional roles, ie Addiction Counsellors, General Nurses, Prison Nurse Officers, Psychiatric Nurses, and Social Workers. In this study, the attitudes of professionals towards drug abuse and drug abusers is looked at. The 5 occupations are all involved in delivering direct care to intravenous drug users. It is important to study the attitudes of professionals as there may be a relationship between attitudes and the emotional response of professionals, which may, in turn, directly affect patient care.

Situations of uncertainty such as dealing with drug users, are likely to provoke strong emotional responses. This client group is generally regarded as demanding, and this is not a new phenomenon. However, the evidence of this study

suggests that more professionals are experiencing stressful contact with intravenous drug users, for the first time.

Furthermore, the occupational background of professionals is likely to have an effect on emotional responses and attitudes. Therefore, the professionals involved are likely to manifest differences in attitudes due to their difference in professional socialisation, and the conditions in which they work with drug users. It is also probable that the more familiar that professionals are with drug users, and particularly drug users with HIV infection, the more likely they are to have positive attitudes.

DRUG ABUSE IN SCOTLAND

In relation to IV drug abuse, the Scottish experience has been different in kind from other parts of the UK. This is particularly so with regard to HIV infection (1). Although the overall level of infection among IV drug abusers in Strathclyde remains low (2), significantly higher rates have been recorded in one area of Glasgow, and it is anticipated that the number of seropositive IV drug abusers in the West of Scotland will increase (3).

However, the explosion of illicit drug abuse in Scotland occurred in the early 1980s, long before public awareness of

HIV infection and AIDS. Many professional carers, especially Nurses, had no expectation of working with drug abusers, let alone people who are HIV positive. They have been thrust into this role by the associated physical and emotional conditions, eg overdose, hepatitis, endocarditis etc. Yet the literature is sparse on the attitudes of carers involved, especially that of Nurses (4). Some studies among GPs have shown that they are reluctant to become involved with drug abusers (5). No such option is open to Nurses. They are obliged to treat drug abusers without discrimination. Moreover, their contact with such patients is usually more prolonged and intimate. Nevertheless, Nurses are not isolated from society. They may well have feelings of fear and prejudice towards this client group, and, consequently, be ill-prepared for a caring role.

Professional carers working with drug abusers are often regarded as being involved in a particularly difficult area. What are the demands of such work, and does it differ substantially from other stressful areas? The 3 factors most likely to affect the nature of demands on carers are as follows:-

- (1) The way in which drug abuse impinges upon carers.
- (2) The skills required to treat such patients.

(3) The nature of the work with clients/patients.

- (1) As drug abusers have been treated for their problems, many Nurses have found themselves involved by chance rather than choice.
- (2) It is also relevant that it is the acute rather than the chronic specialties which are usually involved in drug related work. This places additional stress on staff in areas which were already highly stressed (4), eg Accident and Emergency Units.
- (3) Drug related illnesses, eg HIV, septicaemia, hepatitis etc involve carers in working with young people who are very seriously ill, often terminally so. Such work has long been recognised as demanding. Drug abusers tend to lead a chaotic lifestyle and to be indifferent to their health. As it may well be the first time that the carer has been involved with such patients, it may be a particularly depressing and emotionally draining experience (6).

According to Parsons, to be sick in Western society is to occupy a social role which, while conferring certain rights, also contains a number of obligations. These are:-

- (1) That the sick person recognises that sickness is undesirable and that he or she should attempt to get well again.

- (2) That the patient should collaborate with the professionals involved in treatment (7).

However, IV drug abusers do not fit neatly into this "sick" role, and therefore, such assumptions add further to the stress experienced by carers. There is some evidence that drug abusers do not see themselves as "sick" but accept drug abuse as the social norm (8). On the other hand, there is evidence that professional carers see drug abusers as lying, manipulative, aggressive, and lacking in motivation (9). Obviously such perceptions make it very difficult to slot drug abusers into a typical patient role.

Relatively little research has been carried out about the attitudes of professional carers in the field of drug abuse, and very little indeed on the attitudes of Nurses. What is available is mainly American and/or focussed on medical attitudes.

However, one American study examined the attitudes of Student Nurses towards drug abusers. The results suggested that the respondents tended to have punitive attitudes towards such patients, and that this tendency was reinforced by their training (10). Another US study suggested that treatment outcomes are affected by staff judgements and that perceptions of attractiveness or otherwise, directly affected patient care (11).

It is impossible to directly transpose the American results to the UK context, if only for cultural reasons. Also, the situation as regards drug abuse and HIV infection is much worse in the USA. Having said that, the situation in Edinburgh, with its high numbers of seropositive babies, approaches that of New York (1). This appears to be the exception that proves the rule: the drug epidemic is still much less serious here than in the USA.

British research among Nurses has been scanty. A postal survey of Community Nurses in Scotland was carried out in 1989 (12). This focussed on problems associated with HIV infection and AIDS. The results suggested that many community staff felt insecure and ill-prepared to care for such patients. Their knowledge base was often limited and a substantial minority felt that they should be able to refuse to care for patients who were HIV positive or had full-blown AIDS. Obviously this has very serious implications for future practice.

One British study in 1982 examined Nurse-patient interaction. It did not specifically look at drug abusers but at patients who were seen as "difficult, unco-operative or self-destructive". All these categories could easily be applied to drug abusers (13). Moreover, the authors feel it is the Nurses judgements which are significant rather than any inherent qualities in the patients. Thus, there is clearly a gap in the research available. As Nurses are usually in the frontline of treatment, such a gap is not

acceptable. Most nursing authors agree that when Nurses define patients as bad, this is a problem in delivering effective care. Professional carers may possess a significant amount of negative feelings. These may be conscious or unconscious. In any case, such attitudes may adversely affect patient care to the point of being counter-productive. It is hoped that the proposed study will fill some of the gaps in our knowledge about staff attitudes.

AIMS

The aims of this exploratory study were as follows:-

- (1) To describe the context in which health and social service professionals perform their caring role in the treatment of IV drug abusers. In particular, to assess the implications for staff of different organisational structures, and the extent of interagency collaboration.
- (2) To examine the experiences of a range of caring professionals and to document their responses to the demands encountered in working with this "difficult" client group.

PLAN OF INVESTIGATION

The research method used was a personal interview with each of the respondents, and had the following components:-

- (1) Interviews with qualified nursing staff who are involved in regular and frequent contact with IV drug abusers, ie at least once a week.
- (2) Interviews with a group of social service professionals, ie Addiction Counsellors and Social Workers who also met the criteria.

The age and sex of respondents was recorded but not names. Confidentiality and anonymity were stressed. The location and date seen were noted and staff were asked to state their designation.

The second part of the survey was a "likert type" attitude scale. This was based on an American survey in 1973 (14). It required considerable updating and adapting, eg due to the onset of HIV infection. The scale was constructed as follows:-

- (1) There were 30 bipolar descriptive statements on a 5 point agree/disagree format.

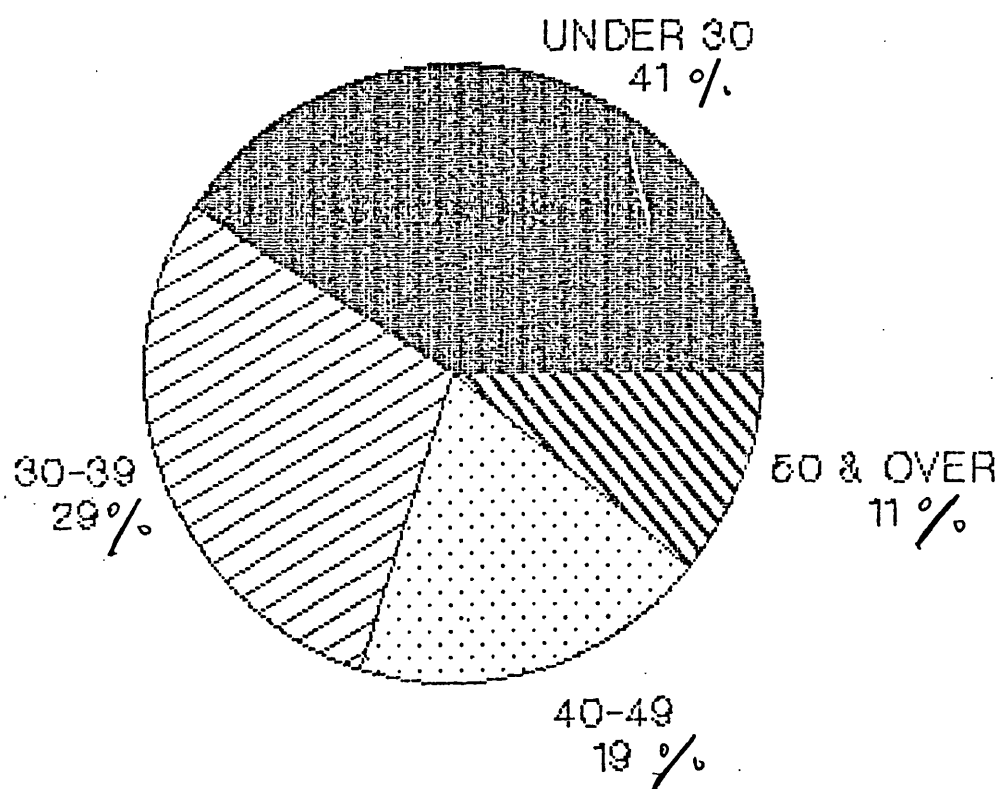
- (2) The scale could be used to determine staff attitudes towards patients rehabilitation.
- (3) It would be helpful in defining areas where staff development and/or in-service training were needed in order to modify existing attitudes. In the longer term, Nurse training could be changed to include awareness of drug abuse.
- (4) The scale could serve as a means of assessing attitudes towards drug abuse. Probably it could determine whether there are significant associations with respondent characteristics, eg age, sex, status, work area etc.

SAMPLE

The overall response rate was 67%. However there were wide variations in response rates among different occupations. Prison Nurse Officers had a response rate of 90%, Addiction Counsellors had a response rate of 86% while Mental Health Nurses had a rate of 93%. The response rate for Social Workers was 64% and for General Nurses only 46%.

About 60% of respondents were female, and the same proportion were over 30. The demographic characteristics of the sample are shown by Figures D:1 to D:5.

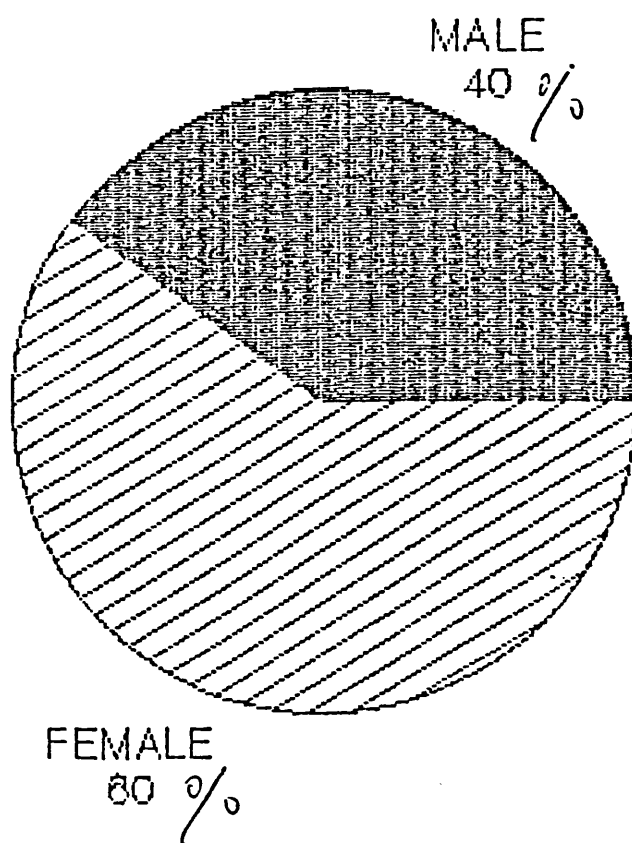
AGE GROUP



n = 248

Figure D:1

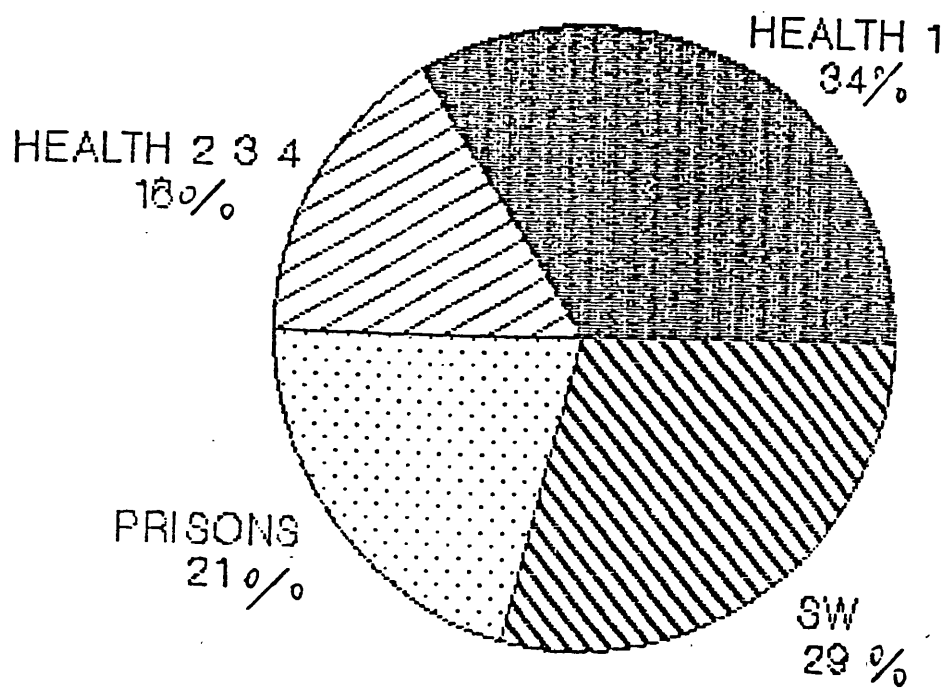
SEX



n = 248

Figure D:2

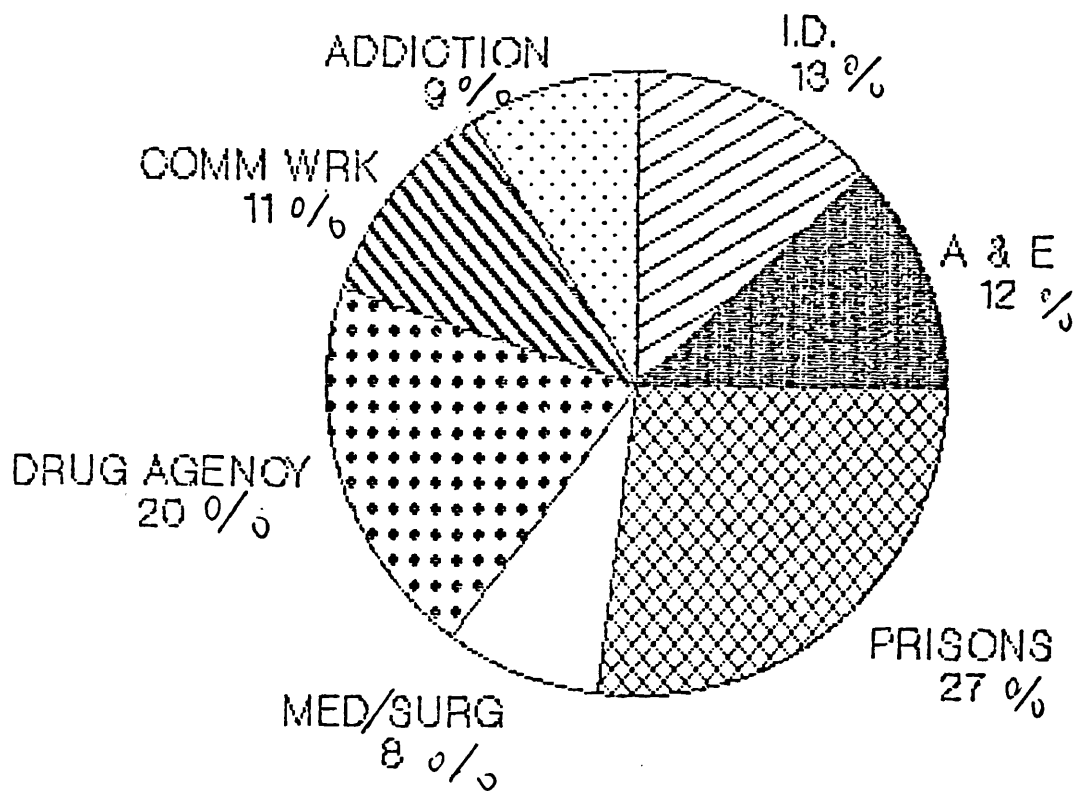
EMPLOYER



n = 248

Figure D:3

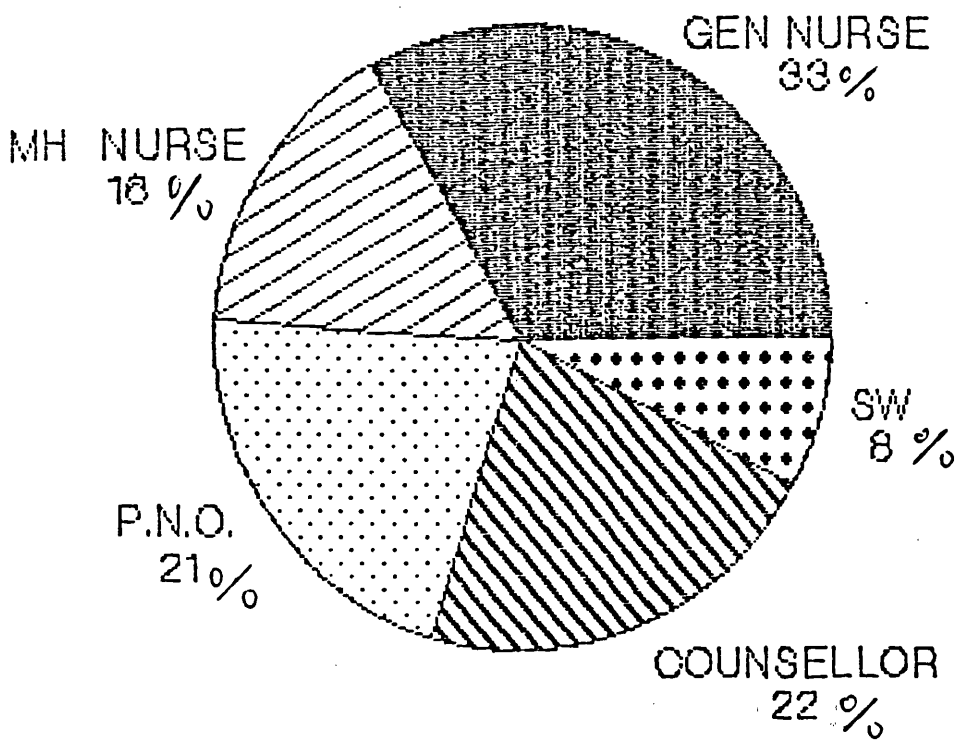
WORK AREA



n = 233

Figure D:4

OCCUPATIONS



n = 248

Figure D:5

RESULTS

In the results, the attitudes of social care and health care professionals are described. One-way analysis of variance was used to determine whether there were any differences in the attitudes of professionals based on occupation.

Table D:1 indicates that there were significant differences in the attitudes of professionals. A consistent pattern is apparent with the specialist group (Addiction Counsellors) having the lowest scores, and non-specialist groups having higher scores. (A lower score indicates a more positive attitude).

<u>Characteristic</u>	<u>Number</u> <u>(n = 243)</u>	<u>%</u>	<u>Attitude Mean</u>
<u>Occupation</u>			
Addiction Counsellor	54	22.2	63.5
General Nurse	81	33.0	76.9
Prison Nurse Officer	51	21.0	80.4
Psychiatric Nurse	38	15.6	68.7
Social Worker	19	7.8	69.5

One-Way Analysis of Variance

F = 32.01, Sig = 0.0000

Table D:1 - Attitudes of Professionals to Drug Abusers

The distribution of scores is very interesting, as it seems to indicate a correlation between degree of motivation and attitude to drug abuse.

The Addiction Counsellors had the most positive attitudes, as might have been expected. They are entirely a specialist group, having chosen to work in this area, although not always specifically in the drug field.

The Mental Health Nurses were the next most positive group, although there is a difference of 5 points. They can also be described as a specialist group, ie drug abuse is generally regarded as being within the remit of psychiatry. The vast majority of this group (33 out of 39) had chosen to work in addictions, although it was sometimes seen as a career stage. Even those staff who had not chosen this area, ie in an acute admission unit, still accepted this responsibility.

Social Workers were next in terms of positive attitudes. The vast majority (18 out of 20) had non-intentional contact with drug abusers, ie through other aspects of their work. Nevertheless, they accepted that they had a caring role and usually tried to work with other professionals. Their attitudes seemed to derive from their training, which encouraged them to be open and tolerant.

General Nurses were marginally negative in their attitudes. Their contact with drug abusers was entirely non-

intentional, they were treated for some associated physical condition. However, there were very wide differences in the attitudes of General Nurses, according to work area. Respondents who worked in the AIDS unit were all volunteers, and were markedly more positive than respondents in other areas, eg Accident and Emergency Departments.

Prison Nurse Officers were the most negative occupation in terms of attitude. This may derive from their dual role, which probably involves a great deal of role conflict. Prison Nurses are employed as Prison Officers, with a nursing qualification. Their basic role is disciplinary, which obviously makes a caring role very difficult. It is probably this perception of drug abusers as prisoners, ie criminal and deviant, which accounts for the predominantly negative attitudes.

Table D:2 suggests that there is a significant relationship between familiarity with drug users, and the attitudes of professionals. Respondents who have had previous work experience with drug users demonstrate significantly more positive attitudes. This finding suggests that having familiarity with drug users does tend to lessen fears and anxieties about this client group.

<u>Characteristic</u>	<u>Number</u> <u>(n = 243)</u>	<u>%</u>	<u>Attitude Mean</u>
<u>Work Experience</u>			
None	90	(37.0)	77.2
Some	153	(63.0)	70.2
		<hr/>	
		100	

One-Way Analysis of Variance
F = 26.26, Sig = 0.0000

Table D:2 - Attitudes and Previous Work Experience

<u>Characteristic</u>	<u>Number</u> <u>(n = 228)</u>	<u>%</u>	<u>Mean</u>
<u>Knowledge of Clients with HIV/AIDS</u>			
Aware	76	33.3	76.2
Unaware	152	66.7	71.0
		<hr/>	
		100	

One-Way Analysis of Variance
Sig = 0.0005, F = 12.3412

Table D:3 - Attitudes and Knowledge of Clients
with HIV Infection

Table D:3 suggests that respondents who are aware of having a drug-using client, who is HIV positive, appear to have more negative attitudes to drug users than respondents who are unaware. This finding is disturbing since it indicates that clients who are most in need of care (for health reasons) are being cared for by the professionals with the least empathy for such clients. One possible explanation of this finding is that awareness of HIV infection may increase the fears and anxieties of professionals, resulting in more negative attitudes to drug users.

It also suggests that familiarity with drug users, especially those with HIV infection, would be associated with positive attitudes among professionals. This hypotheses was only partially supported. Professionals who had previous work experience with intravenous drug users did appear to have more positive attitudes. However, these professionals who were aware of having HIV positive clients appeared to be more negative in their attitudes. This finding suggests that HIV infection induces feelings of fear and anxiety in professionals, which outweigh the beneficial effects of increased contact with drug users, and the rational beliefs of professionals.

CONCLUSIONS

It is likely that attitudes are very important in determining care delivery, and in explaining differences

between professionals who perform these roles. However, it is also likely that attitudes alone are not accurate predictors of care delivery, especially in determining emotional reactions in the workplace.

The research was based on a large sample of professionals in West/Central Scotland, and the majority (67%) of staff in 4 Health Boards, 4 Prisons, and 1 Regional Social Work Department who met the criteria for contact, actually participated.

There is a need for further research into the effects of attitudes, particularly to examine the role conflicts which appear to be facing some professionals. This study should be representative of professionals in Scotland but it is dangerous to generalise as drug use and/or HIV infection are impinging on virtually every area of health and social care.

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