Problem drug users and drug workers: their beliefs in the origins and treatment of problem drug use

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Problem Drug Users and Drug Workers:
Their Beliefs in the Origins and Treatment of
Problem Drug Use

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Presented for the degree of Ph.D.
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August 1997
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INTRODUCTION

The purpose of this dissertation is to examine the models about problem drug use held by problem drug users who are in treatment and professionals who work in drug treatment agencies. Furthermore, it is the intention to examine the influences on these models. For professionals, it is expected that a variety of influences will be at work. These will include their professional training, their previous experience and personal characteristics. The type of agency which employs them may also have an influence, as could the policies of the District or Regional Health Authorities.

For problem drug users who are in treatment, many of the same influences will be examined. These will include their educational background, personal characteristics, and experience of drug use - problematic and otherwise. The type of agency where they choose to attend for treatment or help may also be influential, as could their relationship to the agency.

DRUG CONTROL AND THE STATE

The control of drugs has been seen as a prerogative of the state for many centuries (Bean, 1974). The first taverns which developed along trade routes in the Middle East were regulated by the local authority. Other drug use was regulated by religious and medical institutions which prescribed when and under what circumstances various drugs could be used (Szasz, 1975). The right of the state to intervene in what drugs we use and how we use them has been challenged by civil libertarians. They argue that the state should have no right to determine what we consume. Goldstein (1995) summarises their case,
"Among the many definitions of legalisation is one that is based on the principle that government has no right to limit people's freedom to do what they wish to their own bodies, and therefore to use whatever drugs they wish." (pp. 261)

Part of the legacy of the development of the modern nation state is the willingness of the population of many states to allow government to regulate their personal lives. Simultaneously the state has undertaken to provide services which hitherto have been the responsibility of the individual, such as provision of state education and health services. Increasingly the state takes a broader view of what constitutes the public interest.

Over the last 30 years there has been a rapidly increasing prevalence of drug use amongst the young (Leitner, 1993). Worries about the corruption of youth is a continuing theme, dating back to Socrates, if not before. Drugs are often seen as a corrupting influence. At the same time, many believe there is a growing relationship between drug use and crime. State intervention in the use of drugs is thus assured.

There are several means of controlling the social use of drugs. The most obvious is to simply ban their use through the criminal justice system. Time and experience has shown this means to be insufficient. Another way of controlling the use of drugs is to provide state sanctioned treatment agencies to provide help to those who develop problems as a result of their drug use. This approach recognises that the law itself is unable to prevent the use of drugs, in part because the chances of being caught are low and most people recognise that so many people use illicit drugs
that it is simply impractical to find and prosecute more than a small proportion of them. Treatment agencies are efficient in that they target those with the greatest problems for help. Usually, the greater the drug use problems for the individual, the greater the drug use problem for society as a whole. It is in the interest of society to provide help for problem drug users and for as large a proportion of problem drug users as possible to seek that help. Despite the fact that, within the United Kingdom, help is both free and confidential, relatively few problem drug users take advantage of that help (Hartnoll, 1992).

It is also in the interest of the problem drug user, the treatment agency and the state that treatment be as effective as possible.

In many ways treatment agencies have had less of an impact on problem drug users than most people would have hoped. Perhaps one of those reasons lies in the way that problem drug users perceive and understand their drug use compared to the professional staff who work in those agencies. It is this aspect of differences in beliefs about problem drug use that makes this issue so relevant today.

The academic question relates to the larger question. That is, what precisely are the differences in beliefs between professionals who work in treatment agencies and how do they differ from problem drug users? How can those beliefs be measured and what are the influences on those beliefs?

ENTER THE CLIENT/PATIENT

At a personal level, interest in this study began as a part of my first paid professional experience in working for a drugs
street agency in London in the late 1970s. As part of the induction programme, arrangements were made for observations in a series of interviews at a NHS Drug Dependency Unit where doctors, nurses and a social worker made decisions about who would receive a prescription for oral methadone. Even as an inexperienced and naive drugs counsellor in London I could not fail to be struck by the differences in the perception of drugs use held by the drug user and by their doctors, nurses, and social workers. While the precise words used by the young man in search of a Methadone prescription are long forgotten, the sentiments were similarly expressed by another. When asked why he used drugs, one young drug user said,

"First, when I was on it, like, I dunno.....it made me feel dead pleasant, I dunno....as if I never had a care in the world...." (Pearson, 1986, pp. 39)

When he left the room to allow the team to discuss the merits of his case a debate followed which indicated that they thought he first began to use drugs in order to compensate for his grossly inadequate personality. Once he had "the taste" and recognised the relief from distress, which was overpowering, he was committed.

The discussion amongst the professionals was adequately described by the Rolleston Committee, 50 years earlier;

"...the condition must be regarded as a manifestation of disease, and not a mere form of vicious indulgence. In other words, the drug is taken not for the purpose of obtaining positive pleasure, but in order to relieve a morbid and overpowering craving." (Departmental Committee
on Morphine and Heroin Addiction, 1926, pp.11)

The drug user spoke of pleasure seeking, the second of relief of distress. For those of us who worked in drug agencies the problem was helping drug users become abstinent (or later minimising harm). For most drug users in treatment the problem was getting hold of adequate supplies of drugs. At times it seemed we were hardly talking about the same problem.

THE DEVELOPMENT OF THE MEDICAL MODEL

Traditionally, the overindulgence in drugs was probably not treated but tolerated. In Victorian Britain, the use of opiates (often in the form of Laudanum or opium) was common (Berridge & Edwards, 1981). Treatment for overindulgence of drugs was managed by physicians, if their fees could be afforded. Physicians, however, seemed not to take a moral stand about drug use. Drug problems with psychoactive drugs were, essentially, similar to side effects of the improper use of other drugs. Berridge and Edwards (1981) suggest that withdrawal symptoms were treated without fuss or moralising. The medical problems were the symptoms - not the person using the drug.

As certain types of drug use became illegal in the 20th century, physicians stepped forward to help treat those who were guilty of its use. The emerging medical profession allied itself to the growing movement in public health which had, by the middle of the 19th century, already scored a number of successes. Social problems such as mental illness and crime were redefined as biological, thus medical. It should come as no surprise that addiction should be similarly treated (Berridge & Edwards, 1981).

By the turn of the 19th century and the early 20th century
physicians (especially psychiatrists) developed the view that addiction was the result of personality disorder. Early advocates (Adams, 1937; Sainsbury, 1909) of this position even went so far as to write that normal people who did not suffer from personality disorder were incapable of becoming psychologically addicted. While personality disorder itself was not seen as a disease of the mind, such as Schizophrenia, it was a medical condition which, at least sometimes, was treatable.

It was the medical profession which took the lead in explaining problem drug use. The problem lay in the personality of the drug user and thus came under the authority of psychiatry. When the treatment of problem drug use was given over to the newly formed Drug Dependency Clinics (DDC) in the late 1960s and early 1970s, the physician was still the most influential professional on the team. Other professionals who may have worked in the new DDCs such as Social Workers and Nurses readily accepted their lead.

It was only with the expansion of problem drug use that new non-statutory agencies became involved in providing services for problem drug users. As their numbers and confidence grew, they began to challenge the medical model. Theoretical challenges to the notion that drug use was a symptom of a disordered personality came from a variety of sources. For instance, Martin Plant (1981) suggested that there are many reasons why someone may use drugs and that these reasons may change over time. Personality was only one of many factors.

THE DEVELOPMENT OF THE DRUG TREATMENT INDUSTRY

The growth of problem drug use in the United Kingdom over the last 25 years has been matched by the growth in the number of
agencies dedicated to helping problem drug users. Before 1970, there were only 32 such agencies within the U.K. (19 statutory and 12 non statutory). By the end of the 1980s, 364 such agencies existed (MacGregor, 1991, pp. 69). Furthermore, professional groups such as doctors, nurses, social workers, psychologists, and occupational therapists now dominate drugs agencies - even in the non statutory sector. Over half (56%) of all staff employed in drug agencies held some type of professional qualification (MacGregor, 1991, pp. 63).

Not only have these agencies greatly expanded in numbers, they have become part and parcel of the government response to problem drug use. They are regularly consulted by government bodies about problem drug use and representatives of drug agencies sit on Joint Care Planning Teams for Substance Misuse and Drug Reference Groups in most District Health Authorities. Other professionals in the medical profession, the Probation Service, Social Services, etc. regularly consult them and are a prime source of referrals. The agencies offer training for professionals as well. Formal qualifications for Nurses are now available in the form of approved English National Board courses. Furthermore, National Vocational Qualifications, are being developed for treating Substance Misuse. Over the last 20 years, drug agencies have become legitimate and professionalised.

WHAT NEW ORTHODOXIES?

The rapid change in models and beliefs about problem drug use has left many people confused about what drug workers (of all professions) and problem drug users believe about problem drug use. Professionals require theories and paradigms in order to
make sense of what they do and justify their professional involvement.

Despite the difficulties in definition, paradigm is a useful term when referring to professionals, as Kuhn (1970) does with scientists, because it suggests what a community, in this case a professional community, believe in common. It implies a set of values and ways of knowing. Within a paradigm, a model, or several models can usually be found. Models are representations of a reality that can be examined for validity and reliability. They are less inclusive than paradigms but easier to test. Within a model are sets of beliefs.

Beliefs can be defined as,

"...statements indicating a person’s subjective probability that an object has a particular characteristic." (Oskamp, 1977, pp. 11)

In other words they state a relationship between the object and some characteristic. Beliefs in models of problem drug use form the basis of attitudes.

For the purpose of this dissertation, the term model will be used for the theories of problem drug use which I have asked problem drug users and drug workers to evaluate and rate. These beliefs and models about problem drug use are fundamental in not only training and educating professionals but in individuals identifying with their chosen profession.

The first modern model of problem drug use was the medical model which arose in the 19th and early 20th century. The first major assault on the medical model came from two fronts. The first came from the work of Sociologists interested in deviancy. Most
sociologists give credit to Becker who published articles about drug use in the *American Journal of Sociology* as early as 1953. It was not until 1963 that his classic *The Outsiders* appeared. Becker employed a different model of drug use (in the 1950s and 60s, all drug use was defined as problematic) than that used by physicians. He employed a deviancy model to explain drug use. Little impact was made upon the medical profession though they sometimes conceded the existence of deviancy theory.

Later attacks were launched by the psychology profession in the form of social learning, behavioural or cognitive models of problem drug use. They also had some impact on medical models but not enough to change the practice of working psychiatrists in treatment agencies.

**ORTHODOXIES IN THEORIES OF PROBLEM DRUG USE - THE INFLUENCE OF OTHER PROFESSIONS**

In the past, physicians, for the most part, advocated a medical model. In this sense a medical model is one in which the source of the problem is the inherent personality of the drug user which is the main cause of the drug problem. They are seen as vulnerable because of their personality and a genetic predisposition to use psychoactive substances in a harmful way.

As other agencies (most of which did not employ physicians) developed in response to the greater prevalence of problem drug use in the 1970s and early 1980s, different models of problem drug use were generated.

The differences in the models used by other professionals was most clearly seen in the 1970s. The residential (drug free) rehabilitation projects and the social work style street agencies
became acrimonious critics of the physician lead Drug Dependency Units. They claimed that physicians who prescribed methadone for long periods were simply colluding with drug use and adding yet another barrier to change. They criticised the assumptions that many, if not most, problem drug users suffered from personality disorder (Blenheim Project, 1979).

In the early days the staff at street agencies and residential rehabilitation projects identified strongly with the client group. Many of the staff were former problem drug users themselves. Professionalism was seen as a barrier to client/staff relationships, it was to be avoided. Many of the staff used to occupy squats on the same street as their clients. The staff identified with a counter-culture and were active in a whole range of political groups, especially around housing and squatting. Salaries at these agencies were low, often not much above what their clients collected from Social Security. Their identification only went so far though. The difference was not so much class, many of the staff came from working class backgrounds. The difference was that the staff were relatively well educated and had the choice to find other work if they so desired. Their clients had much less choice.

Eventually other professional groups, such as Social Work and Nursing, came to consider problem drug use and in the last several years began to offer their own views. This is a more recent phenomenon with nursing and social work paradigms of problem drug use being more explicit in what they do not believe (i.e. a traditional medical/biological model) rather than in what they do believe. The word paradigm is used cautiously because,
to the best of my knowledge, neither profession has ever articulated a view that could be called a model. This is, however, to be expected, according to Etzioni (1969) who classifies both nursing and social work as a semi-profession. He characterises a semi-profession as;

"Semi-professionalism denotes that the profession does not rest on a firm theoretical knowledge base ....."

(pp. 153).

Street agencies increasingly allied themselves to residential rehabilitation programmes and turned to various forms of talking therapies as the key to helping their clients become abstinent.

"The work of the Project must therefore be to assist attenders in becoming aware of their real feelings and so put them in touch with their personal potential. Often this can best be done by challenging those statements and actions which appear to stem from the attender's 'street image' rather than the person that he/she really is. This is crucial, since to allow such behaviour to pass unchallenged would be to tacitly collude with, and thus strengthen attitudes which make it almost impossible for the individual to feel fulfilled without the support of drug use" (Lifeline Annual Report, 1981 pp. 18).

This philosophy, to varying degrees, was advocated by all the street agencies and residential rehabilitation programmes. They were not going to offer a remedy in the form of drug therapy, they were advocating a remedy in the form of talk therapy. A variety of therapies such as psychodrama, transactional analysis, and groups of various kinds were
initiated by these agencies. Their clients, however, were as resistant to talking cures as they were to chemical cures. A mistake acknowledged by some many years later.

"For the majority of our customers, their problems were those of homelessness, unemployment, poverty, illiteracy, loneliness. But we wanted to see more. We wanted to dig down to their personal growth bedrock. For us, there could be no half measures. Thinking back, it seems as it had never occurred to us that it can be hard to 'grow' when you can't read and write and you don't know where you're going to sleep that night. We didn't ignore these material issues, but our therapeutic disease belittled and mocked them" (Yates, 1992, pp. 11)

THE EMERGENCE OF NEW ORTHODOXIES

In recent years the beliefs about drugs and the attitudes which arise from those beliefs have undergone even more changes. If anything, problem drug use is seen as even more of a social threat than before (House of Commons, 1995). The sharp increase in prevalence since the mid 1980s, stronger reported links between drugs and crime (especially violent crime involving guns), and the discovery of the association of HIV/AIDS and drugs has further stigmatised drug use and users. At the same time, ever larger groups of people (especially the young) use a variety of illegal drugs. The irony continues as street agencies now are often critical of physicians for not prescribing problem drug users enough drugs or what drug users say they want (i.e. Heroin, amphetamines, injectable drugs).

Many of those who work in agencies for problem drug users now
advocate a model of problem drug use that considers the influence of peer pressure, boredom and economic circumstance as the seeds of the problem. Simultaneously, others point out that we all use drugs of one sort or another and that there is little real difference between legal drug use and illegal drug use. Still others point out that drug use is a rational act by people making positive choices about their life-styles. The line dividing drug use from problem drug use is thus becoming thinner.

Recently, some influential members of the medical profession have begun to reexamine their beliefs about the nature of problem drug use. The relationship between personality disorder and addiction is no longer an article of faith for many psychiatrists. Ghodse (1989) criticises the methodology of many studies which claim to have found a relationship between personality disorder and problem drug use. He points out that most draw their populations from prisons, psychiatric hospitals or treatment programmes. More importantly he says that even if there are differences in personality it may be the result of the illegal status and cost of drugs rather than the nature of the person taking them. There is little evidence that there are premorbid differences between problem drug users and those who do not use drugs problematically. This issue will be considered in more detail in the literature review.

The views of senior physicians like Ghodse were reinforced by a publication from the Royal College of Psychiatrists (1987) which questions the notion of the importance of personality disorder in problem drug use;

"Furthermore, what is being stigmatised as an
underlying personality disorder causing drug misuse may on more sensitive exploration be understood as maladjusted behaviour resulting from involvement in the chaotic and deviant world of the drug user - that young woman stealing and engaging in prostitution not because of an underlying psychopathy but because she needs to pay for her heroin. What passes as sociopathy in the eyes of the middle-class investigator, who is looking at the inner-city drug sub-culture as an outsider, can sometimes more accurately be interpreted as an adaptive set of rules and behaviour for survival in an environment which is alien to that investigator's own background." (pp. 44)

Such views would have been considered heresy twenty years ago, perhaps even by some of the authors of the report in their earlier years.

THE MODELS HELD BY PROBLEM DRUG USERS

While the debate continues among professionals about the nature of problem drug use and users, there is little information about what problem drug users themselves believe about problem drug use. In recent years problem drug users who come to agencies for help have been asked to evaluate that service. Customer satisfaction surveys are increasingly being used by agencies to present to their funders (usually government through the Local Authority or Purchasing Teams within District Health Authorities) as evidence of their efficiency and value. Rarely, however, are they asked about their own models of problem drug use, the origins of those problems, treatment or how they see their
future.
No doubt part of the problem lies within the relationship between the professional and patient/client. Professionals feel the need to be able to offer evidence of their understanding and this is usually done within the framework of models and paradigms. Professionals may claim that their patients/clients are too close to the problem to be objective. Problem drug users may be seen to have a stake in holding onto the status quo. Professionals, however, can be seen by problem drug users as being aloof from the reality of their lives. There may be class differences, age differences and at least in most cases, educational differences as well. Relatively few professionals will have experienced more than recreational drug use and will only know about problem drug use from their training or second hand from problem drug users. It may be that problem drug users see their problems in different ways than the professionals who are paid to help them. This in itself may present a barrier for some problem drug users to come for help. It may also lead to loss of contact and for less than satisfactory relationships between professionals and their clients or patients.

DO MODELS AND BELIEFS MATTER?
What problem drug users and professionals believe about the nature of problem drug use is essential. If their beliefs are diametrically opposed, problem drug users may see little reason for seeking help. Unlike the United States, where a large proportion of treatment is carried out through the criminal justice system, within the United Kingdom the tradition has been to encourage attendance at treatment centres voluntarily.
Despite the encouragement, there is adequate information (Hartnoll, et al, 1992) which suggests that most problem drug users are not in contact with services. This could, in part, at least reflect different understandings of the nature of problem drug use.

Also, dropout rates in most treatment programmes, except Methadone prescribing schemes (Department of Health, 1996) are high, again suggesting a possible lack of agreement between professionals and problem drug users. Furthermore, a mutual understanding of the nature of the problem may be essential for the success of treatment. All forms of counselling and psychotherapy emphasise the need to start "where the client is at" and if there is little mutually held agreement about the nature of the problem, the chances of successful intervention are low.

Agencies which receive Community Care funding (and that includes many agencies which provide services for problem drug users) are routinely required to survey their clients/patients about the efficacy of the service. All agencies must pay attention to these issues as never before.

Potential problems for professionals arise as a result of unshared views about the nature of problem drug use. Most agencies which provide services for problem drug users are multi-disciplinary. Without a commonly held model of problem drug use, goal setting in treatment will be confused. The very nature of the treatment programme assumes (often unstated) adherence to a model which dictates the most appropriate therapy or help. Only when common understanding of these issues can disciplines work together efficiently.
These issues have become even more relevant because of HIV/AIDS and the new interest about the relationship between drugs and crime. The need for agencies to make contact with problem drug users is heavily emphasised in guidance from the Advisory Council on the Misuse of Drugs (Department of Health, 1989). Government interest in drugs as a factor in crime puts additional stress on agencies to effectively "treat" their patients/clients.

THE RESEARCH QUESTION

With so many changes within the field of problem drug use, traditional models are less influential than they have been in the past. If there are new orthodoxies they are as yet not well defined. The first aim of this study is to determine what models of problem drug use are held by those who work within helping agencies. Do different professional groups hold different models of problem drug use and how do they differ from the models held by problem drug users who attend agencies for help. What are the variables in determining what models both drug workers and problem drug user hold. Does age, sex, and education have an influence? Do different types of helping agencies promote different philosophies or do District Health Authority, Regional Health Authority or national policies influence agencies and the individuals who work for them? It is these questions which will be addressed in my thesis.

Much of the literature about these issues is about attitudes towards drugs and problem drug users rather than beliefs about problem drug use. The focus of this thesis, however, is not about attitudes. Attitudes are about the positive or negative feelings or emotions one has towards a person, group or idea (OsKamp,
The focus of my research is about the models which professionals and problem drug users who attend agencies for treatment hold about the nature of problem drug use. The considerable research about attitudes is relevant only so far as the underlying models can be understood. It is these models which are the foundations of the research.

THE VOCABULARY OF PROBLEM DRUG USE

Over the last century the vocabulary used to denote drug use has changed significantly. Though the process of drug dependence and the symptoms of withdrawal have been well documented for centuries, the terms addiction and addicts became more popular at the end of the 19th century. Probably this is because of the discovery of more potent forms of opiates such as Heroin and to a lesser degree the use of Cocaine Hydrochloride in Europe and America. No doubt the invention of the hypodermic syringe in the middle of the 19th century made physical addiction more probable.

The term addict was widely used and took on a different meaning as a result of the passage of the Harrison Act (1914) in America and the Dangerous Drugs Act (1920) in the United Kingdom. Addict was used to designate anyone who used illicit drugs rather than someone who was physically dependent on a drug.

The 1970s saw an increase in the use of the term drug dependence, which was broader and could more easily accommodate psychological dependence along with physical dependence. Also by the 1970s the terms drug abuse and drug abusers gained some currency. By the 1980s these were altered to drug misuse and drug misusers because some authors felt that the term abuse
was pejorative and misuse was less so. Soon the terms drug misuse and drug misusers lost credit as being still too derogatory and were replaced in the mid 1980s by problem drug use and problem drug users for those who have difficulties as a result of their drug use. Drug use and drug user now can be used for anyone who uses any psychoactive substance and as a result has lost some of its meaning. Perhaps the greatest incentive to use the terms problem drug use and user came from local drug prevalence studies which required a more concise way to define those people who used drugs in such a way that they came to the notice of helping agencies. These seem to be the favoured terms at the moment but no doubt will change with time. With each change in terms comes a new emphasis in the way drug and drug users are conceived and reinforces old or new models and beliefs about drug use. For instance, the change from drug dependence to drug abuse to drug misuse to problem drug use or drug use can be seen as a process which acknowledges that not all drug use is dependent forming or dangerous. It emphasises the commonality of drug use and recognises that the division between legal and illegal drugs may be arbitrary and not based on an assessment of the dangers or dependence forming properties of any particular drug. For the purpose of my thesis I will use the terms problem drug use and problem drug user. When referring to the literature of the past I will use the terms which were used by the authors even though they may be less acceptable today. Redefining the addicts of 70 years ago into the problem drug users of today would render no service to accuracy or serve no
useful purpose.
LITERATURE REVIEW

The literature on the models used by professionals or problem drug users who attend drug agencies to explain problem drug use is insignificant. To date there has been little or no attempt to look beyond the issue of attitudes towards problem drug use and users. However, there is considerable literature on the attitudes about problem drug use and users which is held by professionals and problem drug users themselves. For the sake of convenience and consistency the literature on professional groups will be examined first, starting with an overview and then studies which survey hospitals. Next the literature on the medical profession will be investigated and finally other professions such as nurses, social workers, psychologists, etc will be considered.

THE RELATIONSHIP BETWEEN ATTITUDES AND BELIEFS

An exploration of the relationship between attitude and belief is essential in relating the results of this dissertation to the literature review. The overwhelming weight of literature is about attitude towards drug use and there is frankly little about belief though many authors suggest that belief is the foundation upon which attitude is based (Oskamp, 1977). Social psychologists have gone to great lengths to define attitude. Many social psychologists have agreed that attitude is comprised of three elements; the ideas and beliefs the individual holds towards the object, the emotional response towards the object and finally the resulting actions and behaviours which result from the first two. Such a distinction is by no means new. Plato made a similar
observation. He suggested that attitudes consist of three parts; cognition, affection and conation. Later authors, such as Fishbein and Ajzen (1975) have divided these elements and proposed that attitudes should be considered the effective (i.e. emotional) component. They go on to say that attitudes are how we feel about an object, our gut reaction, our feelings of like and dislike toward a person or object. Most of the studies reviewed are of this type. That is, they have tested the "attitude" (as described by Fishbein and Ajzen) towards problem drug users. The reason for this interest is clear. Many commentators have suggested that negative attitudes held by professionals decrease the chance of successful treatment or intervention. Feelings of despair held by the therapist are often transmitted to their patients or clients. Even more problematic is the reluctance to even try to treat or help problem drug users because of 'therapeutic nihilism' or because of negative feelings towards problem drug users as a group.

Social policy implications are in many ways even more important. Public attitudes towards drug users will shape the legal and social responses to drug use. Attitudes which are negative lead to public policy decisions which are based on prejudice and pessimism rather than evidence and realism. Attitudes are not formed randomly and are influenced by several factors. They are a result of a combination of our personalities, our education, training and experience (Oskamp, 1977). Oskamp (1975) says that beliefs are more stable than attitudes. They are not merely about one's mental state at the
time. Suedefeld says,

"Beliefs are important to the extent that they concern
one's own identity, are shared with other people, are
learned by an encounter with the belief object rather
than second hand, and are not merely matters of taste".

(Suedefeld, 1971, pp. 15)

A major determinant of our attitudes is our beliefs about the
nature of the problem. Those beliefs are the foundation of our
attitudes. The purpose of this research is to explore the
beliefs about problem drug use held by problem drug users
themselves and compare them to professionals who are employed
to offer them services. Only by understanding those beliefs
can attitudes be understood.

The literature on problem drug users themselves will be
considered last. Because the literature is more extensive for
problem drug users, it will be considered in the light of the
three broad aims of this research. Firstly, the literature on
those described as "problem drug users", "addicts", "drug
dependants", etc. rather than those who are described as "drug
users" will be reviewed. This term could include anyone who
has even tried an illicit drug once and is not the population
that is being investigated.

The extensive literature on attitudes and beliefs towards
those with alcohol problems will not be reviewed. Attitudes
towards illicit drugs are not necessarily the same as those
towards alcohol which is legal and more widely used than
illicit drugs. The very illegality of some drugs and their
association with different life-styles, crime, and values make
them sufficiently different from alcohol to deal with them separately.

Also, the extensive literature on what the public believe about problem drug use or how it is managed in the media will not be reviewed. Nor will the beliefs of unpaid volunteers be examined. The focus is clearly on professionals who work in drug agencies and problem drug users who attend agencies.

AN OVERVIEW

Freidson (1975) points out that professionals are in a key position as agents of social control. They gain their authority from the state and exercise that authority on behalf of the state. They are granted certain privileges by the state, for example physicians can prescribe drugs which in other circumstances would be illegal. They also gain immunity from obligations of other citizens, even if that is granted informally. Drug workers, by virtue of custom and practice, are not responsible to inform the police of crimes associated with problem drug use, though some may be obligated to report problem drug users to the Home Office Index or Regional Health Authority Data Base.

Agencies, in general, can be categorised as professional or bureaucratic. Human services tend to be more professional than bureaucratic but may still have some characteristics of bureaucracies. Freidson (1971) points out that social control in professional organisations are less formal and rely on influencing the professionals who work in them rather than exerting direct managerial control such as in a bureaucratic organisation. As long as the ethos and goals of the
professions who work in these agencies roughly correspond to the policies of the state, there is minimal conflict. Indeed, professionals are often instrumental in forming those policies. In the late 1980s, when HIV/AIDS was the driving force behind changes in drug policies, professionals in the drug field greatly influenced government policies on funding, treatment, etc.

The views of professionals in the helping business are influenced not only by training and professional allegiance but by other factors such as class. Graff and his colleagues (1971) point out the large differences in social class between psychiatrists and their lower class patients in Community Mental Health Centres. The selection and educational processes of becoming a physician foster a sense of elitism within the medical profession. The authors suggest that lower class mental health patients distrust their higher class helpers, in part because of class differences. If this were so it could hold true for problem drug users as well.

HOSPITAL STAFF

Accident and Emergency Departments

Many problem drug users who do not use treatment services (Drugs Indicator Project, 1989) but do take accidental or deliberate overdoses come into contact with health professionals in Accident and Emergency Departments. Ghodse (1978) surveyed the staff at 62 of 66 London Accident and Emergency Departments about their attitudes towards those who take a drug overdose and are treated by A&E staff. Of 1350 self administered questionnaires distributed, 1248 were
returned, a response rate of 92%. Nurses accounted for 54% of the sample, ambulance drivers for 17%, doctors for 15% and other staff (i.e. porters, receptionists,) for 12%. Only 2% did not give their profession or position.

Overdose patients were divided into three groups, those who took their overdose accidentally, those who deliberately took an overdose (i.e. suicide attempts or gestures) and those who took their overdose in the course of their drug dependence. A total of 30% of staff attitudes towards drug dependants were rated moderately or highly favourable, compared to 51% of those who took an overdose deliberately and 75% of those who took their overdose accidentally. Attitudes towards drug dependents were also far more likely to be rated moderately or highly unfavourable (38%) compared to deliberate overdoses (16%) or accidental overdoses (4%). Neutral attitudes were ascribed to 32% of drug dependents, compared to 33% towards deliberate overdoses and 21% of accidental overdoses. Nurses had more favourable attitudes (33%) than either doctors (26%), ambulance drivers (24%), or other staff (28%) who had less unfavourable attitudes. There were no statistically significant differences between senior medical staff and junior medical staff or between senior nursing staff and junior nursing staff. Also there were no differences because of sex or age. Those staff with the most experience were more likely to have the least favourable attitudes.

In a similar study, Ghodse and Ghaffari (1986), repeated the exercise in Malta. A total of 350 questionnaires were distributed and 323 (92%) were returned. Unlike the previous
study where the majority of staff were women, in Malta the majority (67%) were men. The largest occupational group were nurses (129), followed by medical students (73), doctors (59) and health visitors (49). Patient groups were divided into accidental self-poisoning, suicide attempt, suicide gesture, alcoholism, drug dependence. Not surprisingly, drug dependence had the second least favourable attitudes (36%) and the most unfavourable attitudes (37%). Alcoholism had the least favourable attitudes (40%) and the second most unfavourable attitudes. Nurses had the least favourable attitudes (22%) towards drug dependence, while the doctors and medical students had the most favourable attitudes. Nurses also had far more unfavourable attitudes (49%) than doctors or medical students (34% and 21%).

The reasons suggested by Ghodse for the results of both these studies is because drug dependent patients are far from the ideal patient image which is favoured by professionals in the medical profession. Furthermore, the drug dependents may be seen to have caused their own problems through the pursuit of pleasure or choosing a deviant lifestyle. They may challenge medical authority and as a result of their drug use be aggressive. The research did not enquire into the reasons why they had unfavourable attitudes but only enquired how favourable or unfavourable attitudes were.

The questionnaires were about attitudes towards problem drug users held by professionals in Accident and Emergency Departments. The models used by professionals were not questioned. However, it is fair to say that the strongly
negative attitudes were more likely to be either the result of moralising about problem drug users or labelling problem drug users as suffering from personality disorder.

Hospital Treatment Staff

Romney and Bynner (1972) also questioned hospital staff about their attitudes to three groups of patients, drug addicts, the mentally ill and alcoholics. These groups were not well defined in the study. Out of 700 employees, they were able to secure 209 - a response rate of just under 30%. Staff were divided into nurses (n = 64), doctors (n = 60) and others (n = 85). Others represented a heterogeneous group of administrators, social workers, psychologists, and switchboard operators. Some staff were excluded and those were orderlies, domestic cleaners and maintenance workers. The rules which governed how the authors decided to exclude staff are unclear.

The questionnaire tested four aspects of beliefs and attitudes about drug addiction:

1/ drug addiction is an illness
2/ drug addicts are anti-social
3/ disapproval of doctors spending time treating drug addicts
4/ belief that drug taking expands consciousness

Drug addicts were divided into two groups, soft drug addicts (those who used stimulants, cannabis, and hallucinogens) and hard drug addicts (those who used opiates). These two groups were compared to alcoholics and the mentally ill. Doctors and nurses felt that hard drug addicts were far more
dangerous than soft drug addicts. Nurses believed that hard drug addicts were more dangerous compared to what doctors thought them to be. As this was an agency which prescribed Methadone, it is likely that the hard drug addicts were more deferential to the doctors who had the power to increase, decrease or suspend the prescription, offer admission to hospital and decide about discharge. Nurses did not have this capacity. Also, nurses felt that hard drug addicts were extroverted and doctors felt that they were introverted. They were also seen as non-conformist and sexually unattractive. Both professions firmly placed hard drug addicts in the psychiatric category "psychopathic". Soft drug addicts were not seen as particularly dangerous. In fact, the authors suggested that all hospital staff invested soft drug addicts with a degree of glamour and allure. It was later suggested that these attitudes could prove to be less than therapeutic within a drug treatment agency. The drug using habits of the staff were not investigated. Doctors and nurses felt that hard drug addiction was an illness which deserved treatment. The response rate to this study was poor, less than 30%. The total number of nurses and doctors is not known so it is not possible to judge if those who completed the questionnaire are representative of doctors or nurses within this hospital. Here there is a little more information on what models may be employed by physicians and nurses. Hard drug users were felt by both physicians and nurses to be psychopathic, suffering from a disease and nurses felt them to be dangerous. These beliefs would fit in well with a medical model of problem drug
use. There is no hint, however, how they see the origins of the problem, prognosis or preferred treatment.

Levitt and his colleagues (Levitt et al., 1963) surveyed non medical staff at the United States Public Health Service Hospital at Fort Worth, Texas. The 30 staff were either administration, maintenance personnel or nurses or nurses aids. They were given an attitude and knowledge questionnaire when they began their job (within the first week) and again at 3 months. The authors felt that their attitudes about addicts were stereotyped (negatively) before they began their new work but had not altered much over the 3 months they were employed. Their knowledge base was said to have improved but not necessarily their attitudes. Those with most patient contact showed the largest change. The study did not differentiate between those who were therapeutic staff (i.e. nurses and nurses aids) and administration and maintenance staff. The nature of the questionnaire is revealing about the general attitudes towards problem drug use. For instance, one of the questions in the survey asked;

"Most addicts like to start new things but find finishing them difficult."

The correct answer to this question was suppose to be "yes". This study tried to differentiate between a "moral" model of problem drug use and a medical model. The main finding was that those who had the most contact with problem drug users were the most likely to change their attitude from a moral position to a more medical position.

Non Hospital Treatment Staff
Hart (1976) investigated the attitudes and beliefs of 24 ex-addicts who were now employed at a therapeutic community in New England. A 40 statement questionnaire, developed by Marcus, (1973) for alcoholics was modified for drug addicts by changing the word drug for alcohol and addict for alcoholic. The modification was drafted by Soverow and his colleagues (1972). As a group, the ex-addicts, did not have a consistent opinion regarding the socio-economic class of addicts. They also could not agree among themselves whether addicts were harmless or simply motivated by a fondness for drugs. They could not agree if addicts were able to control their use. Women staff were more hopeful than men staff that addicts were able to recover. This may have been because women were more prone to accept addiction as an illness than men who were more likely to attach a moral element by believing that addicts were weak willed.

This study used a small sample which was further divided into men and women. Defining addiction as an illness in the United States in the mid 1970s was no doubt a radical departure from the prevailing ideology which simply defined drug use as an evil form of vicious self indulgence. Again, the models which underpinned the questionnaire would differentiate between a medical model and a moral model but would not test belief in other models. The influence of other models was not significant until the 1980s.

Other studies have shown that even staff within the same agency often disagree about the nature of problem drug use. Morgenstern and McCrady (1992) surveyed 450 drug treatment
experts (from a variety of professions) but only received a 28% response rate. Using a 35 item questionnaire the authors found that 29% of those sampled preferred an eclectic approach, 20% preferred a disease model, 17% a behavioural model, 10% a psychodynamic model, and the rest, 24%, preferred a variety of less favoured models. The low response rate makes it difficult to draw conclusions but could suggest that a disease (being synonymous with medical) model may be losing favour in the United States.

Soverow and his colleagues (1972) compared the attitudes and beliefs of patients in a treatment agency and the staff at that treatment agency. He used a 40 statement questionnaire measuring attitudes towards alcoholism developed at the Alcohol and Drug Research Foundation in Toronto. He modified the questionnaire by replacing the word drug for alcohol, addict for alcoholic, etc. The questionnaire was administered to 120 addicts in the programme and 37 staff members who had been experience of working with addicts for 6 months or more. The professional designations of the staff were not recorded. One in five of the addicts refused to take part in the exercise but the refusal rate (if any) of the staff was not mentioned.

The results suggested that there is broad agreement in attitude and belief between patients and staff in several areas. These include; the belief that addiction involves a loss of control over the substance use, that addiction is primarily a character defect, and that drugs have strong addictive properties. Also there was agreement between
addicts and staff about the social status of addicts. There was some discrepancy between staff and addicts over other issues. Staff were more likely than addicts to feel that emotional difficulties are a cause of addiction, that the use of very large amounts of drugs are not necessary to cause addiction and that staff were more hopeful for recovery than addicts were. Staff were also much more ready to believe that addiction was an illness and much less willing to construe addiction as a harmless indulgence.

The nature of the treatment programme is not mentioned in the study and this could have been a crucial element in the survey. The small number of staff make the results tentative. However, it seems that the major difference are bound up in the therapeutic role in the staff. It is precisely those aspects of drug using behaviour and the emotional problems which drug workers believe are the origins of problem drug use that staff may feel are treatable. Addicts may not feel that emotional problems were a major causative factor in their addiction but this is where staff may see their expertise.

Nurco et al. (1988) surveyed 900 addict/clients and 237 treatment staff in 25 drug treatment agencies in six states. Attitudinal differences among the clients and staff in diverse treatment agencies was the focus of this research. The agency staff was 51% white, 38% Black, 10% and Hispanic. The agencies were divided into four types, Abstinence (A) agency (those promoting only abstinence), Methadone Maintenance, abstinence, and Naltraxone (MAN) agencies, Methadone (M) only agencies,
and MA agencies which are Methadone maintenance and abstinence. Over half (61%) of the addicts were recruited from the MAN type agency. There are 6 agencies in each group. All the addicts in the Abstinence programmes were Black.

The researchers developed a 142-item questionnaire whose content areas included, the nature of addiction, the origins of addiction, ways of dealing with addiction and personalities and characteristics of addicts. A factor analysis was performed on the questionnaire and from that 5 scales were drawn.

Nurco and his colleagues were able to distinguish differences between the sex and race of staff. He did not identify the staff according to profession.

White, male staff were more sceptical of the efficacy of treatment than their female or black colleagues. They were more likely to believe that addicts were irresponsible. Black male staff had a strong belief that the availability of drugs was a crucial issue as a cause of addiction and that friends are not very influential in leading to addiction. They also felt strongly that taking drugs is unacceptable. White, female staff were similar to white male staff but had a stronger belief that one's parents and society were to blame for addiction. Female, black staff were similar in their beliefs about drug use to male black staff. They had the strongest belief in the efficacy of treatment.

This study used a large cohort from 25 agencies but there are no addicts who are not in treatment. While the sample may represent treatment populations it can not be ascertained if
it is representative of addicts not in treatment. Like all
dependent questionnaires, it relies on reasonable levels of literacy
which can not always be guaranteed. Professional training was
not considered in this study.

Psychologists

Knox (1976) sent postal questionnaires to psychologists and
trainee psychologists who worked for the Veterans
Administration in the United States. She received 827
completed questionnaires, a response rate of 68% for
psychologists and 66% for trainees. The questionnaire sought
to define drug abuse, list its causes, recommend treatment,
guess prognosis, and determine personal commitment to treat
drug abusers. The results were compared to attitudes and
beliefs about alcoholism.

Out of 18 possible response, over 1/2 of the group chose peer-
pressure as a major cause of drug abuse. This was followed by
cultural pressure, anxiety and low tension tolerance. Parental
neglect or over-control were not seen as significant causes.
Therapeutic communities were seen to be the favoured choice of
treatment followed by synthetic narcotic prescribing (i.e.
Methadone) and then group therapy. Prison as an option was
rarely mentioned as being a suitable institution to treat drug
abuse. The psychologists felt that motivation was a key issue
in attaining a successful treatment result. Prognosis for
complete abstinence was poor, according to 84% of the
psychologist respondents. However, 71% felt it would be a
successful outcome if the opiate users changed to a milder
drug such as cannabis.
Compared to nurses and other treatment staff, psychologists seem to hold more liberal views of the origins of drug abuse. The comparison is not direct as other studies often use the term addiction rather than drug abuse. Psychologists see peer pressure and cultural reasons as key factors and do not see parental neglect or over control as particularly significant. They were not asked if drug abusers were psychopathic but the answers they gave did not indicate that they found personality disorder to be the major factor.

Though the study was large, the only group of psychologists that were surveyed came from the Veterans Administration Hospitals. The patients who they saw were either ex-service men or women or their immediate families, probably not a representative group.

Psychology students were administered a questionnaire, by Brehm and Back (1968), to determine their attitude and orientation towards drug use, rather than their actual drug use. The authors concluded that most of the students did not feel the need to change the way they felt or were sufficiently dissatisfied with their life to be likely users of drugs.

Nurses
Professional roles are difficult to maintain in the face of persistent drug use by their clients or patients. The confusion about professional roles is inherent in the business. Persistent drug users often simultaneously feel the need to use less drugs or become abstinent and to repeat their drug use for pleasure or to avoid withdrawals. This ambivalence towards wanting help and wanting drugs does not
neatly fit into most therapeutic regimes which call for clear and consistent goals. Morgan and Wilson- Moreno (1973) attempt to help resolve this issue for nurses and find themselves offering conflicting advice within the same article. On the one hand;

"The nurse must be non judgmental, and neither preach or exhort." (pp. 499) followed by the subsequent judgment;

"Is addiction a valid life style? Never!" (pp. 500).

Heiman (1979) sees the dilemma somewhat differently. The problem for him is encompassed in the conflicting notions that problem drug users must be held responsible for their own actions and the counsellors duty of care to offer help. He suggests that this is more acute for those in the "helping business" who see problem drug users compared to those who see patients with mental health problems where more sympathy is felt because mental health problems do not have the stigma of being self-inflicted.

Heiman (1979) declares that other therapeutic problems are inherent in the nature of helping problem drug users which lower staff moral. Repeated failure of clients or patients to achieve goals (even if those goals are not abstinence) can make staff at treatment agencies feel helpless, angry, guilty and defensive. He offers no easy solutions except to advise on the importance of frequent staff meetings where these frustrations can be aired. The lack of clarity about the models of problem drug use which Heineman has in mind make it difficult to place this article within the realms of one theory or another.
Moodley-Kunnie (1988) investigated the attitudes and beliefs of nurses in South Africa about alcoholics, soft drug abusers, nicotine abusers and hard drug abusers. The author used the questionnaire developed by Romney and Bynner (op. cit.). The nurses were recruited from a South African hospital and included student nurses as well as qualified nurses. Like Romney and Bynner, she found that nurses differentiated between these various forms of substance abuse. They felt that hard drug users were in most need of therapeutic intervention as well. Though they were prepared to offer treatment to hard drug addicts they held unfavourable attitudes towards them as individuals. She suggested that nurses were not prejudiced against substance abuse, just the individuals who abused them! These attitudes were thought to be anti-therapeutic and at least partially responsible for the high drop-out rate in the addiction treatment programme.

The methodological problems are significant. There is inadequate indication on how the nurses were recruited and if they are volunteers from a larger group of nurses. There is no way to tell how much contact they have had with addicts or what training they may have received (if any). Whatever model of addiction was being used, attitudes towards problem drug users were negative.

MODELS OF PROBLEM DRUG USE HELD BY PHYSICIANS

The literature on the models of problem drug use held by physicians is meagre. Most of the literature relates to the
attitudes about problem drug use held by physicians. It is possible, however, to gain some insight into the beliefs and models they hold from their attitudes. The review of the literature concerning physicians will begin with General Practitioners and then move onto physicians in Accident and Emergency Departments. Finally, the literature from psychiatry will be considered.

GENERAL PRACTITIONERS AND DRUG USERS

Since the publication of the first governmental report on the treatment of drug addiction (Ministry of Health, 1926), physicians have been assigned a key role in the treatment of problem drug use. Even from 1926, physicians were warned about their patients who would come to them with drug problems. By the mid 1970s, if General Practitioners were left in any doubt about the dangers of treating drug addicts they found advice from those specialists who were charged with treating them. Bewley (Bewley et al., 1975), Consultant Psychiatrist in charge of one of the newly organised Drug Dependency Unit in London warned GPs of being deceived by drug abusing patients. He conducted research into his patients methods of obtaining drugs by asking 100 problem drug user St George’s and Lambeth Hospitals in London to complete anonymous questionnaires. He asked them how they approached doctors, what drugs they asked for and the reasons which they gave for needing drugs. Bewley et al. (1975), who wrote the article for the Journal of the Royal College of General Practitioners, concluded that drug abusing patients learned about GPs who had provided prescriptions for psychoactive drugs from other drug users.
Bewley suggests that drug abusing patients are cunning and manipulative. They choose a busy surgery time when the waiting room is full and the physician is busy. They sometimes refuse to leave until they receive a prescription for a psychoactive drug. They know enough about the law to give their correct name but a false address so if he or she obtains a prescription it will have his or her name on the bottle in case they are stopped by the police. Bewley and his colleagues (1975) also asked his patients how they disposed of their drugs. They found that only 39% consumed all the drugs themselves, the rest sold, traded or gave away at least a proportion of their prescriptions. Bewley offered GPs powerful incentives to send drug abusing patients away before they could even ask for their favourite drug, or in some cases seeking medical advice unrelated to their drug use. In 1975, drug abusers were, compared to today, few and far between. Those who became in-patients at one of these two large London teaching hospitals could well have been atypical and more difficult than drug abusers as a group. Bewley pointed out that 63% of his sample of drug abusers had a least one criminal conviction for possession of "unauthorised dangerous drugs", 21% had at least one conviction for "supplying dangerous drugs" and 20% had at least one conviction for "forging prescriptions". Certainly a major reason for negative attitudes towards drug users is the fear that drug users are simply trying to secure supplies of drugs rather than help in giving up their habit. McKeeganey and Boddy (1988) used tape recorded, semi-structured
interviews with 23 Glaswegian GPs working in 5 Glasgow Health Centres about 50 consultations with heroin users. Of the 50 consultations, the 5 GPs felt that 29 (58%) were initiated in order to obtain psychoactive drugs. The authors commented that;

"Many of the doctors reported that drug-abusing patients were manipulative in their relationships, that they are adept liars and that they were rarely motivated to give up their drug taking." (pp. 74)

The authors felt that the confusion which this perceived behaviour caused the GPs meant that they could not rely on the normal doctor/patient relationship where the two have shared assumptions about the illness, the symptoms and the means to help improve the situation. Perhaps these sorts of problems diminish when the physician accepts the notion of maintenance prescribing (long term prescribing which seeks to stabilise drug use instead of achieving abstinence in the short term) rather than having hopes of a quick solution. There are no grounds to believe that these 23 GPs are representative of GPs as a whole but their responses seem to be consistent with other studies.

Advice about prescribing was to be found in the Advisory Council on the Misuse of Drugs report, "Treatment and Rehabilitation", 1982. Warnings were issued to GPs about the dangers of prescribing to problem drug takers and gave 4 reasons why they should be weary:

1/ They lack specialist knowledge.

2/ Drugs they prescribe may end up being sold on the
illicit market.

3/ They may not be able to withstand the pressure put on them by problem drug users and if they prescribe will find that word spreads that they are an easy target.

4/ They lack the support of other professionals.

The report stops short of suggesting that all GPs simply refer problem drug users to specialist agencies but gives them little encouragement to entertain them as patients.

In recent years GPs, especially in some areas, are more likely to come across problem drug users than in the past. Bucknal et al. wrote in the British Medical Journal (1986) that their practice in Edinburgh was treating 164 heroin users and that their mean attendance rate for treatment was once every 5.5 weeks over a period of 3 years. Bucknal and his colleagues noted that most attendances had nothing to do with attempts to obtain drugs. Many of their patients were already on prescriptions for controlled drugs. They concluded that the Department of Health needs to realise that GPs provide most of the medical help which is required by problem drug users and that hospital clinics see a numerically smaller group of problem drug users. It needs to be noted that Edinburgh at that time had a high prevalence of problem drug use and a notable lack of specialist services for problem drug users.

Bell et. al. (1990) concluded after a survey of 206 General Practitioners in Inner London that,

"GPs generally regard opiate users as especially difficult to manage, beyond their competence to treat and
less acceptable as patients than others in need of care."
(pp. 56)

By this time, opiate users were not uncommon and 78% of the GPs surveyed said that they had seen one or more in the last year. Only 30% of the respondents felt that general practice was the appropriate place for them to come for help. The results need to be interpreted cautiously because the response rate was less than half (49%) and Inner London may produce more problematic drug users than the country as a whole.

Glanz (1986) conducted a much larger and satisfactory survey of all General Practitioners in England and Wales. He surveyed a random sample of 5% of all GPs in 1985. He received a total of 845 returns from his postal questionnaire representing 72% of the GPs who were sent questionnaires. Those GPs who did not respond were similar to those who did in terms of the numbers of patients on their lists and the number of partners in the practice.

Glanz and Taylor (1987), using the same information, found that about 1 in 5 GPs had contact with an opiate misuser during a four week period. Their attitudes towards this group were similar to other studies. A total of 76% agreed or strongly agreed with the following statement;

"Misusers of heroin/other opiate drugs are likely to present more severe management problems for the general practitioner than any other types of patient." (Glanz & Taylor, 1987, pp. 33)

Only 10% disagreed or strongly disagreed, with 13% uncertain. Not surprisingly, they are reluctant draftees in the war on
drugs. Only 31% agreed or strongly agreed with the next statement;

"I am prepared to undertake the treatment of heroin/other opiate drug misusers as willingly as any other type of patient in need of care."

Almost half (49%) disagreed or strongly disagreed with the above statement and 20% were uncertain. One of the variables mentioned by Glanz and Taylor was age, younger GPs seemed to be somewhat more favourably disposed towards opiate misusers than older GPs.

Another survey by Abed and Neira-Munoz (1990) had similar results from a survey of all GPs in Norwich Health Authority in 1985. They collected 203 questionnaires from this group, representing a 87% response rate. This group of GPs, however, were not as experienced with problem drug users as the group that took part in the survey by Glanz and Taylor. Only 37% had any contact with "drug addict patients" over the last 12 months.

When asked to agree, disagree or record uncertain to the following question;

"Drug addicts are deceitful, unreliable, unwilling to cooperate with treatment" (Abed & Neira-Munoz, 1990, pp. 134),

about 2/3 of GPs agreed and less than 1 in 10 disagreed, the rest were uncertain. Again, younger GPs were more well disposed to addicts than older GPs.

Acquiring attitudes towards people who suffer from alcohol or drug problems probably start long before Medical School is
even contemplated. Chappel and Schnoll (1977) suggest that medical students are heavily influenced by attending physicians in their training;

"Negative attitudes toward chemically dependent persons are often taught indirectly in the medical school. Pejorative statements made by attending physicians about 'junkies and winos' are a familiar part of medical education." (pp. 2318)

They go on to say these attitudes are entrenched and that only long, intensive courses designed to challenge those attitudes can succeed in altering them. One way or another, the impressions of the problematic drug user has become part of the folklore of medicine. It must not, however, be assumed that the poor reputation of problem drug users is not at least in part the result of the behaviour of some. What is significant is how all problem drug users are seen to be the same and how attitudes are passed on from one generation of physicians to the next.

From attitudes such as these it is not difficult to detect the beliefs and models which are implied. Perceiving all problem drug users as manipulative, deviant and troublesome suggests one of two models. The first is a moral model which implies that problem drug users are simply unscrupulous and degenerate and require help from the church or the police once they break the law. The second is a medical/biological model which suggests that they suffer from a personality disorder. The recognition that injecting problem drug users are at high risk from HIV/AIDS did nothing to change those attitudes, beliefs
or models.

Ronald et. al. (1992) recorded the experience of one GP practice where both problem drug use and HIV/AIDS was common. This particular surgery (in Edinburgh) identified 432 problem drug users and those with HIV/AIDS over a period of 10 years, 1981-90. Drug users were described as manipulative (Ronald et. al., 1992,) and he suggests that they change doctors frequently because of their lifestyle and because they may have been "struck off" by other doctors. It is difficult to generalise to all GPs from the experience of this Edinburgh practice. Edinburgh has a history of a high prevalence of HIV (Ronald, et. al., 1992) and underdeveloped specialist services for problem drug users. Also, until recently it was difficult to obtain a long term prescription for opiates. These factors alone could have added to the burden of providing medical care for drug users from this one practice.

Even in comparison with other problematic patients such as those suffering from mental health difficulties, benzodiazepine or alcohol problems, those with illicit drug problems are seen as the most burdensome.

In Australia, recent research using convergent focus groups (Roche et al., 1991) found that General Practitioners were not well disposed towards opiate users. When compared to other substance users (i.e. tranquilliser users, those with alcohol problems) they were described as being the least favoured patients.

Greenwood, a former GP and now psychiatrist in charge of Edinburgh’s Community Drug Problem Service, recognised the
irrational aspect of some GPs in their attitudes towards problem drug users;

"A variety of emotional reactions and beliefs, some rational and some irrational, seem to interfere with normal coping mechanism and medical rigour."

(Greenwood, 1992, pp. 8)

She further warns about the dangers of turning those emotional reactions and beliefs into dogma enforced by policy. She cites a number of reasons why they can be difficult patients, including difficult to interpret local accents, use of jargon and swearing, aggression or sometimes violence when drug users are seeking drugs and the fear that they may alienate other patients. Other reasons may have to do with the time and cost (especially now that so many GPs are fund holders) of seeing and prescribing for problem drug users. More money, however would probably not significantly alter the reluctance of many GPs to treat problem drug users.

Her article is a thorough examination of the difficulties in treating this group of patients and if not read with a sympathetic view could deter a GP from ever treating problem drug users. Her remedy in managing this client group was to work in close harmony with the local drug services.

In a letter to the British Medical Journal, Rozewicz et al. (1992) said they surveyed 102 GPs (out of a population of 170) in Croydon. The questions were about what incentives would they choose to increase their involvement with drug misusers. The two most popular options were direct access to a community nurse with special training or more support from a local drug
dependency clinic (42% and 41% respectively). More training, as an incentive, was favoured by only 30% and an enhanced capitation fee was favoured by only 17%.
The reasons for the unpopularity of problem drug users with General Practitioners are not always clear. It may not always be because GPs take a moral position against the perceived indulgence of this group. It may also have to do with the totality of the social, health and personal problems that this group of patients presents. One Edinburgh GP (Robertson, 1985) reported that 1/2 of his 162 heroin using patients had presented him with illnesses directly related to their drug use, 38% had jaundice, 5% bacterial endocarditis, many had abscesses, etc. Irrespective of their behaviour when being interviewed by a physician, they may be seen as problematic because of the amount of care they require. This survey represents the patients in just one Edinburgh GP practice and may not be representative of all practices in Edinburgh. The practice covers an area of high social and economic deprivation and this may be a factor in the poor health of its' patient. Also, this practice is well known for its' work with problem drug users and it may attract those who would not be seen or even struck off by other GPs.
McKeganey (McKeganey, 1988) conducted semi-structured interviews and consulted enhanced medical files to look at 50 interviews with problem drug users in a Glasgow GP practice. Nine of 23 doctors interviewed drew attention to the threat of violence they felt when interviewing opiate abusing patients. This was not to say that they all experienced violence, though
some had. Others recounted stories of medical colleagues who had experienced violence or threats. Some GPs recognised that their fear was not always rational but it did not prevent the emotional reaction that fear generates. One GP said;

"I'm terrified when she comes in the room and I think, gosh, why am I so terrified, this girl's smaller than me and she can't get herself together at all so why am I so frightened of her?" (pp.74)

Strang et al. (1991) conducted research to see if General Practitioners in 3 District Health Authorities in the North Western Region could be encouraged to take a more active role in treating problem drug users. By offering close contact with a Community Drug Team, Strang hoped to significantly increase GP involvement in treating problem drug users. Within 3 District Health Authorities he chose a sample of 60% of GP practices. There were 116 GPs working in these practices. For his first interview he achieved a compliance rate of 87% (101 GPs). The researcher also interviewed 15 General Consultant Psychiatrists to see if their involvement with problem drug users could be increased. After the first interview all 3 District Health Authorities received more specialist input from a Community Drug Team. The model which was advocated involved the Community Drug Teams which provided advice and consultation to GPs and Consultant Psychiatrists about most problem drug users and would only see a minority of cases which were proving difficult. In fact, at the second interview the number of cases seen by GPs and Consultant Psychiatrists actually fell rather than increased. It was apparent that, if
given the choice, GPs and Psychiatrists would prefer to refer problem drug users to a Community Drug Team rather than treat them themselves with the advice and guidance of the CDT. Strang offered two explanations for the results. He said that GPs and Psychiatrists may have become disillusioned with problem drug users who rarely wanted help in stopping their drug taking but rather a supply of drugs to continue it. He cited the difficulties that problem drug users have in following treatment regimes and that GPs quickly became disillusioned with non compliance and missed appointments. Many were not prepared to provide maintenance prescribing and many were reluctant to prescribe anything because they were afraid of being deceived. The second reason which Strang cited was that most GPs and Psychiatrists felt that problem drug users mainly required counselling rather than medical input and that they neither had the time or inclination to provide time consuming counselling. Strang did not ask about the attitudes of the physicians towards problem drug users and he may have simply missed a key issue, that physicians as a group find problem drug users difficult and at times threatening. The need for more training and education about problem drug use was cited by over 80% of GPs as essential if they are to take a more active part in helping problem drug users. In practice though, only 24% availed themselves of the training offered.

In an unpublished survey by Short (1989), 56 of 141 GPs from North Derbyshire (40%) returned a questionnaire which asked them about their attitudes and treatment of problem drug
users. He found that 91% of North Derbyshire GPs who responded to the survey felt that drug misusers were less compliant than other patients and that 40% thought that this group provided a greater problem than any other (kind) of patient care. Furthermore, 55% felt that they were deliberately lying, 68% felt that they would abuse the doctors trust and 92% thought that they would not take their prescriptions appropriately. While the response rate was low, the data supports other surveys which questioned GPs about their attitudes towards drug users.

Sometimes a negative attitude toward drug users and their motivation to stop using drugs can motivate GPs to consider maintenance prescribing. Cohen and Shamroth (1990), two GPs in London, reviewed the cases of 85 illicit drug users referred to them from needle exchanges or local drug projects. They felt little hope for immediate change in just over 1/2 of this group and decided to prescribe oral Methadone for 44 (52%) who they described as having several features in common;

"...manipulative behaviour; continued to identify with their peer group sub-culture; isolated from normal society, failed to keep appointments; failed to comply with previous treatment programmes." (pp. 316)

They went on to say that they felt uncomfortable with prescribing controlled drugs for long periods but realised that hopes for an instant remedy were unrealistic. They drew an analogy that it had to be dealt with like any other chronic illness, i.e. compromise on the best possible management.
solution rather than seek an immediate solution. The most recent advice from the Department of Health came in the form of a 57 page booklet ("Drug Misuse and Dependence: Guidelines on Clinical Management", Department of Health 1991) sent to every GP in the country. It emphasises the view that drug misusers are not all the same;

"2.3 Drug misusers are a heterogeneous group of people. They include adolescents experimenting with drugs, illicit drug users whose lives are centred on drugs, stable long-term drug users and patients who have become dependent on prescribed drugs." (pp.ix)

It includes some mention of unhelpful attitudes towards drug misusers;

"Doctors often have the impression that patients who misuse drugs are difficult and unresponsive to help." (pp. 10)

Despite this, it leaves not doubt about the doctors responsibilities;

"Drug misusers have the same entitlement as other patients to the services provided by the NHS. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs." (pp. 9)

THE ACQUISITION OF ATTITUDES, BELIEFS AND MODELS

It could be argued that the folklore about the difficulties in treating problem drug users is the result of negative articles in journals and the results of junior doctors acquiring the
attitudes of more senior physicians who they rely on for good references and not the result of clinical experience. If this were the case, then once physicians gained some experience in treating problem drug users their negative attitudes would dissipate. Physicians who regularly treat problem drug users should have more positive attitudes than those who rarely treat them. This is by no means always the case. Sowa and Cutter (1974) asked the staff at the Washingtonian Centre for Addictions to select a list of adjective to describe the characteristics of alcoholics and drug addicts. A total of 82 staff took part in the study representing 80% of the staff at the Centre. The adjectives were derived from the Gough Adjective Check List and were rated either positive or negative. Each adjective was used to characterise drug addicts or alcoholics to a "great degree" (2 points), an "average degree" (1 point) or not at all (0 points). Sowa and Cutter hypothesized that staff involved in the therapeutic care of alcoholics and drug addicts would have more favourable views than those who were not involved. The authors divided the staff into low, middle and high status groups. Doctors, social workers, senior administrators and psychologists were accorded a high status group. It was this group which had the most therapeutic input that had the least favourable attitude towards both alcoholics and drug addicts. These results need to be interpreted with caution because it is not known how many of the high status group were doctors or precisely how much experience they had in working with these groups. Sowa and Cutter thought that the reasons why the high status group
had more negative attitudes towards alcoholics and drug
addicts was because of the social distance between the groups
and that low status staff perceived less of a social distance.
Also, the authors thought that the higher status groups were
more involved in assessment and that some of the adjectives
could have been used in the technical vocabulary applied in
psychiatric diagnosis. The authors concluded, however, that
the primary reasons for the negative attitudes though were the
most obvious;

"First, they may be value judgments with a flavour
of moral failure." (pp. 214)

First-year Psychiatric Residents in Boston City Hospital (USA)
were asked to complete attitude surveys regarding drug abuse
and drug abusers. Gertler and Ferneau (1974) used a sample of
just 6 first-year residents and had them complete a Drug Abuse
Questionnaire which was a modified version of an Alcoholics
Questionnaire developed 10 years earlier at the Alcohol and
Drug Research Centre in Toronto, Canada. The authors simply
substituted the words drugs for alcohol and addict for
alcoholic. The questionnaire was comprised of 40 statements
answerable by rating, on a scale of 7, their complete
disagreement (rated 1) to their complete agreement (rated 7).
They were given the questionnaire before they began their work
in a section of the hospital which treated drug addicts and
retested after they completed a year working with this group.
The authors concluded that the 6 Residents were generally
ambivalent in their attitudes towards drug addicts before they
began their work. After a year, however, they were less
certain that emotional factors were a key causal element in formation of addiction. Belief in emotional factors was seen as an indication of positive attitudes towards drug addicts and this belief did not increase as a result of experience. They became more aware of social factors and the authors concluded that this was their way of depreciating drug addicts. Compared to alcoholics, drug addicts do not come off well;

"Drug addicts, by virtue of their generally well defined, anti-social behaviour and personality, extract a more uniform response from individual residents" (Gertler and Ferneau, (1974), pp. 373)

The use of a modified alcohol questionnaire may not be appropriate for determining the attitude towards drug users and the small numbers of doctors in residency surveyed makes the conclusions of the authors tenuous.

DRUG USERS IN ACCIDENT & EMERGENCY DEPARTMENTS

Ghodse (1978) surveyed the hospital staff in 62 of 66 Accident and Emergency (A&E) Departments in London. From the 1350 questionnaires which were distributed, 1248 were returned (92%). A total of 189 (15%) were from Medical Staff but there was no indication of what the response rate was from the total population of medical staff in the 62 A&E Departments.

Ghodse, using a Likert Scale, asked A & E staff how favourably they viewed 3 types of overdose patients; those who overdosed as a result of their drug dependence, deliberate self-poisoning and accidental self-poisoning. Not surprisingly, the accidental self-poisoning patients were the most
favourably rated - 75% were rated highly or moderately favourable, the deliberate self-poisoners were next (51%) and the patients who were drug dependent were least favourably rated (30%). Medical Staff were even less favourably disposed to drug dependent over-dose patients than the rest of the A & E staff (26%). Ghodse found no statistical differences in the attitudes of senior or junior medical staff in his sample. Ghodse et al. (1986) carried out a similar survey in an Accident and Emergency Department in Malta. In this survey he found that 31% of physicians held "unfavourable attitudes" towards patients diagnosed as alcoholic compared to 34% having "unfavourable attitudes" towards drug dependents. This part of the data is confusing because the two other possible attitudes towards drug dependence tested for are "favourable", 42% and "neutral", 44%. The total of the three possible answers (34% unfavourable attitudes, 42% favourable attitudes and 44% neutral) is 120%! All the remaining attitude groupings equal precisely 100%. Medical students had a far more positive attitude towards drug dependents, only 21% were found to have "unfavourable" attitudes towards drug dependents, 33% were "neutral" and 46% had "favourable" attitudes. Ghodse suggests that the reasons for these unfavourable attitudes are that they do not match the stereotype of the ideal patient, i.e. compliant, undemanding, a victim of a mistake. Overdose patients suffering from alcohol and drug problems are seen less sympathetically than those who are making a genuine attempt at suicide, making suicidal gestures or simply overdosed by accident because they suffered their overdose in
pursuit of pleasure or as a result of over indulgence. Also, drugs and alcohol can have a disinhibiting effect on behaviour and this may not always be taken into account. Ghodse speculates that the poor attitude of Casualty staff may aggravate an already difficult situation. This survey was conducted in Malta. The number of physicians and medical students who took part in the study was relatively small, 57 and 72 respectively. The exact meaning of the study is obscured by the fact that the response rate of doctors is more than 100%!

Ghodse (1986) noted in a later survey of 62 London Accident and Emergency Departments that physicians with the least favourable attitudes were those who had the most contact with drug dependent over-dose patients over the last year. This could simply reflect the fact that most (58%) over-dose victims are drug dependent but could also reflect the fact that they are seen as more aggressive, less willing to take advice and more aggressive than other over-dose patients. Some of the behaviour could also be attributed to the effects of certain psychoactive drugs which alone or in combination with other drugs (especially alcohol) could precipitate aggression or violence. Finally, Ghodse points out that there could be an element of self fulfilling prophecy, i.e. that A & E staff treat drug dependent patients in a way which increases the likelihood of behavioural difficulties.

DRUG USERS WITHIN PSYCHIATRIC SERVICES
Even within psychiatric services, there seems to be a great deal of inconsistency in attitudes towards drug users. Romney
and Bynner (1972) surveyed staff at a Canadian Psychiatric Hospital which treated drug misusers. All staff, including administrative and support staff, were sent questionnaires. Only 209 of a possible 700 questionnaires were returned and used in the study. Within that sample were 60 physicians but there was no information about the size of the total population of physicians at the hospital so it is not possible to say how representative they are. The authors, using a 5 point Likert attitude scale, suggest that doctors find "hard drug addicts" dangerous, unassertive, non-conformist, somewhat introverted and very psychopathic and unattractive sexually. "Soft drug addicts, however, are seen as far less dangerous, sexually attractive, assertive, extroverted, not at all psychopathic and equally non-conformist. Here it is difficult to understand why Canadian physicians should see "hard drug addicts" as dangerous but not assertive. This study is unique in not ascribing problem drug users as assertive or aggressive. It is difficult to draw conclusions from this survey because it is not known how representative the physicians who returned the questionnaire are of Canadian physicians as a whole or even those that work at the hospital involved in the study. Also, the terms "hard" and "soft" drug addicts are not defined, only the drugs are defined as being "hard" or "soft" rather than the 'addicts' choice of drugs and their drug using habits.

THE MEDICAL PROFESSION AND DRUG USERS
Throughout the literature there is a remarkable consistency about the nature of drug users, drug abusers, drug addicts and
addiction as a whole. From the late 1960s, the literature suggests that those who choose to use illicit substances have to be treated differently from other patients. Much of the literature implies that drug users must be suspected of ulterior motives, dishonesty and lying. The literature suggests that the ordinary rules which govern the doctor/patient relationship need to be suspended and new rules adopted. Up until the discovery of the relationship between HIV/AIDS and drug use and the increases in the prevalence of drug use in the mid 1980s, GPs in the United Kingdom were encouraged to simply refer their drug using patients to Drug Dependency Units (Strang et al., 1991). By the late 1980s it was apparent that even expanded specialists services could not cope with the numbers and the General Practitioners were encouraged to provide help for drug users but now with the support and guidance of specialist services within the NHS and the growing voluntary field.

The new advice still implied that drug users were a special case and needed to be managed with great care and attention but called on General Practitioners to do their duty for the sake of public health. The attitudes and beliefs held by some physicians can best be summed up by the title of a recent Australian article on the subject, (Ross and Drake, 1992) "Mad, bad and dangerous to know: dimensions and measurement of attitudes toward injecting drug users".

Other reports have, however, suggested that not all drug users or even problem drug users suffer from psychopathology. In 1981, the Advisory Council on the Misuse of Drugs (ACMD, 1981)
advised that;

"The majority (problem drug users) are relatively stable individuals who have more in common with the general population than with any essentially pathological sub-group. However, for a minority, problem drug taking is sometimes one facet of a serious personality disorder or even a mental illness. There is no evidence of any uniform personality characteristic or type of person who becomes either an addict or an individual with drug problems." (ACMD, 1981, pp. 31,)

That view was echoed by the Royal College of Psychiatrists. In a report entitled "Drug Scenes" (1987), a distinguished panel of well-known psychiatrists and senior academic researchers stated that;

"The best evidence is that no single underlying trait or unique constellation of personality features can be identified as predisposing to drug misuse." (Royal College of Psychiatry, 1987 pp. 43).

They do not discard the notion of personality disorder altogether though. They do caution on its use;

"If one dimension of character disturbance relates to non-specific aspects of personal distress, another dimension relates to a propensity to rule-breaking, to disregard for social expectations, and to a willingness to engage in deviant behaviour. However, it is too easy to leap from postulating that such personality characteristics may sometimes
have a bearing on the genesis of drug taking to the all-embracing assumption that drug misuse must be a variant of so called "sociopathy" or "psychopathy". (Royal College of Psychiatry, 1987 pp. 43,)

Not many years before such a statement would have been considered heresy, perhaps even by some of the members of the panel.

WHAT MODELS ARE HELD BY PHYSICIANS?

Virtually the whole of the literature about physicians beliefs and attitudes towards problem drug users suggests that they hold a consistent model about the nature of problem drug use. That is, that problem drug users suffer from personality disorder and their drug use is simply part of their unpredicatable, anti-social behaviour. Even compared to other unpopular patients, i.e. those with mental health problems and problem drinkers, problem drug users come out poorly. Many physicians were afraid of problem drug users and this was a common feature in many of the studies. Their fear was sometimes recognised as being mostly unfounded.

Some of their collective dislike of problem drug users may be explained by what they see as a challenge to their professional standing. Problem drug users often have very firm ideas about not only the nature of their treatment but about the very drugs which a physician may prescribe (Pearson et al., 1986). Not many patients will have such strongly held views or be so ready to challenge the authority or expertise of their doctor. Physicians often felt that they were being deceived and doubted the sincerity of their drug using patients.
None of the literature addressed the question about the origins of problem drug use. It would be difficult to ascertain this from the literature and this is an area where the current research is relevant. The only treatment which is surveyed in the literature is drug prescribing. Most physicians surveyed were less than optimistic about the efficacy of treatment but various kinds of treatment were not mentioned. There was little data about the eventual outcome of problem drug use but what research can be generated from the literature is pessimistic. This is another area which the current research will cover more thoroughly. While the psychiatric profession has traditionally taken the lead in both treating and theorising about the nature of problem drug use, their views about problem drug use seem to be the least rigid of the professional groups studied and undergoing considerable change. Most recent publications suggest that not all problem drug users suffer from personality disorder and is more optimistic about treatment. Comparing the models held by General Practitioners and Psychiatrists within the current research may suggest considerable differences.
MODELS HELD BY PROBLEM DRUG USERS

The literature about the models of problem drug use held by problem drug users who attend agencies is limited. However, similar to the literature about professionals, there is a substantial literature which addresses the issues of attitudes and beliefs. By reviewing that literature it is possible to deduce data which are relevant to models held by problem drug users.

Broadly, the literature can be divided into 4 categories;

1/ Why problem drug users say they first try drugs and what they think about the attributes of drugs.
2/ Why problem drug users say they seek treatment or help.
3/ What problem drug users think about treatment and the helping process.
4/ What problem drug users think about themselves and other problem drug users.

These groupings roughly correspond to the two categories in which each of the theories of problem drug use are analyzed. They form the basis of the questionnaire;

1/ what is believed about the origins of problem drug use
2/ what strategies or treatment are the most helpful

WHY PROBLEM DRUG USERS SAY THEY FIRST TRY DRUGS AND CONTINUE TO USE DRUGS

Chein and his colleagues (Chein et al., 1964) were amongst the first researchers to interview drug users and ask them about their drug habits. The research was carried out in 3 boroughs of
New York City (Manhattan, Brooklyn and the Bronx). Their sample size was large, between 1949 to 1954 a total of 2,950 young people aged 16-21 were interviewed. The primary sources for finding the drug users were municipal hospitals and the courts. A large proportion of those interviewed were involved with juvenile gangs and consequently the influence of those gangs was paramount to their study.

While the fact that the sample came from the criminal justice system or treatment agencies no doubt biased the sample, the bias may be minimal because so many young people (particularly young men) were in contact with the criminal justice system, particularly from impoverished inner city areas. If the sample is representative, it is probably representative of those inner city areas rather than the population as a whole. Most of the population in the sample were not dependent upon opiates but had used them from time to time, sometimes for many years. During that period in American history, illicit drug use was rare in most parts of the United States.

Chein et al. (1964) suggested that the influence of friends and associates was the most important reason for trying heroin. For most, it was a quick decision, given on the spur-of-the-moment;

"It was raining, and I was tired. I was standing in a doorway when this friend of mine came by. He said, "Want a pick-up?" I said "Sure," so we popped."

(Chein, 1964, pp. 151)

On another occasion a young drug user said that it was at a party where a group of people were using drugs;

"I was at a party. Everybody was having a good time.

65
I wanted to be one of the crowd. I thought, if it didn’t hurt them it wouldn’t hurt me. That started the ball rolling...." (Chein, 1964, pp. 151).

Ninety percent of those interviewed said that their first experiment with heroin was free, usually gratis from a friend. Other delinquents who were offered drugs turned them down, usually because of fears for their health, acquiring the reputation of a drug addict or concern about character deterioration.

Most of these users sniffed the heroin and only a minority injected the first time. Of those who became occasional users, less than 1/2 reported a pleasant experience and about 1/3 a negative reaction (usually nausea). Some persisted through the unpleasant effects until they were gone and then felt the pleasure;

"It gave me a sense of peace of mind. Nothing bothered me, it felt good." (Chein et al., 1964 pp. 158,).

Another said;

"Felt like heat was coming through my body and head. It made me forget all things. Felt like nobody existed but me, I was by myself" (pp. 158).

Nearly all of those who tried heroin had been aware of the positive effects before they tried it.

Other ethnographic accounts tell a similar story. Larner (1964) simply interviewed 12 addicts in New York during the early 1960s. Again it was the influence of a friend which helped to overcome the initial reluctance;
"I guess it was sort of a lark. At that time anyway, we were all off on a kick. I was sixteen years old exactly, and I was walking with one friend on Henry Street, and he asked me, have you ever smoked pot before? I didn't know what pot was, and I had to ask him, so he told me it was marijuana and I almost fell with shock. But then he talked about it, and he explained there was nothing to worry about.....Three months after that I started snorting heroin. I got in on that because it was so cheap..." (Larner, 1964, pp. 35).

This drug user did not appreciate that his subsequent "yawning and tearing" were withdrawal symptoms. A friend had to tell him that the cold symptoms he was suffering from were in reality withdrawal symptoms from heroin.

Many years later Teck-Hong Ong (1989) surveyed 100 drug abusers randomly selected from voluntary treatment agencies in Singapore to complete a questionnaire about the influence of their peer group in experimenting with drugs, continuing to use drugs and becoming abstinent. He found only 17% of drug users used drugs alone, the other 83% were with friends. Friends, classmates, relatives and co-workers were sited 92% of the time as the person who introduced them to drug use. The reasons for using drugs for the first time, chosen from a scale of 21 reasons, which were most frequently mentioned were;

1/ "Curious and wanting to see what it was like" - 76%
2/ "To enjoy drug effects with friends" - 56%
3/ "To try anything new" - 55%
Teck-Hong Ong felt that exploration (1 & 3) was the most important reason, followed by peer group pressure (2 & 4), followed by hedonism (5 & 7) with problem solving (6 & 8) next to last, followed by rebelliousness. The reasons for stopping drug use were because of fear of being arrested, followed by health fears, followed by pressure from friends. The author concluded that peer pressure was mainly a negative influence, i.e. to use drugs rather than seek treatment. The answers about the reasons for stopping drug use may be influenced by the harsh penalties for conviction of drug related offenses in Singapore. The interview group was found from treatment agencies which is similar to this research. They may not be representative of drug abusers in Singapore as a whole. More general questions of peer group influence were asked in the questionnaire and a control group of 100 non drug abusers matched to drug abusers by age, sex, education, etc. were used as well. Ninety-five percent of the sample was male. The author concluded that drug abusers were more prone to peer influence than non abusers. As a test of the validity of the research the author instructed the participants to bring along a significant other (i.e. friend, parent, girlfriend) to check the validity of the answer. This strategy could well have had the opposite effect, that is the respondent may have altered his or her answer because they had a significant
other sitting by their side. Such a result would have been consistent with the findings, i.e. peer group pressure is a key element in decision making about drug use.

In a study of the drug taking career of opioid users, Bennett and Wright (1986) asked 135 opioid users about their drug taking careers and why they first tried opiates. They acquired their sample from six sources which included 2 Drug Dependency Units (DDUs), one General Practitioner within the NHS, one Private Practitioner, and two separate groups of illicit market users. The average age was 29.4 years and there were 99 men and 36 women in the group. The main method was a combination of semi-structured and structured interviews which were tape recorded and later transcribed.

Like the drug users from Singapore (Teck Hong-Ong, 1989) curiosity was the most important reason for 5 of the 6 sub-groups in the Wright and Bennett study. The second most important reason was deemed to be to "share in the addict lifestyle" (Bennett and Wright, 1986, pp. 5). This is similar in many ways to being influenced by friends. The other answers which were chosen far less frequently were, "self medication", "availability" and "other".

The cohort used by Bennett and Wright was reasonably large but the sub-groups were only between 11 and 40 subjects. It had the advantage of being drawn from two localities (Bristol and Cambridge) and included 36 opioid users who were not being treated.

Pearson et al. (1986) asked a number of heroin users why they first used heroin. Nearly all of their sample had tried other
drugs previously and no doubt had impressions from other heroin users on the effects of the drug. Their answers tended to be of two types. The first type suggested that they experimented with the drug and found it to be intensely pleasurable;

"First, when I was on it, like, I dunno....it made me feel dead pleasant, I dunno....as if I never had a care in the world......."

"It was just the nicest thing going. You feel great! Just....phoo..." (Pearson et al., 1986, pp. 39)

The second type suggested that it temporarily solved all your problems;

"I’d just finished with my girl.....and I suppose I was on a bit of a downer myself like, a bit depressed and all that. As I say I took some heroin, and all my worries that I had just seemed to float away"

"Tek’s all yer worries away and them becomes a bigger one itsen." (Pearson et al., 1986 pp. 40)

Though the number of heroin users was small, Pearson et al. selected the sample by means of a snowball methodology rather than the usual route of treatment agencies. They are probably more representative of heroin users as a whole than samples drawn from treatment populations.

Whether young people who describe themselves as primarily Heroin users are representative of problem drug takers as a group is another issue. It is likely that other drugs are not quite so pleasurable as Heroin (with the possible exception of cocaine) and therefore would be less likely to be valued so highly.

Brown et al. (1971) surveyed 214 addict-clients from 3 treatment
facilities in Washington D.C. They asked addict-clients about critical periods of a drug using career such as the reasons for first drug use, reasons for first withdrawal, and the reasons for first failure at withdrawal. Like Tek-Hong Ong, they found that "curiosity" (sited by 45% of adult males, 40% of adult women and 29% of juvenile males) and the "influence of friends" (43% of adult males, 51% of adult females, and 66% of juvenile males) were the two most powerful reasons for using heroin for the first time. "Seeking a high" was said to be the reason by 16% of adult males, 6% of adult females and 15% of juvenile males. This was a much lower proportion than the Singapore sample when compared to the similar "hedonism" questions asked by Tek-Hong Ong. "Relief of personal disturbance" was seen as even less important than the Singapore sample (16% of adult males, 20% of adult females and 12% of juvenile males). The reluctance of American addict-clients to site "seeking a high" as reason for their first use of heroin may be the result of the influence of the treatment programmes from which they were recruited. Many American drug rehabilitation programmes are confrontational in nature and would probably find, "seeking a high" as unacceptable.

Jurich and Polson (1984) asked a small group of Kansas high school adolescents who were classified as "drug user" (those who occasionally used 'non-addictive' drugs) and "drug abusers" (those who were physically and psychologically dependent upon drugs and used them daily) about the reasons for their drug use. They found that drug abusers were more likely to be motivated to use drugs for reasons of "escape" (12 of 24 abusers interviewed) or "relief of personal stress" (17 of 24 abusers interviewed)
than drug users who were motivated for reasons of "escape" (8 of 24 users interviewed) or "relief of personal distress" (6 of 24 users interviewed). Abusers were also more likely than users to mention "external locus of control" more than users, (18 to 9 respectively) and "disillusion" (19 to 8 respectively). There was little identification with the counter culture for either group as only 5 users and 5 abusers felt that rebellion was a motivating factor in their drug use. It is hardly surprising that drug abusers are having more difficulties with their drugs use than those who use far less often. Only two questions about the reasons for drug use which had a positive connotation, "improvement of self-concept" which no one from either group mentioned or "recreation", which was referred to by 18 users and only 4 abusers.

The sample group in this study was small and the means by which people were divided into two groups - abusers and users was less than rigorous. Even one experiment with cannabis many years ago might have meant someone was categorised as a "user". Also, users only used "nonaddictive" drugs without specifying what those drugs are. Alcohol was classified as a "nonaddictive" drug? Finally, the categories which formed the basis of the analysis of the interviews was said to have been derived from "reading the literature". Nearly all the reasons mentioned were negative rather than the more positive reasons (i.e. enjoy the effect of drugs) used in other surveys.

While most people recognise that some drugs, like cannabis, can be used without problems, some researchers have suggested that even drugs which can quickly produce physical dependence do not
always do so. Blackwell (1983) found that not all opiate users were physically dependent on opiates. She interviewed 51 opiate (mainly heroin) users and found her sample from advertising in magazines and personal contacts. She also asked those who she interviewed to provide more names and this produced 13 of the 51 respondents. A total of 12 of the 51 interviewees were women, the other 39 were men.

Most of her sample came from advantaged backgrounds, i.e. 90% of their fathers’ occupation were in the top 2 census categories of occupations compared to 23% of males in Great Britain. The sample population was well educated compared to opiate users drawn from London Drug Treatment Centres, 63% had achieved degree or diploma entrance qualifications, a university degree or diploma. This compares to only 5% of the Drug Treatment Centre population (Blackwell, 1983, pp. 222). Not surprisingly, her sample was mainly employed (71%) and many of them had academic or professional jobs or career oriented employment.

Blackwell established that only 14 (all men) of her sample of 51 opiate users were physically dependent at any time and only one was physically dependent at the time of interview. She found that the group which she sampled were either "drifters", i.e. they moved readily between a sub-culture which accepted opiate use and more conventional society, "controllers" who recognised the addictive properties early and established rules of use to diminish their potential dependence or "overcomers" who acquired a physical habit but managed to end it before losing their jobs, status, non-drug using friends and family.

The author did not ask why they first tried drugs. She says she
assumed they found it pleasurable. She did find that most then (even if they became addicted later) entered a period of "drifting". They used opiates when and where they found them but did not go out of their way to obtain the drug. She felt that this happened at social events and concluded that for this less problematic using group that drug use was both a pleasure and a social event. Drifting became more problematic when the user identified more strongly with a drug using sub-culture and was therefore more likely to come into contact with heroin more frequently. Those who had good jobs and careers found "drifting" less likely to lead to addiction. Also, women seemed to be better at "drifting" than men. Blackwell suggests that this is because women are excluded from the distribution system and therefore are more passive in their drug use. Dealing required a stronger commitment to the drug sub-culture and women, for the most part, were excluded from this activity.

This population of problem drug users is very different from those samples drawn from treatment agencies. Despite having the financial resources and contacts to obtain opiates, they chose to use it occasionally, develop rules to minimise the chances of addiction or if addicted, find strategies to overcome their addiction. Perhaps it is their social position and education which makes this pattern of drug use possible. Social position, education and valued employment could be a prophylactic against more problematic use. These attributes offer reasons not to use drugs because they are valued and drug use is a threat to them. The reasons for first trying and using drugs was a feature of research conducted by Awiah et al. They conducted interviews with
Asian men and women about their experience of drugs and services. They found that Asian cannabis users did not see the harm in the recreational use of cannabis but rejected both heroin and heroin users. Heroin users, on the other hand, gave a variety of reasons for trying and continuing to use heroin. Most, however, said that they were influenced by friends to start. Others gave reasons that suggest social and economic reasons;

"It's the people who have nothing to look forward to. They're the ones who'll get hooked on it. People who've got a bit of self-respect and they know they've got something to do with their life, they won't."

(Awiah et al., 1988, pp. 17)

Other Asian drug users considered that it was an act of rebellion;

"You start smoking powder and drugs just to, only reason you're doing that, believe it or not, is trying to get your parents' attention......" (Awiah et al., 1988, pp. 17)

Some young Asian heroin users felt that it gave them respect from their peers;

"All my mates thought I was big, right. That's what influenced me more 'cause they thought, ah, look at him. Yeah, yer hard, smoking powders and all this" 

(Awiah et al., 1988, pp. 17)

Clearly there are a variety of reasons why people first try illicit drugs and go on to use them more regularly. However, two reasons seem to stand out and that is curiosity and the influence of friends. Sometimes the decision seems to be almost
nonchalance, a quick decision made on the spot. Addiction rarely seemed to follow immediately. Bennett and Wright (1986) found that of their cohort of 135 opioid users drawn from 4 treatment agencies and two groups found using a snow-ball technique, that for each sub-group, the period of time between first opioid use and daily use was longer than one year for 5 of the 6 sub-groups. Between 19% and 35% became addicted after 3 years. Addiction was not the inevitable consequence of using heroin. Chein et al. (1964) showed this to be true with delinquent drug users in New York in the 1950s and Blackwell (1983) demonstrated the same with middle class opiate users in London in the 1980s. All surveys which ask drug users about their first drug experience suffer from the inevitable distortion when past experiences are interpreted with the aid of hindsight many years later. Yet there is a consistency in replies which is striking over time and much the same between men, women, black people and whites.

The reasons for first drug use in the literature would suggest a social/economic model more readily than a biological or psychological model. Relief of distress was rarely mentioned as a major reason for trying any drug for the first time. Curiosity and the influence of friends were the most frequently quoted reasons. Problems with relationships, especially parental, were rarely mentioned. Childhood problems did not arise as a source of first drug use either. This suggests that psychological models are not relevant. There may be differences between those recruited from agencies and those recruited by other means. Those recruited by other means, such as the snowball method, were
far more likely to have more control of their drug use. The association of problems with drug use may be a precursor to becoming involved with a treatment agency, or perhaps may be learned at the agency itself.

WHAT DRUG USERS THINK ABOUT DRUGS AND ADDICTION

Severow et al., (1972), conducted a study which sought to examine the attitudes of heroin addicts towards addiction and compare them to the staff of a Methadone Treatment Programme. The population chosen was from a group of 120 heroin addicts who were being treated for their addiction. The patients were chosen randomly but there was no information about the size or characteristics of the whole group of patients from this agency. On average, they had been in treatment for 5 months. Twenty percent of those approached refused to be interviewed.

The group was randomly divided into two and each administered a questionnaire consisting of forty statements, each of which the subject rated, on a scale of 7, according to their opinion of the correctness of the statement. One questionnaire was about drug addiction and the other about alcoholism. The original questionnaire was developed as an instrument to measure attitudes towards alcoholism. The authors adapted it for use in assessing attitudes towards drug addiction.

The results suggested that addicts believe that they experience loss of control over their drug using habit and that they suffer from a character defect. They also believe that most drug addicts come from the lower socio-economic strata of society and that heroin is a highly addictive drug. Addicts had low expectations of their prognosis. They were not willing to accept that drug
addiction was an illness (as were staff) and are more willing to see their addiction as a harmless indulgence compared to staff. The authors say that the patients can not be regarded as typical addicts on the street. They interpreted their participation as a sign that, as a group, they were highly motivated to achieve abstinence. It could be, however, that the opposite is true, i.e. that as a group they were highly motivated to continue their addiction through prescribed Methadone use! The refusal rate was high, 20%. There was no normative data on the questionnaires, and only a brief comparison between addicts attitudes compared to staff and addicts attitudes towards drug and alcohol addiction. The authors did not reveal the numerical results of the questionnaire but merely stated trends, so it was not possible to examine the data.

As most research populations are drawn from treatment agencies, it seems likely that problem drug users attitudes towards drugs and addiction are influenced by the agency. Conversely, it may be the case that in areas where there is a choice of agencies, problem drug users will more likely gravitate to those agencies where attitudes towards addiction and drugs are closer to their own. This is not to minimise the immense differences in attitudes which may exist between staff and clients or patients at treatment agencies. Most treatment agencies will see it as their duty to try to change the attitudes of their clients or patients towards a more negative stance on drugs, an inevitable source of conflict.

Attitudinal differences among the clients and staff in diverse treatment agencies was the focus of research conducted by David
Nurco and his colleagues (Nurco et al., 1988). Data was collected from a large sample, 783 addicts and 230 staff, from 24 drug treatment agencies in 5 states. The addicts were mainly white (57%) and the remainder were black or Hispanic. The ratio of men to women was 2 to 1. The agency staff was 51% white, 38% Black, 10% and Hispanic. The agencies were divided into four types, Abstinence (A) agency (those promoting only abstinence), Methadone Maintenance, abstinence, and Naltraxone (MAN) agencies, Methadone (M) only agencies, and MA agencies which are Methadone maintenance and abstinence. Over half (61%) of the addicts were recruited from the MAN type agency. There are 6 agencies in each group. All the addicts in the Abstinence programmes were Black. The researchers developed a 142-item questionnaire whose content areas included, the nature of addiction, the origins of addiction, ways of dealing with addiction and personalities and characteristics of addicts. A factor analysis was performed on the questionnaire and from that 5 scales were drawn. The first of these scales is called drugs OK. This scale measures respondents attitudes towards the notion that drug taking is a normal pursuit, no different from using legal drugs such as tobacco and that society and its laws are the problem. Those clients from abstinence orientated programmes (type A) were far more sceptical of this notion than those who attended programmes using Methadone.

On the scale labelled addicts need control which mean that addicts are irresponsible and dangerous, in need of punishment rather than treatment, those from type A agencies were more in favour of this view compared to those from Methadone programmes.
The same was true about the factor labelled ex-addict/methadone good, and group good which is the factor about the efficacy of group therapy and self help, those from abstinent agencies were far more likely to agree. When considering the last factor addicts can change, which suggested that treatment is better than punishment and that prescribing drugs is bad, those from Methadone programmes were more likely to be given a significantly higher scores. The scoring of staff has been discussed in other sections of the literature review.

This study used a large cohort from 24 agencies but there are no addicts who are not in treatment. While the sample represents treatment populations it can not be ascertained if it is representative of addicts not in treatment. Like all questionnaires, it relies on reasonable levels of literacy which can not always be guaranteed.

Paterson and Hammersley (1990) theorised that heroin users have more positive attitudes towards drugs than a matched group who are not heroin users. They also investigated how heroin users think about themselves and other drug users. They recruited a study group of 21 heroin users (those who have used heroin at least 5 times in the last month) from 3 drop-in centres and one drug-free centre in Strathclyde. A matched group (in age, employment status, and sex) was recruited from an unemployment centre. The questionnaire was divided into three parts; attitudes to drugs, attitudes to drug users and dealers, and attitude to treatment and law enforcement. All questionnaires were answered on a 7-point Likert type scale. The results indicated that attitudes to heroin were virtually the same for the heroin and
the control group. Most subjects in both groups agreed that heroin was addictive, harmful to health and harmful to the quality of life. Heroin users, though were more favourably disposed towards cannabis than the control group. Both groups had distinctly negative attitudes towards "crack" cocaine but the heroin users thought it as even more highly dangerous than the controls. They saw themselves as less deserving of punishment than the control group and were almost as prepared as the control group to punish dealers. The term 'dealers' was not defined and it may be that the control group would consider some of the activities of the heroin group as 'dealing' whilst the heroin group may have only considered a certain level of dealing as sufficient to be described as 'dealing'. Both groups favoured treatment for heroin users. Neither group had strongly negative stereotypes of dealers or users. Both groups rated alcohol as dangerous and tobacco as relatively risk free.

The study suggests that heroin users have quite similar attitudes towards drugs, drug users, treatment and punishment as a control group who do not use heroin. Explanations of this similarity may be that heroin use is now so common in Strathclyde amongst the unemployed that even those who do not use it share most of the same cultural values as those who do. Could the increased prevalence of heroin use be making it less deviant? Still, while producing notable results, the survey sample was small and confined to one geographical area. This alone could have accounted for the unexpected results.

Drug preference and means of administration have been shown to be correlated to attitudes about drugs by Gossop and Connell.
The subjects were 50 drug-dependent individuals who presented as patients at the Drug Dependency Unit of the Mausdley Hospital in London. They were receiving either in-patient or out-patient treatment at the time. All subjects were multiple drug users though they each had a preference for one drug or another. They were divided into 4 groups, injecting out-patients, injecting in-patients, oral out-patients and oral in-patients. Their mean ages ranged from 22 to 25 years and the ratio of men to women was 5 to 2. Mostly they were Caucasian, few were regularly employed. Two instruments were presented to the subjects, the first was simply a list of drugs which they ordered in preference and marked the ones which they would not take. Also they were asked to order the means of administration which they preferred. Secondly, they were asked to complete a version of the Osgood Semantic Differential which was altered to enable it to be applied to their preferred drug and nonpreferred drug as determined by the first questionnaire, and also heroin and methadone.

The results showed that intravenous users, heroin and methadone were the preferred drugs while oral users had a larger repertoire. In all groups, Methadone linctus was the least favoured form of the drug. It was also shown that oral drug users had a somewhat more favourable attitude towards both preferred and non-preferred drug than the injecting groups. The mean length of time each group had been using illicit drugs was similar. This could be the result of oral drug users having had fewer health problems than injecting drug users and therefore having less reason for feeling negative towards drugs. For injecting drug
users, both methadone and heroin were more favoured than it was for oral users. Injectors felt that heroin was far more potent than any other drug and oral users felt that their preferred drug not to be very strong.

The authors drew several conclusions from the results, including confirmation that oral methadone linctus is the drug associated with the least gratification for oral and injecting drug users. This may be interpreted as giving credence to charges of some drug users that doctors are trying to take the fun out of drug use. Another result which they found disheartening was how highly valued drugs were to both in and out patient clinics, thus questioning the motivation of their patients to simply obtain a cheap, legal supply of drugs rather than make efforts to become abstinent.

The use of treatment populations has its drawbacks, which have been mentioned several times. The small number of subjects in this study makes it difficult to sub-divide them into even smaller groups. It does however provide some evidence (inadvertently) that methadone treatment populations may not be all that different from similar drug users who are not in treatment. Both obviously value drugs and it could be argued that those on prescribed opiates have simply found a means of obtaining cheap, legal drugs. Their motivation to become abstinent may be no higher than untreated populations. Indeed it may be less if they feel they have a supply of free drugs without the problems of maintaining a habit.

Attitudes towards drugs and addiction, held by problem drug users, are influenced by a variety of factors. Severow et
al. (1972) showed how stark the differences in theories (such as perceiving addiction as a disease) can be between clients and staff at treatment agencies. At the same time there seems to be a common agreement about the "character defects" of problem drug users. Nurco et al. (1988) demonstrated the influence that agencies have on forming attitudes about drugs amongst their clients in the United States. Gossop and Connell (1975) described the positive attitudes towards drugs held by patients in a London Drug Dependency Unit. Finally, Paterson and Hamersley (1990) suggested that the attitudes towards drugs, dealers and the law held by heroin users and a control group matched for age, locality, etc. are perhaps quite similar, bringing into question the whole notion about how deviant heroin users are in at least some communities.

It is difficult to ascertain what models of problem drug use are held by the problem drug users from agencies surveyed in this section of the literature search. Most of the surveys were about attitudes towards drugs and drug users and fitting attitudes into models is not always possible. The same attitude can be held using different models of problem drug use.

Some features of their attitudes and beliefs are significant. Firstly, those problem drug users who feel that treatment is rarely successful may reflect a "medical/biological" point of view. If personality disorder is the main source of problem drug use and it is by definition untreatable, then problem drug use would also be untreatable. Still, some addicts were directly asked if they considered drug addiction as an illness. Those who were on Methadone programmes, on the whole, did not consider it
as an illness, while those on an abstinence programme were more likely to consider it an illness (Nurco, 1988). Here we may observe the influence of the agency on the models that problem drug users use to understand their drug use.

WHAT PROBLEM DRUG USERS THINK ABOUT THEMSELVES AND OTHER PROBLEM DRUG USERS

In an unpublished MSc. thesis, Diamond (1990) used a repertory grid (an instrument used to measure an individuals concept of "self" in relation to others, the ideal self, etc.) to examine how problem drug users who receive Methadone prescriptions perceive themselves in relation to a 'counter culture', their ideal self, feelings of isolation and alienation and how they understand their own lives. He used a standard repertory grid and altered it to use with problem drug users. Only 12 subjects were interviewed, 8 men and 4 women. Their mean age was 38 years. All had been receiving oral Methadone on a regular basis for at least 2 years and the average length of time for being on Methadone was 7 years.

Diamond concluded that only one of the 12 identified with counter cultural values. Most of the subjects held conventional values and did not feel rebellious. Only 3 felt that their actual self was similar to their ideal self and the rest felt that they had a way to go to reach their ideal self which if not drug free was at least less dependent on drugs. None of those interviewed viewed themselves as being "sick" but rather felt remorse that they were "hooked", i.e. dependent on drugs. They felt that the staff at the Drug Dependency Clinic where they received their drugs had similar views of them as they had. They did not think
that the constructs used by the staff was very different from their own.

Four of the 12 subjects felt that poor relationships with their parents as the most important reason why they first started to use drugs but on the whole they perceived their ideal self as similar to their parents. While 5 of the addicts perceived themselves as lonely, none were isolated or alienated as defined by Norris (1976). Most of the addicts interviewed (10 of the 12) thought that they were working towards an ideal of their self image.

Of the 12 addicts, 9 had a problematic childhood and were either raised by single parents (much less common 25 or 30 years ago than today) or in Local Authority Childrens Homes. Just over half, 7 of the 12, were said to have a low opinion of themselves. The research portrays a picture of older, mainly male addicts on a Methadone prescription who, despite their problems, are able to function relatively well. Most of the addicts had secure relationships, children and a degree of stability.

While this study paints a relatively normal picture of drug addicts it was drawn from a small sample. Initially, 16 subjects were approached but only 12 took part. The refusal of 25% of the potential population questioned could have influenced the results. The average age was 38 years, considerably older than most populations of addicts which appear in similar studies. Many had been prescribed Methadone (mean prescription was 50 Mg. per day) for years. One of the effects of opiates like Methadone is to make the user disregard their personal problems and not worry about the future. The results could be at least in part explained
by the drug itself. Their relatively stable lifestyle and conventional beliefs could be part of the process of nearing the end of their drug careers.

This study suggests that the addicts receiving Methadone were not particularly distressed or anxious about their situation. They had difficult childhoods and some had low self esteem but they were not distressed.

Eiser and Gossop (1979) drew the distinction between addicts feeling that they were "hooked" on drugs and those who felt that they were "sick". The authors suggested that those addicts who perceived their addiction in a way that they were fearful of withdrawal, felt unable to give up drugs and unwilling to try were then described as "hooked". Those who were described as "sick" were those who recognised other problems apart from their drug use, felt that they had no right to continue using drugs and conceived their addiction as an illness. These concepts are not at the opposite end of a pole, rather their relationship is tangential. There were a total of 40 subjects (10 women and 30 men) given a questionnaire (a variation of the Rotter questionnaire which tests the degree in which the participant feels that their locus of control is internal, i.e. within the individual, or external, i.e. within society or another individual) at a London Drug Dependency Clinic. The average age of the participants was 30 years old. Just over 1/2 (22) were prescribed psychoactive drugs from the clinic. Opiates (Heroin or Physeptone) were the preferred drug of 19 of the subjects, 18 of those were in receipt of a prescription, mainly for Methadone. The questions were asked about the individuals personal drug use
and their perceptions about the drug use of other addicts who attend the Clinic.

Most of the drug users had little confidence that they would be able to give up drugs and would not be able to reject the offer of drugs in the future. Women felt much less confident about turning down an offer of drugs in the future than men. Most of the sample saw themselves as both "sick" and "hooked". This was true of both their ratings for themselves and others. Those whose preferred drug was heroin perceived themselves as less "sick" than those who primarily used other drugs.

The sample group was similar to the research by Diamond (1990). The methodology, however, was different. The same criticism of the sample holds true. The purpose of the research was solely to examine how they understood their addiction rather than examine how they understood its origins or treatment.

Lincoln et al. (1973) surveyed young (average age 18) drug users in treatment, along with students and staff, about their general attitude towards other drug users, the police, etc. The sample were multiple drug users but 92% had used amphetamines and 75% had used heroin. Other heroin users, dealers, closely followed by amphetamine users were seen as most unfavourable. More favourable attitudes were prevalent about LSD users and marijuana users. The police were seen as more favourable than LSD users but not as favourably as marijuana users. The questionnaire was from Osgood's Semantic Differential which measures attitudes towards groups of people and ideas.

The results could be a reflection of the treatment programme where it was probable that other drug users and dealers would be
viewed negatively if the treatment programme was effective. Rejection of a drug subculture would be a desired treatment outcome. The authors, in their discussion, suggest that for this reason it can not be assumed that drug users in treatment are different from those who are not. Finally, categorising drug users by the drug they use is difficult because most drug users use a variety of drugs at the same time.

Lindblad (1977) was one of the few researchers to employ a control group to compare self concepts between addicts and a control group matched for age and gender. They were chosen from two geographical locations. The addicts, not surprisingly, were far more likely to have suffered an arrest or record for criminal conviction (99% compared to 44%). They were also matched for class (Middle) and race (White). In order to find a closely matched group, the non addicts were recruited from friends and acquaintances of the addicts who had never used "narcotics". (It is sometimes difficult to know what American researchers mean by "narcotics". It is often used in a generic sense to mean socially disapproved of drugs like cocaine which is not classified pharmaceutically as a narcotic.) They had used other drugs such as marijuana but there is no indication if they used stimulants such as amphetamines. The Tennessee Self-Concept Scale (TSCS) was used. This consists of 100 self-descriptive statements which the respondents reply on a five-point scale. The scale is self-administered.

The results indicate, that on the TSCS, addicts had a much more negative self-image than a normative sample and the control group. (One of the geographical sub groups from the control
sample had a significantly higher level of positive self image than the normative data. (The results of being intoxicated on amphetamines perhaps?). The control group, taken as a whole however, was similar to the normative data. The author also looked at antecedents to the development of self-attitudes. He found that the control group consistently reported more affection, acceptance and trust from parents and significant others than addicts. The control group was more successful in school and reported more limit-setting by parents than the addicts. On the whole, addicts found their childhood much less satisfactory than non addicts. The methodology employed in this study selected a control group which seemed to be well matched to the sample of addicts. Besides the fact that the opiate drug users came from a treatment programme, there is no indication that they are addicted. Surely, not everyone who attends a treatment programme is an addict. It is likely that many of them came via the criminal justice system but this information is not provided. It can not be assumed that they represent addicts as a whole and the number of addicts used in the study is relatively small. The influence of the treatment programme could be crucial. Many drug treatment programmes in the United States in the 1970s employed confrontational techniques which can be destructive to self-image, at least at the start of the programme and the results could be a result of that process. In many ways the 39 drug users interviewed by Blackwell (1983) were similar to the Lindblad sample. Thirty-four of the 39 had suffered an arrest and 23 had been convicted of offenses under
the drug laws. They too, came from predominantly middle class homes. They all used opiates to varying extent and over several years but only one was physically dependent at the time of the second interview. At the time of the first interview 14 were dependent. None had undergone treatment during that year. Most of the drug users did not regularly administer their drug by injecting, most snorted or smoked heroin. Blackwell concluded that only some of those she interviewed suffered from low self esteem, this was not empirically measured. She also felt that those who suffered from low self-esteem were those who were most at risk of becoming dependent. She felt that none of her sample identified with a "junkie sub-culture" and if they referred to themselves as "junkies", it was with irony or wit rather than a serious intent.

MODELS OF PROBLEM DRUG USE

Only one of the above mentioned studies (Lindblad, 1977) used a control group to compare attitudes towards other drug users and attitudes about themselves. Lindblad demonstrated addicts have a less positive self-image compared to a matched control group. He also showed that addicts had a less satisfactory relationship with their parents than a control group. Both of these findings would suggest that the addicts he interviewed suffered from psychological problems and their situation could be explained by a psychological model. In all but one study (Blackwell, 1983) the drug users were recruited from treatment programmes. All of those programmes could have altered the attitudes of their clients and indeed this was no doubt one of the goals of the treatment. One suspects that adopting negative attitudes about
drug users (selves included) is not a long term outcome of most treatment programmes. It may simply be an artifact of the low abstinence rates reported by most abstinence orientated programmes. Blackwells more middle class drug users did not however identify with a drug sub-culture or show signs of a negative self image. She did feel, however that those with low self esteem were more at risk of dependence than those with higher self esteem. She had no empirical evidence to substantiate her view.

Eiser & Gossop (1979) suggest that most of the addicts that they surveyed defined themselves as hooked & sick while the majority of those interviewed by Diamond (1990) did not see themselves as being sick. Both groups came from treatment programmes using Methadone. Those who defined themselves as being sick would closely fit a "medical/biological" model but it is unclear from the literature if this is a predominant view of problem drug users who attend agencies for help.

The notion of an addiction-prone personality was addressed by one well-known American addict, William S. Burroughs;

"Addiction is an illness by exposure. By and large those who have access to junk become addicts....But there is no pre-addict personality any more than there is a pre-malarial personality, all the hogwash of psychiatry to the contrary....Knock on any door. Whatever answers, give it four half-grain shots of Gods's Own Medicine every day for six months and the so-called "addict personality" is there!" (from 'Kicking Drugs: A Very Personal Story', Harper's
WHY PROBLEM DRUG USERS SAY THEY SEEK TREATMENT OR HELP

Pearson et al. (1986) points out that even with heroin, there are different levels of involvement with the drug. They suggest that the different levels of involvement can be labelled:

1/ The non-user
2/ The initial offer and experimentation
3a/ Occasional use on a recreational basis
3b/ The 'grey area' of transitional use
4/ Addictive use

Progression from one level of involvement to the next is not necessarily inevitable. Movement from one level to the next may be a conscious process for some people but for others will involve a subtle process which is not immediately recognised. The authors contend that this is often the case when one moves from a grey area of transitional use to addictive use. It is probable that most drug users are in the grey area of transitional use or addictive use before they seek help.

The reasons given for first trying to achieve abstinence from heroin were recorded by Brown et al. (1971). They found that "efforts to change life pattern" was the most frequently given reason by 39% of adult males and 35% of juvenile males but only 27% of adult females. When referring to their current attempts to withdraw from heroin this had changed to 44% of adult males, 50% of juvenile males and 32% of adult females. "Drug related physical problems" were mentioned by 46% of adult female addicts but only 19% of adult male addicts and 22% of juvenile addicts in their first attempt to withdraw from heroin but only 16% of
adult females, 9% of adult males and 16% of juvenile males. The "expense" of the drug was reported as the main reason between 14% and 18% of the sample and "drug-related family problems" by between 9% and 13%. Fear of the criminal justice system was rarely a factor. None of the adult males or females mentioned "concern about punishment for illegal acts" as being the main reason they first tried to become abstinent and only 13% of juvenile males gave this as the main reason. In their current efforts of achieving abstinence it was only cited by 7% of adult males, 10% of juvenile males and 16% of adult females. This would be a surprising result if this study was contemporary rather than 25 years ago. This is because so many treatment programmes in the United States in the 1990s are attached to the criminal justice system.

These results could come as a consequence of that very treatment programme which likely emphasises personal responsibility, motivation and choice as signs of progress and fear of the law would not feature as a preferred response. While the influence of friends may have been an important reason for first trying drugs, it featured little as a reason for first attempts at withdrawal (less than 5% for adult males and females and only 13% for juvenile males) or for the current efforts either.

Oppenheimer et al. (1988) found a similar group of problem drug users drawn from 3 London treatment agencies. They developed a self-completion questionnaire which comprised 54 items related to reasons for seeking help and further asked if any of the events referred to in the list happened to them in the last 2 years. They also used a self-completion "fears" questionnaire
which dealt with their apprehensions and worries about seeking treatment. Forty-three percent of their sample of 150 (107 men and 43 women) problem drug users had received no previous treatment while 57% had some treatment in the last year. Only 78% were regular opiate users compared to 100% of heroin addicted users in the sample from Brown et al. (1971).

Unlike the method used by Brown et al. (1971), subjects were not asked to give one major reason for wanting to withdraw from drugs but were simply asked about a variety of reasons. The authors performed a factor analysis of the results which yielded 6 factors which were relatively important. These factors were:

Factor 1 - becoming dependent
Factor 2 - supply of drugs
Factor 3 - personal crises
Factor 4 - personal decline
Factor 5 - loss of assets
Factor 6 - was difficult to interpret and was neither named or reported on.

The authors found major differences between the populations of the treatment agencies. There were 3 treatment agencies used in the study, a crisis intervention centre, a residential therapeutic community and drug treatment centre. It is probable that the drug treatment centre offered prescriptions for drugs while the other two were drug free or only offered quickly reducing prescribed drugs. This difference in what treatment means is a major methodological problem. It is likely that most of those who went to the drug treatment centre were aware that the major form of treatment involved receiving a prescription for
controlled drugs. It is difficult to compare that group to the other two where immediate or short term abstinence is the only legitimate goal. How do you compare similar reasons and fears of treatment for those drug users who may be approaching treatment to become abstinent in one agency and possibly increase or maintain their drug use in the other?

Having considered the methodological problems, some of the results, taken from the raw data affirm the results of Brown et al. (1971). The most important reasons stated for coming to treatment were those that are at least similar to Browns et al.'s "effort to change life pattern". A total of 93% of the sample said that their 'life was out of control', that they 'realised they have no self respect' (84%), and that their 'drug problem became chronic' (80%). In Great Britain, where the criminal justice system is thought to be less important a feature in treatment than in the United States, 81% said that they sought treatment because they were 'directed by the court' and 69% because their 'Probation Officer put pressure' and 54% because they were 'arrested'. Concern for physical health was also an important reason for 83% who said that they 'need immediate medical attention' and for 74% who said that they 'feel ill much of the time. In fact, physical health reasons ranged from a high of 83% and 74% down to 10% who said that they 'have had abscesses' and 12% who have 'had serious injuries'.

The Drug Indicators Project (1989) compared 240 problem drug users with 1/2 (120) drawn from 6 local agencies providing services specifically for problem drug users and 1/2 who were not currently using services. Those who were not using local drug
services were found by means of the snowball technique. Some of that sample were found by interviewing the agency problem drug users and asking about their friends and acquaintances, thus starting the snowball. This procedure could have influenced the non-agency sample and may not have been representative of problem drug users in the area. The sample was drawn from the more committed and heavier end of the drug using population. Irregular users and adolescents were probably under represented. There is, of course, no way to know how representative any sample of problem drug users are.

The two groups were similar in many ways; age, sex, social class, criminal activity, health and educational background. The agency group, however, had a drug use history that was 3 years longer than the non-agency group, were more likely to be using heroin and somewhat more likely to be injecting. Not surprisingly, the agency group were more likely to perceive their drug use as a problem. They associated other problems such as physical health, emotional problems and accommodation with their drug use more readily than the non agency group. Similar to the heroin users in Browns study (1971), dissatisfaction with their lifestyle was a major reason for seeking help. Those attending services had a better knowledge of what services were being offered in the area.

The problems of primarily amphetamine users were researched by Hilary Klee (1992). She claims that most studies of problem drug use tend to concentrate on those whose main drugs of choice are opiates. She says that amphetamine use is more common and that opiate users tend to be older. More importantly, she suggests
that only about 10% of amphetamine users are in touch with even the least demanding services (i.e. needle and syringe exchanges). Hartnoll (1992) reviewed the recent literature on help-seeking and suggested that there are broadly 3 main hypothesis which are mentioned by the literature. Briefly, these are;

1/ that seeking help is a function of the severity of the drug users problem drug use.
2/ that help-seeking behaviour is mainly a function of individual characteristics, environmental circumstances and (the) sociocultural context.
3/ that the availability and treatment policies of the agencies are at least in part determinant in seeking help.

Hartnoll suggests that the literature in relation to the hypothesis are mixed, there is evidence that severity of problems is stated as a factor in some studies (Graeven & Graeven, 1983) but in others does not seem to be a factor (Rounsaville & Kleber, 1985).

It is often said that ethnic minorities and women tend not to present for treatment because services are seen to cater for the needs of white, male problem drug users. This hypothesis is not easy to test because there is insufficient data on the prevalence and characteristics such as the gender and race of problem drug users. However, perceptions are important in this regard and it is probable that even if it is not true, the belief that it is could be sufficient to make drug problem drug using women and ethnic minorities weary of approaching services.

Rounsaville & Kleber (1985) compared opiate addicts drawn from a treatment population and compared them to a non treatment group
which was found using a snowball technique. They found that the treatment population was very similar in most ways to the community population but that the treatment population was much more likely to be depressed or suffer from dysphoric symptoms of opiate addiction. Possibly the psychological states (i.e. intoxicated) of the drug users prevented them from seeking help? Finally, the availability of treatment services and the policies of those services is another possible factor. Again, this is a difficult variable to evaluate. While it makes sense that shorter waiting lists, non-judgmental attitudes, acceptable treatment policies and liberal prescribing are probably important there is little empirical evidence to show that this is true. Hartnoll (1992) suggests that one more factor may be important. That is that most drug users (problematic or otherwise) do not define their drug use as a problem. There seem to be no clear cut reasons or themes which are universal which account for why drug users approach agencies for help. Several authors (Pearson, 1986; Brown et al., 1971; Oppenheim et al., 1988) suggest that the reasons are a function of the level of involvement with drugs which the individual has at the time. Fear of dependence, efforts to change life style are frequently mentioned. Broadly, these kinds of reasons would fit a "social/economic" model. Brown et al. (1986), suggested that women were likely to want help for health reasons. This might coincide with wanting to become or believing that they are pregnant, it is difficult to know. Finally, as mentioned before, different kinds of treatment have different goals. Traditionally abstinence has been the goal
of treatment but now most agencies subscribe to a hierarchy of goals advocated by the Advisory Council on the Misuse of Drugs (ACMD, 1989) of which the first goal is to deter needle and syringe sharing in order to prevent the spread of the HIV infection. Abstinence now comes last in this hierarchy of goals rather than first.

If problem drug taking is largely the result of genetic and or biological influences than current treatment prospects (usually based on counselling) would, by definition, be poor. Likewise, if problem drug taking is the result of deep seeded psychological problems than treatment prospects would be poor unless large efforts were made to resolve or at least modify those psychological problems. Finally, if social and economic conditions are the most influential factors than there is little hope for problem drug users until the economy improves and social inequalities are effectively addressed. Yet, there is considerable evidence that many drug users change their behaviour even without treatment. (Robins, 1993).

WHAT PROBLEM DRUG USERS THINK ABOUT SERVICES, TREATMENT AND THE HELPING PROCESS

Recent changes in the National Health Service such as the purchaser/provider split, the introduction of Community Care and changes in the contractual relationship between voluntary agencies and their statutory funders have all given emphasis to achieving customer satisfaction and measuring that satisfaction. Jones and her colleagues, (Jones et al., 1994) surveyed a cohort of 164 drug users from 2 Drug Dependency Units and 2 General Practitioners who were receiving help. All were primarily opiate
users who had been using opiates for 1 to 21 years. A total of 74% of the sample had injected and all but 23 had or were currently receiving a prescription for Methadone. She used a semi-structured interview to conduct her survey.

The survey was conducted on behalf of a District Health Authority to ascertain drug users views on an "ideal" Methadone prescribing programme. They were not asked to rate existing facilities. The drug users felt that some groups (those who are HIV+ and pregnant women) of drug users should have a priority "fast track" through the system. Twenty-six percent said that they would like Methadone available in injectable form, 23% said that they would like a combination of oral and injectable Methadone and 45% said that they would only want oral Methadone linctus. A large majority desired urine testing to ensure that other drugs were not being used with 56% wanting random tests. Only 7% said that there should be no tests. Most of the drug users were prepared to accept that certain behaviour (i.e violence or threats of violence) should warrant expulsion from the programme. A total of 72% said that violent or antisocial behaviour should be reason for being discharged, non attendance (33%), persistent illicit drug use (30%) and the breaking of contracts (26%) were given as other reasons for being discharged. Most of the sample wanted a variety of other services as well. Education and counselling about HIV were the most desired services, 91% and 85%. The majority of other frequently requested services were not about drugs. They included legal advice (83%), counselling for emotional problems (79%), housing advice (79%), etc. The authors of the article felt that the model which most opiate users
promoted was entirely reasonable. There is no way to know if the opiate users attending services are representative of opiate users who are not being treated, much less other problem drug users who may prefer other drugs such as stimulants. Though no names or other markers were recorded, the lack of anonymity which is inherent in semi-structured interviews may also be a problem. Many of the interviews were conducted at the agencies.

Many of the problems which Drug Dependency Units are seen to have in the eyes of their patients were made clear soon after the DDUs opened their doors in the late 1960s and early 1970s. Roberts (1973) interviewed 210 new London DDU patients between November 1970 and November 1971. This was a random sample of 3/4 of all new DDU patients. There were three criteria which had to be fulfilled in order to take part in the survey; they must have injected, they must have been seen by a doctor at the clinic and they must not have received a regular opiate prescription before. The respondents were administered a semi-structured interview which was part of a larger survey which looked at the differences between those who obtain a Methadone prescription from a DDU and those who do not (Blumberg et al., 1974).

When asked about how they would improve the service, 28% made no suggestions. A total of 37% thought that "clinic intake should be simplified, made quicker and more rigorous". Another 28% thought that a greater range of drugs should be available, in greater quantities and heroin was preferred over physeptone. The rest of the comments had to do with the need for more experienced and sympathetic staff (24%). The author suggested that it was his
impression that those attending the clinic wanted more psychological and social help. They wanted the time to explore the reasons why they became narcotic addicts. Here a "psychological model" would seem to be important to problem drug users.

Like the previous studies mentioned, this group comes from a treatment agency and then only those who are new to the service. It is not known, therefore, how representative they are of all problem drug users, particularly those who prefer other drugs such as stimulants.

Awiah et al. (1988) interviewed Asian drug users and asked about their perception of services. They felt that previous experience of racism with generic services was bound to adversely affect the way they felt about drug services. Most Asian drug users, the authors say, prefer to speak to Asian drug workers, not only because of the possible language barrier but also because they felt that a white person would not understand the cultural context within which they used drugs. One heroin user said:

"I think it is easier to talk to an Asian counsellor because I don't think there would be the language problem and I think that they will be able to be quite open about their use and explain fully." (pp.45)

Other surveys asked for problem drug users to rate present services, seek consultation on what type of service they wanted, and enquire about the type of medication they preferred.

Dennis (1991) sent a postal survey to 202 current out-patients at a large East Midlands Drug Dependency Unit (DDU). Questionnaires were returned by 63 clients (31%). The majority
of the respondents were male (73%) and 56% were in the age range 25-34 while 21% were 35-44. All but 10 of the 202 clients were receiving prescriptions for opiate drugs, mainly Methadone.

Like the cohort in the survey by Jones and her colleagues, most of the DDU respondents, 53 (84%) approved of urine screening procedures and 39 (62%) accepted the need for inspection of injection sites. Just over half, 33 (52%) said that they were satisfied with their prescriptions and this was closely correlated with them being satisfied with the overall service, 57%. Those who were on a prescription for a shorter time (6 months to 2 years) were more satisfied than those who had been receiving a prescription for a longer time, more than 2 years. Surprisingly, those most satisfied with the service were those who were on reducing prescriptions while those on static or increasing prescriptions were less satisfied.

Clients appeared to be more satisfied with having a nurse as key worker than a social worker and most preferred to have 2 key workers (often a doctor and either a nurse or social worker) rather than one.

The least satisfied clients were those who only saw a doctor. Often these doctors were Registrars who only served for 6 months, so many clients, especially those who had been with the service for many years had seen a series of doctors. The more frequently patients are seen, the better they rate the service. Clients preferred to discuss problems other than drug problems. Most of these problems were either psychological or social (i.e. housing, welfare rights) in nature.
The postal questionnaire used by Dennis made the exercise seem more confidential and anonymous than a face to face interview. No doubt, at least a few of their clients still did not trust even this method. Despite instructions not to sign it or put on their names, 3 clients signed the returned form and used the opportunity to ask for more Methadone. The response rate was not high but postal questionnaires often illicit low response rates. It is difficult to ascertain whether those who are most satisfied or those who have the most complaints are the most likely group to respond.

Fazey (1988) conducted a similar survey in Merseyside. She administered questionnaires to 164 drug users who attended a Merseyside DDU over a 4 week period. The total treatment group was 480. The rest did not respond for a variety of reasons, mainly because the questionnaires were only completed in the waiting room and many of the patients were called in to see their key worker before they finished the questionnaire. The questionnaires were not given out systematically but left on a table to be filled in. The DDU staff did not always remind the patients to fill in the questionnaires. This may have achieved a nearly randomised sample but it is probable that those who had to wait the longest were the most likely to fill in the questionnaire and it excluded those who failed to attend appointments or did not have an appointment. New patients did not complete the questionnaire because it was thought that they had insufficient experience with the agency to form an opinion. It is not known how many of them there were. An assurance of anonymity was given.
Of those who completed the questionnaire, 68% were men and 32% were women (against an agency population of 75% men and 25% women). There was no information about the average age but the range was from 18 - 40 and it mirrored the age profile of the entire agency client group. The two main complaints about the service was the travel time (the serve covered the whole of the Regional Health Authority) and the waiting time. Some complained that they had to wait for as long as 4 or 5 hours on occasions while 80% said that they had to wait an hour or more. Unlike the East Midlands service, 80% of the clients had not been seen at home but only 13% said that they would like to have been seen at home. The last main area of complaint was about prescribing. Many (but not stated how many) wanted to have an increased dosage of drugs but only by a relatively small amount, 10 or 20 Mg. Another 14 (8%) who were receiving non injectable drugs wanted to have injectable drugs instead. Injectable drugs were liberally prescribed in Liverpool where 32% of the clients received them. The overwhelming majority (over 85%) of those who completed the questionnaires were either satisfied or very satisfied with the service. The staff were rated highly as well, over 70% said that they were very understanding, or had good understanding "of my problems" and that they were polite (80%) and helpful (almost 80%). On the whole, those who attended the DDU were grateful for the service. One respondent summed up the impact that the DDU has had on his life;

"Staying out of jail, not having to commit crimes. Having some money to eat with. More self respect and not so angry with doctors. Less hectic life style."
Less risk from muggers, police, dirty gear and organised crime" (Fazey, 1988, pp. 125).

The Drugs Indicator Project (1989) interviewed 240 regular drug users (i.e. those who used drugs at least 3-5 times a week). The cohort of 240 was drawn from 6 treatment agencies (120) and by using a "snowball" technique to contact the remaining 120. The cohort and methodology are previously mentioned.

The authors compared the two subgroups (i.e. those from treatment agencies and those who were not attending treatment) and found that, not surprisingly, those in treatment agencies expressed far more worries about a number of aspects of their lives, drugs (83% compared to 38% of those not attending agencies), means of support (66% compared to 28%), physical health (61% compared to 39%), and emotional/psychological concerns (63% compared to 38%).

In fact those attending agencies were more concerned about every area of life surveyed by the authors but to a lesser degree. Those included legal, accommodation, social relations, partners, children and parents. Their perceived need for help with the areas of concern were similar with their expressed areas of concern.

It is not surprising that those drug users who attended agencies were more distressed about all aspects of their lives than those who did not. While agency non-attenders were not as aware of services as those who attended agencies, they were still quite knowledgeable about what services were on offer.

After 3 months in treatment, 63 of the agency cohort were asked if they were satisfied with the service. As the cohort of 63 was divided into 6 agencies, the numbers of respondents from each
agency was small, never more than 8 and as few as 4. A majority (65%) said that they were "satisfied" with the service, 19% said they were neutral and 17% were dissatisfied. When asked, "To what extent they got what they wanted", 54% replied "Mostly", 27% replied "Partly" and 19% "Hardly". A total of 72% said that they would go back to the same agency if the same problem arose again. Those interviewed said that their contact with the agency had a significant impact on 3 areas of their lives: drugs (60%), emotional and psychological state (56%), and physical health (49%). When asked about what aspect of the service they most valued, "relationship with the staff" was the most frequently mentioned (73%), followed by "informal chat/support", followed by a "prescription" (63%). (Note that one half of the agencies did not offer a Methadone prescription so it was not a choice for 3 of the 6 agencies.) Those aspects with a low rating were; "counselling/therapy" (27%), "contact with other clients" (24%), and the "nature of the contract" (24%).

Telfer and his associates (Telfer et al., 1990) noted that drug users often do not turn to their General Practitioner for help. He remarked that within the literature GPs reported negative attitudes towards drug users and many felt themselves incompetent to help. The authors developed a brief questionnaire comprised of 10 statements which focused on their estimation of the attitudes of the GP when or if they approached the doctor because of their drug problem. The questionnaire was scored on a five-step Likert scale. The cohort was drawn from a local Drug Dependency Unit and comprised 116 consecutive new patients. All were heroin users. The mean age was 24 years and 31% were women.
The mean duration of heroin dependence was just over 5 years. Smoking heroin was the most popular form of administration of the drug and 55% said that they had not injected over the last year. A large majority (82%) had received some form of treatment for their drug problem in the past.

Most of the cohort were self referrals (44%) or referred from community centres (26%). General Practitioners only accounted for 11% of the referrals. Twenty-five percent of the sample had not consulted their General Practitioner about their drug problem. Most of the heroin users reported that GP appointments were easy to obtain. However, GPs rated low on "usefulness". This could reflect a policy of not prescribing opiate drugs. The heroin users also felt that GPs were not understanding, critical and unsympathetic.

Again, treatment populations provided the sample of heroin users and there is no way to establish how representative they are of heroin users as a whole. The profile of the heroin users was similar to other local treatment agencies in age, sex, etc.

Bennet and Wright (1986) compared opioid users attitudes towards Drug Dependency Units, General Practitioners and Private Practitioners. They collected a cohort of 135 opiate users from six sources which included 2 Drug Dependency Units (DDUs), one General Practitioner within the NHS, one Private Practitioner, and two separate groups of illicit market users. The average age was 29.4 years and the there were 99 men and 36 women in the group. The main method was a combination of semi-structured and structured interviews which were tape recorder and later transcribed.
The results reveal that most of the opioid users approached a physician specifically for a prescription for opiates rather than other types of treatment, 62%. A large proportion had approached a doctor before they went to their current GP, DDU, or Private Practitioner. Unlike other studies which suggest that opioid users prefer heroin, especially on the illicit market (Drugs Indicator Project, 1989) this group of opioid users preferred Methadone to heroin, 62 to 43. Injecting was the favourite means of administration, 92 compared to 28 who prefer oral preparations.

The cohort was drawn from six separate sources and this is obviously a better spread than cohorts drawn from just one sample. Each source provided between 11 (one illicit market source) and 40 (a private practitioner) subjects. It was difficult, therefore to compare one group to another because of the small numbers involved. However, the results suggest the opposite of Telfers conclusions, i.e. that opioid drug users do not prefer GPs because of their lack of sympathy. Similar to other studies (Drugs Indicator Project, 1989; Chein et al., 1964; and Dennis, 1991), counselling was not highly valued by opioid users.

These results would indicate that whatever model problem drug users were using, it was not a "psychological" model. If the heart of their problem, as seen by the problem drug users, was psychological in nature, they would have placed higher value on "counselling and psychotherapy". The high satisfaction rates with services could simply be an artifact of those who chose to take part in the surveys. The response rates were usually quite low.
Similarly, they could indicate a general level of satisfaction with the service. If this is the case, it could mean that whatever the models which are used by problem drug users, they may not be far removed from the models used by the professionals who work at the agencies. Major differences in beliefs about the nature of problem drug use and models which inform treatment policy would probably manifest itself in a high level of conflict between the staff and professionals. Such conflict appears to be minimal.

WHAT PROBLEM DRUG USERS THINK OF TREATMENT

Definitions about what should constitute treatment are contentious, particularly if staff at treatment agencies and clients or patients do not agree about what is helpful. The relationship between doctor and patient is often a difficult one. Within the field of problem drug use, that relationship is often even more difficult. Often the patient does not come in for advice about their medical condition. This is especially true of services which mainly prescribes drugs for their clients. They are already perfectly clear about their diagnosis and sometimes even more clear about what treatment they think is necessary, i.e. a prescription for drugs. The patient may also know exactly what form the drug should be in, the specific generic name of the drug and the monitoring which they feel is suitable. The appropriate dose is often a contentious issue as well. The doctor may feel that the dose should be no more than is necessary to relieve withdrawal symptoms while the patient may want enough to feel intoxicated. In no field of medicine is the patient better informed.
Jordon (1985) surveyed 77 male patients at the Seattle Veterans Administration Drug Dependency Treatment Program and 13 program staff and asked them to rank in importance various topics which could be part of a group. The staff included one nurse, one psychiatrist, one psychologist, one social worker, 2 pharmacists and 6 counselling staff. They had, on average, 8 years experience in treating substance abuse.

Patients preferred groups which focused on skills and information, while staff preferred groups which were more psychotherapeutically orientated and focused on 'insight'. The polydrug users choice of groups was similar to the staffs groups and the Methadone group (when the polydrug users are excluded) had even greater differences to the staff group. Perhaps the drug users did not necessarily see their problems as having a psychological basis and therefore were reluctant to take part in that type of therapy.

The results, however, need to be considered cautiously because the sample of drug users could not be considered to be representative of drug users as a group, i.e. all in one treatment programme and all male. The number of staff was small, 13, and could not be considered to be representative of staff at drug treatment centres. This study does highlight how differently staff and patients or clients can view various forms of treatment.

Murphy and his colleagues (1989) asked drug users who were physically dependent on drugs about their experience of withdrawing. They distributed 134 self administered questionnaires in a variety of treatment agencies in Merseyside.
and North West Regional Health Authorities, 56% were completed. They found that most dependant drug users, even drawn from treatment agencies, do not often turn to professionals for help when withdrawing from heroin addiction. Only 18 of the 70 (26%) sought professional help while the others relied upon family, fellow drug users or their girl friend or boy friend. Murphy also asked about why they decided to undertake withdrawal in the first place. The withdrawal period had to be "unmodified", i.e. without the assistance of prescribed drugs and of sufficient length, lasting into the second day. Excluding those who were not voluntary, i.e. in a police cell, hospital, the interviewers found five motivational factors which they used to form 5 scales which were administered to the cohort. The five motivational factors "were relating to relationships, own well-being, seeking a new job, maintaining a job, and contact with the legal process" (Murphy et al., 1989, pp. 676). Murphy et al. demonstrated that those who were successful in withdrawing were more likely to have been motivated by concern for their own well being and relationship reasons rather than concern for the law, seeking a new job or maintaining a job.

It is difficult to interpret these results because it may simply be that the low correlation between success in withdrawing and work or the law is simply a function of the fact that those who responded in that way had no court case or pending or current work. Also, as the authors point out, the data is retrospective in nature and the results are possibly biased by poor memory, and how much they value these motivational attributes. Finally, the 56% response rate leaves many opioid users untested and it is not
possible to know how they would have responded to the questionnaire.

In the United States, Sutker and her colleagues (Sutker et al. 1974) administered questionnaires to 207 heroin addicts about their views of Methadone as a form of treatment. The sample was drawn from a drug treatment programme (n=143) and a random selection of prison inmates serving sentences for a variety of convictions at a local prison. All the subjects were literate and completed the questionnaire on a voluntary basis. The subjects were all male. They were in their late 20s and they claimed to have been addicted to heroin on average for 4 - 7 1/2 years.

Nearly 50% (n=91) of the sample had never been on a Methadone programme, 66 had been attending a Methadone programme for between 1 and 6 months, 26 for 7 - 12 months and only 24 for one year of longer. Older heroin addicts were more likely to have attended a Methadone programme and been on the programme for a longer period.

The questionnaire was in the form of 21 questions which the respondent could agree or disagree with. The respondents were informed that their results would not lead to a Methadone prescription being prescribed. They were also asked to put their name on the questionnaire.

Most of the heroin addicts believed that Methadone treatment was helpful in a variety of ways. In response to the statement, "I think in general that Methadone programs are beneficial", 85% agreed. Most (77%) thought that it gave addicts a new outlook on life and 84% thought it gave addicts a second chance. More specifically, nearly all (97%) thought that it has helped addicts
maintain a steady job. They were also in common agreement with the statements which said that Methadone is responsible for keeping many addicts out of prison (93%), and that addicts steal considerably less when taking Methadone (93%).

On the negative side, nearly all recognised that Methadone interferes with their sexual functioning (63%), and that it is more difficult to go "cold turkey" on Methadone compared to heroin (86%). Only 42% thought that it keeps addicts from taking illicit drugs. They seemed to have no illusions about it being a cure. Most (57%) thought that Methadone was just another way of not dealing with their problems. Only 8% thought that Methadone programmes were a waste of time and money. Most of the negative aspects of Methadone were associated with long term use, such as sexual dysfunction, problems in withdrawing and accepting that Methadone Maintenance is "just another form of addiction" (72%).

The research did not differentiate between those drawn from treatment programmes and those drawn from prison. As a large proportion of those who attend treatment programmes in the United States are under some sort of court supervision, the effects of the criminal justice system may have been evenly spread. The practice of having the respondents identify themselves on the form could have introduced bias into the results. Those on treatment programmes are often carefully monitored and those in prison could be hoping for parole. Such fears and hopes could have influenced their answers. For instance, only 55% said that they preferred heroin over Methadone. This could reflect an attempt of those interviewed to make their drug use seem more
acceptable (i.e. they no longer value the euphoria or "rush" from heroin) or maybe just the poor quality of most American heroin. Early surveys on client satisfaction with treatment services suggested drug users who attended them were cautious and guarded about the service. Over one-third were critical of the assessment procedure and waiting period (Roberts, 1973). More recent surveys of client satisfaction indicate that clients of drug services seem more satisfied with services than before. This could reflect the relatively new emphasis on making services user friendly in order to attract more drug users into services and the willingness of agencies of advocate harm reduction, which for many drug users is a more acceptable goal than abstinence. The Advisory Council on the Misuse of Drugs (ACMD, 1988), while advocating harm reduction, said that abstinence should be the eventual goal. Their relative satisfaction (Dennis, 1991; Fazey, 1988; Drugs Indicator Project, 1989) with the service could also reflect a more liberal prescribing policy which all drug users who attend services crave.

The large increase in the number of drug services throughout the United Kingdom over the last 10 years has also given drug users more choice. Perhaps too, the existence of drug services for over 25 years has made agencies more aware of their clients needs and more willing to accede to those needs. Drug users by now probably are more aware of what they need to do in order to receive the service they want. Those who are willing to attend services probably have a pretty good idea of what to expect.

It is speculation on how services are seen by those who do not attend. Only rarely (Drugs Indicator Project, 1989) are they
sought. Two issues seem to have been kept alive over the years. The first is the call for a more liberal prescribing regime and the second is the fear and suspicion of the Home Office Index.

WHY PROBLEM DRUG USERS SAY THEY SEEK TREATMENT OR HELP

At what point do and why do problem drug users say they seek treatment. Studies (Sutker, 1974; Drugs Indicator Project, 1989) suggest that it is often several years after problems begin before problem drug users come for help or seek treatment. The reasons problem drug users say they seek treatment give some insight into how their attitudes and beliefs about problem drug use are formed.

Chein et al. (1964) interviewed a subgroup of 100 regular heroin addicts (within a much larger study) in New York in 1953. The interview was semi-structured and involved young men only. Part of the interview was about efforts "to break the habit". Chein and his associates found that most of the young addicts gave several reasons for trying to stop using heroin. Four reasons were spontaneously mentioned by the respondents;

1/ they felt it (heroin use) was wrong
2/ they were anxious about raising the money to buy heroin
3/ the use of heroin made them feel unwell
4/ they worried about becoming "hooked", i.e. more addicted

Another two reasons arose when the young men were further questioned, fear of the criminal justice system and the influence of other people to discontinue drug use. Other reasons included fear of mental health problems ("losing my mind"), sexual impotence, fear of overdose, etc. The authors claimed that one particular reason differentiated between the delinquent and the
non delinquent addicts, that is the users perception of character
deterioration, social withdrawal and aggression;

"I wasn’t myself. I became arrogant, sarcastic,
wanted to better myself. Didn’t want people to think
my family wasn’t raising me right. Didn’t want to be
around a bunch of lousy guys." (Chein et al., 1964,
pp. 169)

Efforts to achieve abstinence did not always meet with success.
Of the 100 young addicts interviewed, three-fourths made at least
one attempt to achieve abstinence from heroin, half had made more
than one attempt. At the time of the study, twenty had reduced
their consumption and fourteen achieved abstinence.
The researchers found that few of their cohort sought medical
help, only one-fifth had received any medical attention. Most of
those occasions were not voluntary but followed an over-dose or
arrest.

One of the more unexpected findings from Chein is that those
young addicts from gangs often had pressure exerted on them from
gang members to reduce drug use or become abstinent.
Experimentation with drugs was part of gang culture but habitual
use was looked down upon. Even in gangs where drug use was
popular, active efforts were made to dissuade some members from
using.

"One key figure known to me stated that he had held a
series of informal talks with one of the club members
who began to use drugs and as a result of these talks
got him off the kick." (Chein et al., 1964, pp. 172,)

Lindesmith claims that habitual heroin users have an
approach/avoidance relationship with their habits. On the one hand they seek the pleasure from their drug use and on the other feel pressure from friends, family and society to quit. The process begins as soon as the addict realises he or she is addicted;

"Prior to addiction, the addict generally shares the negative attitudes of the society toward junkies or dope fiends. When he himself becomes addicted he necessarily applies these attitudes to himself and his conduct......The desire to quit is so much an integral part of being addicted that it should perhaps be included in the definition of addiction."

(Lindesmith, 1968, pp. 137)

Lindesmith acknowledges that relapse is common but uses that as evidence for what he sees as the addict's continual need to attempt "a cure".

Ball and his associates asked staff and heroin users from a Methadone treatment programme in Pennsylvania about their view of Methadone Maintenance (Ball et al., 1974). Interviews were obtained from 224 randomly selected patients from a population of 924 patients at Philadelphia General Hospital. The patients were primarily young (66% were under 30), black (65%) and resided in Philadelphia. Men outnumbered women by 7 to 1. The educational attainment of the group roughly corresponded to the population as a whole. Almost 1/3 of the patients had worked 8 or more years since leaving school and 72% had worked 3 or more years since leaving school. The most frequent drug of initial use was marijuana (34%) but this was closely followed by heroin (25%) and
cough syrup (17%). Most of the addicts had been in the programme at least three months but only 1/3 had been in the programme longer than 13 months. The average dose of Methadone was between 80 - 120 Mg per day.

When asked why they felt that they required treatment, 44% of the Methadone Patients say that they wanted "to get off drugs", 26% "that they wanted to keep from being sick", and 27% say they wanted "to secure other help". Only 3% said it was because of legal problems.

When asked if they suffered from a physical illness, only 20% of the addicts felt that they did while nearly twice as many (38%) of the staff felt that they did. Only 21% of the addicts felt that they suffered from Mental illness but over 95% of the staff felt that they did so. Finally, when asked if addicts are difficult to treat, 33% of the addicts thought they were and 71% of the staff thought they were. Fewer women patients felt that addicts were easier to treat than men (21% to 35%) and were more likely to think that addicts suffered from Mental Illness (29% to 19% for men).

The authors point out that there is a great discrepancy between how problem drug users conceptualise their addiction and how staff see the problem. Staff were white and middle class and it must be assumed retained middle class values. The patients, however, were primarily black and ghetto raised. They do not see themselves as sick or psychologically impaired. Not surprisingly, those who have been in treatment longest were the most likely to hold views similar to the staff. The authors conclude that the clinic was unlikely to have an impact on the lives of addicts.
until a closer convergence of views occurred. He felt that this was primarily the responsibility of the staff. This study, while again suffering from the inherent problems of drawing the sample from a treatment population, shows the dramatic differences which can occur between the perceptions of problem drug use of clients and staff. Staff, in this case seem to primarily hold a "biological/medical" model which was rejected by the majority of their clients/patients. Not surprisingly, the authors felt that there was a great deal of tension between the patients/clients and the staff.

The role of the American criminal justice system was considered by Pringle (1982) where he reviewed the literature relating how alcoholics enter alcohol treatment programmes and applied the same principles to substance abuse. He suggests that a model exists about how someone enters treatment. The first stage is recognition of a problem (always to do with drugs), followed by failure of self-help efforts, followed by choosing an agency and finally, deciding that treatment can help. This model is mainly based on an analysis of Alcoholics Anonymous literature. While this is not the only treatment available in the United States it has had a profound effect on most treatment programmes. Pringle then goes on to say that the recognition of a problem can be recognition of any problem whether it is drugs or not. It may be a health or criminal justice problem. This is followed by recognising that an outside agency is needed, choosing that agency and finally recognising that a drug problem exists (followed now by the other previously mentioned steps). It is in this way that Pringle believes that the criminal justice
system can play a critical role, i.e. demonstrating that a problem of some origin exists. Most of the above mentioned research however does not place the criminal justice system as high on the list of reasons of what motivates people to seek treatment. This difference in perception is fundamental to understanding dissimilar views of studies from the United States compared to those from the United Kingdom. In general, client/patient models seem to be closer to professionals models in the United Kingdom than in the USA. This could reflect the more biological/medical approaches in American treatment agencies compared to the UK.

In the United Kingdom, where treatment agencies are less prone to use a biological/medical model and where treatment goals are not necessarily abstinence, patients or clients may hold different views. Several more recent authors (Dennis, 1991; Hartnoll, 1992; and Fazey, 1988) suggest that most patients/clients of drug treatment programmes have a high regard for the programme and the staff and that most are well satisfied with their treatment. These three studies cover both statutory, and non-statutory agencies, advice centres and prescribing agencies as well. This could be because these agencies adopt a more psychological or social/economic model than those in America.

Summary

Why problem drug users say they first try drugs and continue to use them.

The literature which addresses this question is remarkably consistent. Starting with Chein (1964), it has been shown that
drug users first start using drugs for pleasure, new experience and because their friends use drugs. These reasons come up time and again over years and across many cultures and countries, New York (Chein, 1964), England (Pearson, 1986), Singapore (Teck-Hong Ong, 1989) when the population is at liberty even though they may be undergoing treatment. The literature suggests more of an adherence to a social/economic model compared to a psychological or medical/biological model. Relief of distress was not a major factor, even amongst those who had significant problems as a result of their drug use. Perhaps none of the three models adequately deal with this issue. Pleasure seeking through association with friends and by chemical means could provide the basis for a new theory by itself.

**What drug users think about drugs and addiction.**

Problem drug users answering this question were heavily influenced by the agencies where they were found. Some described positive attitudes (Gossop & Connell, 1975) towards drugs because they relieved symptoms, at least temporarily. Symptom relief could fit any of the three theories depending on which symptom is being relieved (i.e. psychological, biological or social/economic). Most of the research is not entirely relevant to this question. Those that ask directly if drug addiction is a disease (Nurco, 1988) seem to be heavily influenced by the agency from where the sample was drawn. Those from abstinence orientated treatment programmes (where a disease model was used) were more likely to consider it an illness than those who were not on such a programme. Sometimes there were major differences between the views of staff (who would accept a biological/medical
disease model) and clients who did not accept it as a disease (Severow, 1972). As I mentioned earlier, it is not easy to ascertain what theories of problem drug use are relevant to what attitudes. One can say however that problem drug users who are pessimistic about treatment outcome may be more influenced by a medical/biological theory which probably suggests a less successful outcome than the other two theories.

What drug users think about themselves and others.

Few studies employ control groups when considering this issue. One of the few that does (Lindblad, 1977) suggests that problem drug users perceive that they have had a more problematic childhood than those who did use drugs problematically, thus suggesting a psychological model or possibly a biological/medical model. Studies that acquired their samples (Blackwell, 1983) from non treatment sources had not suggested that drug users suffered from negative self images. Some problem drug users from a treatment agency did not perceive themselves as suffering from a disease (Diamond, 1990). On the whole these results suggest a social/economic model rather than a psychological or biological/medical model.

Why problem drug users say they need help or treatment.

The results from this section of the literature do not readily fit into one theory. Several studies (Pearson, 1986, et al. 1971; Hartnoll et al., 1993) suggest that severity of problems associated with drug use is a key factor in seeking help. Other studies (Chein, 1964; Brown et al., 1971) suggest that a change in lifestyle is the key element in deciding to seek help.
What problem drug users think about services, treatment and the helping process.

Much of the literature is from the United States where treatment philosophy is considerably different from Great Britain. Most treatment programmes are based on a disease model where abstinence is the only legitimate goal. As most problem drug users do not perceive themselves as being sick there is an inevitable conflict between the staff and clients. In Great Britain, patients/clients seem to have a more positive view of services, possibly because the agencies adopt a more psychological or social/economic model than do their American counterparts.

What is clear from the above is that no one model is clearly favoured by problem drug users over another. If anything, the clearest message is that most problem drug users reject a biological/medical model. Different models are favoured for different questions, for instance a social/economic model seems to be favoured when considering how and why drug use began. Certainly problem drug users as a group represent such a wide variety of people that it is not surprising that the mere presence of problems associated with drugs should make their opinions uniform.
METHODOLOGY

The purpose of this study is to examine the beliefs in one of three held by problem drug users models and assumptions about problem drug use held by problem drug users who attend drug agencies and compare and contrast them to those held by professionals in drug agencies. The major aims of this research are:

1) To determine the number and characteristics of agencies specifically for problem drug users within a defined geographical area.
2) To determine the characteristics of the problem drug users who attend agencies which influence these beliefs, such as education attainment, sex, age, drug use patterns, etc..
3) To determine the influence of education, training, and experience on those assumptions and models about problem drug use.
4) To determine the influence of the agencies and the positions of the workers within the agency on their assumptions and models.
5) To determine the influence of national, regional, district and agency policy on those assumptions and models.
6) To determine the models which drug workers and problem drug users who attend drug agencies employ to understand the nature of problem drug use.

Within these sets of aims are a number of subsidiary aims
which relate to the main aims listed above.

1) To determine the number and characteristics of agencies specifically for problem drug users within a defined geographical area.
   a. To investigate the pattern of service provision within a given geographical area.
   b. To determine the staffing levels, professions, etc. at each agency.

2) To determine the characteristics of problem drug users who attend agencies which influence these beliefs, such as educational attainment, sex, age, drug use patterns, etc...
   a. What are the essential personal characteristics of problem drug users who use drug agencies?
   b. What is the influence, if any, of the agency on the attitudes and beliefs on the problem drug user?
   c. Do problem drug users feel satisfied with the service they receive and identify with the agencies they attend?

3) To determine the influence of education, training, and experience on those assumptions and models about problem drug use.
   a. What professions work in agencies which provide services for problem drug users?
   b. What is the role of experience in determining beliefs and models about problem drug use?
   c. How does educational attainment influence both problem drug users who attend agencies and drug
workers?

4) To determine the influence of the agencies and the positions of the workers within the agency on their assumptions and models
   a. What are the goals of drugs workers in drug agencies? What issues arise in their work with problem drug users?
   b. How do these goals relate to the work of the agency?
   c. Do the goals of problem drug users and drug workers coincide?

5) To determine the influence of national, regional, district and agency policy on those assumptions and models.
   a. How can drug agencies be categorised and how many of that category exist in a geographical area?
   b. What are the current national, regional, district and agency policies within the geographical area where the research will be conducted?
   c. How are their policies passed onto their workers? Do workers identify with their agencies policies, regional, and national policies?

6) To determine the models which drug workers and problem drug users who attend agencies employ to understand the nature of problem drug use.
   a. What are the beliefs of problem drug users who attend agencies and drug workers about the origin and effective interventions of problem drug use?
b. What help do problem drug users who attend agencies feel they need and what help do drug workers say they offer?

c. How consistent are the models which are used?

d. If inconsistent models are held, are various aspects from more than one model used, and if so what are they?

METHOD

Each aim had to employ a distinct method to answer the question.

AIM 1. 1) To determine the number and characteristics of agencies specifically for problem drug users within a defined geographical area.

METHOD FOR AIM 1.

In the first instance, local and national directories of drug services were consulted and an initial list of agencies were recorded. The two Regional Health Authorities provided further lists and from these sources a combined listing was made. The essential features of the agencies were that they:

1/ were located in either of two Regional Health Authorities where the study was based
2/ employed paid staff
3/ had as their primary brief the treatment or assistance of problem drug users

AIM 2. To determine the characteristics of the problem drug users who attend agencies which influence those beliefs, such as educational attainment, sex, age, drug use patterns, etc.

METHOD (Details of the questionnaire design are addressed in
the Method for aim 6.) The questionnaire was designed to elicit demographic information such as age, sex, race, preferred drugs, length of drug use, educational levels, etc. for drug users.

AIM 3. To determine the influence of education, training, and experience on those assumptions and models about problem drug use.

METHOD - The same questionnaire that was used for Aim 2 was also used for aim three, but only the self completing questionnaire rather than the semi-structure interview. For staff and problem drug users at drug agencies there were questions about educational levels & qualifications and professional qualifications.

AIM 4 To determine the influence of the agencies and the positions of the workers within the agency on their assumptions and models.

METHOD - The same questionnaire that was used for Aim 2 was also used for aim four, but only the self completing questionnaire rather than the semi-structure interview. The position that the member of staff occupied within the agency is also of importance. Etzioni (1961) showed that the position held by employees at an agency will influence their attitudes and beliefs about a whole range of subjects, including to what degree they identify with and accept the values of the organisation.

AIM 5 To determine the influence of national, regional, district and agency policy on those assumptions and models.

METHOD The last section of the self-completing questionnaire
addressed Aim 5. Furthermore, information about national, regional, district and agency policy was gathered from agencies District and Regional Health Authorities and National agencies.

AIM 6 To determine the models which drug workers and problem drug users who attend drug agencies employ to understand the nature of problem drug use. METHOD - Two types of questionnaires were chosen:

a/ self completion questionnaires with basic, relevant information on the demographic characteristics, education and professional training of problem drug users who attend agencies and drug workers.

b/ a semi-structured interview to enable problem drug users who attend agencies and drug workers to expand on their beliefs.

There are several ways of investigating the models which are held by problem drug users who attend agencies and professionals. Semi-structured interviews, as the sole method, was rejected for a number of reasons. Firstly, it would be very time consuming and it would not have been possible to obtain a sufficiently large sample to subdivide them into smaller groups for the purposes of comparison and analysis. The results of the semi-structured interview would have to be transcribed and this would have been time consuming and expensive. Also, it would have been difficult to make quantitative comparisons between different groups (i.e. problem drug users who attend agencies and drug workers). Instead, it was decided to conduct a small number of semi-
structured interviews for two purposes; to have yet another check on reliability and to enable some respondents to express their assumptions and beliefs about useful models in a more comprehensive way.

Finally it was decided that a questionnaire, which required respondents to answer questions within the framework of three models, would be used. Though there are a number of models about the nature of problem drug use, most of these are variations of one of the three models which were used. These models are by no means mutually exclusive but each represents an explanation for the main causes of problem drug use, and what treatment or method of helping is most appropriate. The questionnaire was designed to allow for the allocation of a numerical score for belief in each of the 3 models to each respondent or group of respondents, thus allowing one group to be compared to another (i.e. problem drug users who attend agencies with drug workers). It was necessary to find a sufficiently large sample to allow it to divide the major groups into sub groups for comparison, i.e. compare professional groupings (such as doctors, nurses, social workers etc.) agency groupings (such as community drug teams, residential rehabilitation projects, and drug advise centres), and educational achievement for drug workers. For problem drug users, comparisons of sex, age, pattern of drug use, and educational achievement were used.

Each questionnaire was preceded by a brief set of instructions. The instructions assured the respondent of anonymity and included a reminder not to put their name on the
questionnaire. A brief explanation of the purpose of the questionnaire was stated. The written instructions were a reminder because in most cases the questionnaire was explained verbally. The research worker remained available for questions while they were answered. Self-administered questionnaires were used to reduce as much as possible the influence the research worker would have on the answers.

In a minority of cases, drug workers were left the questionnaire to complete after the researcher had left. This was necessary because of staff being off ill, too busy to complete the questionnaire at the time the researcher was available or simply not being at the agency on the day the researcher visited. When leaving a questionnaire for the drug worker a self addressed stamped envelope was provided to encourage their reply. Most agencies were visited only once but the larger agencies were visited 2 or 3 times. When visiting the agency more than once the researcher tried to return as soon as possible, often the following day.

The main body of the questionnaire was the same for both problem drug users who attended agencies and drug workers. The three models were derived from a review of the literature on problem drug use. An example of the use of the three models was used by Plant (1981). He named them the constitutional approach, individual approach, and the environmental approach (pp. 44). Other authors (Goode, 1993) have used a similar means of labelling models of problem drug use. For the purpose of this thesis, they have been renamed as follows:

1/ The Medical/Biological Model - This model
attempts to explain the phenomenon of problem drug use in terms of biological and/or genetic causes as being the main component. Most problem drug users would be seen as suffering from forms of "Personality Disorder" which is a recognised Psychiatric condition, even if it is not an illness. Probably the most appropriate form of treatment would be seen as pharmacological rather than counselling or help with social problems.

2/ The Psychological Model - This model attempts to explain the phenomenon of problem drug use in terms of learning theory, especially learning which takes place in childhood and adolescents. Problem drug use is seen as a response to the discomfort generated by unresolved emotional difficulties. The most relevant treatment would be seen as counselling or psychotherapy. Learning theory would suggest that habits could be "unlearned" given the right circumstances and drug using habits could be altered.

3/ The Social/Economic Model - This theory attempts to explain the phenomenon of problem drug use in terms of the individuals response to social problems such as unemployment, poor housing, deviant life style, boredom, etc. This model suggests that some people are denied legitimate access to jobs, education, housing, status, etc. so they respond to their social condition by using drugs in a
problematic way. It may also reflect the influence of alternative cultural values held by the social groups which problem drug users belong. The most suitable form of helping would be to either alter society or help the individual gain access to better social conditions.

These models may accept the influence of aspects of other models. For example, the Psychological model may well accept that unemployment may make an individual more vulnerable to problem drug use by lowering their self esteem. Each model, however, has a definable source of the problem, i.e genetic or biochemical abnormalities, insufficient or incomplete learning, or unequal social opportunity. Often it is a matter of emphasis as to which theory is held.

The intention in using the questionnaire is to ascertain to what degree the drug worker and the problem drug user who attends a drug agency base their beliefs on one of the three models and how consistent their beliefs are within those models. The models can be divided into two parts:

1/ The origins of problem drug use
2/ What treatment or help is the most affective in facilitating change.

The questionnaire is divided into 4 parts.

Part 1 - comprises the demographic information for problem drug users and staff and educational and professional training and qualification.

Part 2 - comprises 18 questions, asking both problem drug users who attend agencies and drug workers to
rate on a scale of 1 to 5, how much they agree or disagree with statements that test their beliefs in one of the three models. They rated each question on the following scale: Strongly agree, agree, neutral, disagree, strongly disagree. The three models were divided into 2 parts (as above) and each of those had 3 questions. The reasons that 3 questions were used for each part was to test validity.

Part 3 - comprises 10 questions on the views of problem drug users who attend agencies and drug workers about their relationship to the agency and government policy.

Part 4 - asked problem drug users and drug workers to record (often, sometimes, never) how often they spoke to their clients or key workers about issues related to one of the three models such as relationships, criminal activity, welfare rights.

Methodology for Part 2 - The questions to test their beliefs about the three models were devised by forming a series of preliminary statements which were consistent with each of the theories. A questionnaire was then designed using the preliminary statements and asked a number of problem drug users who attended agencies and drug workers in Nottingham to place each statement within one of the three models, which were carefully defined. By process of elimination, statements were rejected or modified until they received over 90% agreement as to which statement was most consistent with which model. Eventually, most of the questions achieved 100%
agreement as to which model is most likely to be consistent with it. This was a time consuming process which required four separate attempts before a sufficiently reliable set of questions was devised. These statements were then turned into questions which were again asked of a group of problem drug users and drug workers to place within one of the three models. The questions were then ordered randomly in the questionnaire. The questionnaire was developed along the lines of a Likert scale. This scale was chosen because it allowed a numerical summation of the respondents acceptance or rejection of one of the three models of problem drug use. The range of answers (from "strongly agree" to "strongly disagree") allows the respondents a limited (5 possible answers) but easily accessible means of making a judgment about the statement. The answer "Don't Know" was included to insure that respondents did not feel that they had to answer a question which they felt unable to answer.

In order that all the questions were asked in the same way, "negative" questions were not asked which may have been more likely answered by "strongly disagree" or "disagree" or been misunderstood.

Methodology for part 4 - The questions in part 4 again relate to the three models previously mentioned. Unlike, part 2, the questions were ordered in relation to treatment in clusters belonging to each theory instead of randomly assigning their order as was done in part 2. This decision came as a result of piloting the questionnaire. Several problem drug users said that drug workers talked to them about
issues such as "emotions" and "coping with anxiety or depression" and it was more realistic to consider them in a group or at least in a cluster rather than have them in random order.

In order to add depth and give some interviewees a chance to elaborate on their answers, semi-structured interviews were conducted with a total of 10 (5 each) taped recorded semi-structured interviews with problem drug users and drug workers. The 10 open ended questions came from the questionnaire and allowed those interviewed to elaborate on their own theories. The taped, semi-structured interviews lasted between 30 minutes to about 1 hour. Each tape was transcribed. The first 10 problem drug users from agencies and drug workers who were available for the interviews were chosen. Two problem drug users and two drug workers declined to be interviewed. The 10 interviews were completed early in the research.

RELIABILITY AND VALIDITY

Gathering reliable and valid information from problem drug users is a difficult exercise from the start. Problem drug use is not only a form of behaviour which most people disapprove of but, in most cases, is illegal. Problem drug use has this in common with many forms of what is often regarded as deviant behaviour. Becker (1963, pp. 168) says;

"It is not easy to study deviants. Because they are regarded as outsiders by the rest of society and because they themselves tend to regard the rest of society as outsiders, the student who would discover the facts about
deviance has a substantial barrier to climb before he will be allowed to see the things he needs to see."
The task was made manageable by using the assistance of the agencies which participated in the study. The problem drug users interviewed were clients of the agency and the researcher benefitted from association with the agency. The fact that the agency accepted the research was both a benefit and a potential problem. The problem lies in the research workers association with the agency and the understandable fear that information may be shared with the agency despite the assurances to the contrary. This fear may be exacerbated by the use of some drugs (especially stimulants) which can induce paranoia.

Some problem drug users who attend agencies may underestimate their drug use, especially if they fear that there could be repercussions if found to be using drugs when they are meant to be drug free or using unprescribed drugs when receiving a prescription from the agency. In order to account for this problem the questionnaire was worded to refer to drugs they have used and not about their current or recent drug habits. Also, it could work the other way, i.e. drug users may try to impress the researcher with their drug experience by stating that they have used drugs which they haven't.

Despite these problems, most of the literature (Darke, et al., 1991; Davies, & Baker, 1987) suggests that problem drug users answer questions about their drug use honestly, neither over or underestimating their habits. The exception to this rule may be when reporting to a physician about their drug use
if they are trying to obtain a prescription for psychoactive

Another potential influence on the reliability and validity of
this research is the effect of drugs on the individuals who
completed the questionnaire and who were interviewed. Only a
small proportion of the problem drug users were drug free or
in a state of physical withdrawal when they filled in the
questionnaire. Most of those were in residential
establishments. There is no way of estimating what the
effects of intoxication or withdrawals (physical or
psychological) would have on the results. Perhaps, less than
it would seem at first thought. Most of those who took part
in the study were experienced drug users. Some held down
jobs, full or part time. Others were enrolled in courses or
further training. These activities would not have been
possible if they were seriously impaired by their drug use.
Most of the problem drug users were receiving prescriptions
for psychoactive drugs and this probably helped to maintain
them in a relatively steady state. Those drug users who were
heavily intoxicated (i.e. impaired speech, impaired
consciousness, agitation, poor coordination) were not asked to
fill in a questionnaire. This only happened on 6 occasions.
Four questionnaires were also discarded because their state of
intoxication only became clear after they had partially
completed it.

Some (a total of 12) drug workers also expressed reluctance to
take part in the research. Efforts to persuade them were made
and eventually 8 of the 12 completed the questionnaire. Three
drug workers thoroughly questioned the confidentiality of the questionnaire but they also took part. Others were reluctant to take part because of "research fatigue", i.e. other researchers had been visiting their agencies recently. It is not possible to estimate the effect that these factors may have had on the validity of the exercise. However, most drug workers were cooperative, interested and helpful.

In order to test the reliability of the questionnaire the researcher asked six questions about each of three models of problem drug use. The six questions were divided into 3 questions each about the origins of problem drug use and the preferred means of treating or helping problem drug users. By comparing the consistency of the three answers it would be possible to determine the reliability of the questions. This measure is similar to the "internal consistency" model of testing reliability examined by Lemon (1973). Lemon suggests that one means of testing the internal consistency of a measure is to divide the measure and then to intercorrelate the two parts.

Also, as a second test of reliability, the questionnaire answers to the semi-structured interviews will be used as a check against the self-administered questionnaire. These were carried out 24 hours or more apart to minimise the effect of answering the questionnaire upon taking part in the semi-structured interview.

Validity was tested by devising questions about the origins and treatment preference for problem drug use within the framework of the three models. These were then presented as a
pilot to drug workers and problem drug users and each was asked to assign a statement to one of the three models. Those statements which failed to be associated with the intended model were either altered or dropped altogether. Each of the two features of the model (origin and treatment) should have a relatively high correlation with each other if the individual completing the questionnaire has a reasonably consistent model of problem drug use. In other words, there should be a clustering of item intercorrelation. This could be used as a test of "construct validity" and will be part of the analysis (Ghiselli et al., 1981). More importantly, there should be a high correlation between the three questions about each of the two features of the theories. This will also be tested in the analysis.

GEOGRAPHY
In 1991 there were 550 (MacGregor, et. al., 1991, pg. 36) agencies within the United Kingdom, whose main brief was to provide services for problem drug users, henceforth referred to as drug agencies. Certainly a large number of generic services also provided help for problem drug users but that was not their prime concern. For example, the Probation and After-Care Service help many offenders who have drug problems, the difference being that they see them as offenders first and problem drug users second.

Drug agencies are not uniformly distributed throughout the United Kingdom. By 1991, after a series of central government directives, nearly all District Health Authorities provided some sort of service which offered face to face help to
problem drug users. DHA’s did not always need to incorporate those services into their own organisation but could provide resources for non-statutory agencies instead. Roughly speaking, the spread of drug agencies followed the pattern of known prevalence of problem drug use. Thus, areas of high prevalence, such as London, Liverpool, Manchester gave birth to the largest number of drug agencies and the largest cohort of drug workers.

There were several considerations in choosing the geographical area in which to conduct the research. Previous experience and the experience of other researchers suggested that trying to obtain a high response rate from all 550 agencies throughout the UK was simply impractical. Also, some of the agencies were bound to refer me to District Health Authority Ethical Committees and negotiating with scores of such committees would be extremely time consuming and difficult.

Therefore, two Regional Health Authorities were chosen. There were not enough agencies within any one Regional Health Authority to provide an adequate sample. The number of agencies, and therefore problem drug users and drug workers, was crucial because it was apparent that a sufficiently large cohort was not available in all areas of the country. Trent Region was excluded because the author worked with a large number of the drug workers and problem drug users in the area. Northwest Regional Health Authority and Merseyside Regional Health Authority were finally chosen as the geographical areas where the research would be conducted. These two Regional Health Authorities fulfilled the following criteria, they:
* had well defined (at least compared to other Regional Health Authorities) policies about problem drug use.
* had a large known prevalence of problem drug use and a cohort of problem drug users would not be difficult to find.
* had a relatively large number of drug agencies and drug workers within those agencies.
* were within a relatively short distance from the base of the researcher and made visiting agencies more practical.

The two Regional Health Authorities had a history of supporting research and the research would have a better chance of cooperation from agencies which had previously taken part in research projects. In practice, this was found to be a mixed blessing. A few agencies complained of "research fatigue" and were less willing to cooperate because other researchers had recently been to their projects and interviewed clients. Also, by the time the research began, it had become custom and practice for researchers in both regions to offer clients of agencies £2 telephone cards for their cooperation. In fact, several agencies made this a precondition to their participation.

It was concluded that the provision of a £2 telephone card would not influence the results, especially when comparing them to drug workers. After all, drug workers mainly completed the questionnaires during work time so in effect they were
paid for their cooperation.
In order to answer the questions which the research sought to answer, a cohort of 100-150 problem drug users who were attending drug agencies and 300 drug workers were needed. More drug workers were needed because the analysis required smaller sub-groups, i.e. by professions.

FEATURES OF THE NORTHWEST REGIONAL HEALTH AUTHORITY AND MERSEYSIDE REGIONAL HEALTH AUTHORITY

NORTH WESTERN REGIONAL HEALTH AUTHORITY - North Western Regional Health Authority roughly covered the metropolitan area of Manchester and extends from Southport in the South to Lancaster in the North. The Eastern boundary are the Pennines and the Western boundary is Blackpool, West Lancashire and Wigan. The population of the Regional Health Authority is just over 4,000,000 (NWRHA, 1993). Most of the population reside in the city and suburbs of Manchester. The rural areas tend to be in the Northern portion of the Region. The urban areas have a known high prevalence of problem drug use, particularly over the last 10 years. In 1991, there were 2,582 "drug addicts" notified to the Home Office from North Western Regional Health Authority. This was a rate of 643 notifications per million, the second highest rate in the country. (NWRHA, 1993).

The region was divided into 19 District Health Authorities (DHAs). Each of those 19 DHAs have a Community Drug Team. The size and staffing of the Community Drug Team is decided by each DHA but all District Health Authorities have agreed to play a part in the Regional Health Authority plan for services for problem drug users.
MERSEYSIDE REGIONAL HEALTH AUTHORITY - Merseyside Regional Health Authority was divided into 10 District Health Authorities. Most of the District Health Authorities are in urban conurbations. Merseyside is an area with high unemployment and considerable deprivation. Problem drug use is a common feature in nearly all communities. Notifications to the Home Office Index are the highest in the United Kingdom. In 1991, there were 3,459 notifications, representing a rate of 1,440 notifications per 1,000,000 population - over twice the rate of the next highest Regional Health Authority, North Western Region at 643 notifications per 1,000,000 (NWRHA, 1993).

ETHICAL COMMITTEES
After consultation with officers in the Regional Health Authority, it became apparent that the approval of at least one District Health Authority was essential. On the advice of several people within the Health Authority, ethical approval was not applied for within the other Regional Health Authority. As the research would have no influence on treatment and no personal information from patients or clients which could identify them, the advice was that contacting Ethical Committees was not mandatory.

It was felt, however, that it would be helpful to gain the support of the Regional Drugs Advisor in the Northwest Regional Health Authority. After a brief discussion he agreed to write to the Ethical Committees of all 19 District Health Authorities and enclose my research proposal, which he endorsed.
In the event, only 4 of the 19 District Health Authorities had any questions or objections:

1/ One Health Authority simply asked for more details on how precisely the drug users would be chosen. Procedures were provided on methods which were to be employed on choosing drug users for participation in the study. These included assurance that sufficient time would be allocated to each agency to allow the researcher to consult with the staff on the best way to approach their clients. They accepted that the researcher would simply sit in the Waiting Room and ask anyone who came in. Those who were excessively intoxicated (e.g. slurred speech, poor coordination, poor attention span) were excluded.

2/ Another Health Authority Ethical Committee demanded a second reassurance of confidentiality and asked that the consent of the staff was obtained before the client was approached. In practice, the quota of problem drug users was already filled by the time the agency in question was visited.

3/ A third Health Authority Ethical Committee asked for a form for to be completed. The form was 5 pages long and had questions which were relevant to medical research. For example, there were questions about what radioactive
substances were intended to be used, what experimental drugs were being tested, etc. They also asked that a signed release from any patient who filled in a questionnaire be obtained. This was agreed.

4/ A fourth Health Authority Ethical Committee insisted that the researcher attend a meeting of the Ethical Committee to present the protocol and answer questions. In order to promote the project, letters of support were provided from three Consultant Psychiatrists in the Drug Field (including their own Consultant) and Professor Bean from Loughborough University. On the day the researcher had to present the proposal to 15 members of the Ethical Committee who spent 45 minutes considering issues of ethics and methodology. The outcome was favourable and they agreed on the provision that all agencies be contacted at least 4 weeks before they were visited and that drug users sign a consent form which reminds them that this research will in no way interfere with their treatment. Also, they would ask for a yearly progress report, which they have received.

**DRUG AGENCIES**

While negotiating with the last two Ethical Committees in District Health Authorities, the fieldwork was started.
Although Ethical Committee approval was not yet granted, it was clear that the research could go ahead in at least 17 of the 19 DHAs in Northwest Regional Health Authority. Within two months the last 2 remaining Ethical Committees agreed that the research could proceed. All 19 District Health authorities were included in the research. There was no impediment in Merseyside Regional Health Authority. Information was gathered about the drug agencies in both Regional Health Authorities. A preliminary list of agencies was found in the Directory of the Standing Conference on Drug Abuse. Their directory, however, was by then two years old and more up-to-date information was required. This information for the Northwest Regional Health Authority was readily found in a recent publication which they sponsored called the "Resource Directory for Drug, HIV/AIDS & Alcohol Services in the North Western Region", November 1991. The resource directory is 214 pages and has detailed information about agencies providing help for the previously mentioned groups of people. It is divided into sections on each of the 19 District Health Authorities and also region wide services. There is a separate page on each agency which includes address, telephone number, opening hours, several paragraphs on services provided and a list of all staff designations and how many of each. Merseyside Regional Health Authority had no similar list but did provide a photocopied "Directory of Drug Services for Residents of Liverpool". This directory listed 21 agencies which provided help for those with drug problems. It also included self help groups, services for tranquilliser users
and generic counselling services. There was a sentence or two about what each service provided.

Clearly not all agencies were to be used in my research. As the main interest is the differences in beliefs held by problem drug users compared to professional drug workers, self help groups which were staffed by volunteers were excluded. Volunteers, even if they worked for agencies where the rest of the staff were paid, were also excluded. All agencies which had as their main brief the provision of help or services for problem drug users were included. There were no agencies which only provided help for people who had problems with tranquilliser use. All of the drug agencies served some clients or patients suffering from tranquilliser problems. Agencies who’s main brief was to provide services for those with alcohol problems, even though they may also have problems with illicit drugs or tranquillisers, were excluded. Also, agencies who’s main brief was to provide services for HIV/AIDS and incidently would see a small number of problem drug users were excluded. The agency had to fulfil the following criteria:

a/ The main work of the agency had to be the provision of help or services for problem drug users. Several agencies worked with both alcohol and drug users but in practice saw few alcohol users. One agency mainly served solvent users but when a worker from that agency was interviewed, it became clear that they were mainly young polydrug users.

b/ The agency had to be situated in a District
Health Authority which was part of Merseyside Regional Health Authority or Northwest Regional Health Authority.

c/ The agency had to have at least one paid member of staff and deal directly (i.e. face to face) with problem drug users. This, therefore, excluded drug training agencies if they did not also provide face to face services for drug users and a telephone hotline as they never had face to face contact with problem drug users.

In choosing the member of staff to interview, they had to fulfil the following criteria:

a/ They had to be part of the staff team for at least 1 session (i.e. 2 1/2 hours) every two weeks. They may have been employed by other agencies and seconded to a drug agency. This was the case in many of the Community Drug Teams which employed General Practitioners and had sessional work provided by Probation Officers and Local Authority Social Workers.

b/ Administrative staff were excluded unless they performed tasks which required them to interview, advise or assess problem drug users. In those cases where Administrative Staff were included it was because they frequently made assessments or actively took part in at least one of the services provided by the agency such as the needle exchange.

Many of the agencies provided essentially the same service
even though they had different names. Drug Dependency Clinics and Community Drug Teams (with one exception) all provided a prescribing service where mainly oral Methadone was used. In four of the Drug Dependency Clinics, there was a more liberal prescribing policy and they were more likely to prescribe injectable drugs, heroin or amphetamines. Some of these services were hospital based.

Of the above agencies, a majority are statutory and all the statutory services are within the NHS. The proportion of non-statutory agencies is higher in Merseyside (41%) than in the Northwest (18%). This is because of the agreed regional development plan in Northwest Region where each District Health Authority agreed to have a Community Drug Team within statutory health service provision.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>DRUG AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statutory</td>
</tr>
<tr>
<td>Northwest Region</td>
<td>20</td>
</tr>
<tr>
<td>Merseyside Region</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

The final list of agencies which were going to be included in the research was not determined until after most of the agencies were actually visited. In each visit to an agency a list of agencies was shown to the staff they were asked for the names of agencies which were missed. This was particularly important in Merseyside where no accurate and up-to-date information similar to the "Resource Directory" available for
the North Western Region was available.

VISITING THE AGENCIES

In order to obtain the cooperation of the agencies, the director, coordinator, or Consultant was contacted at least one month before the visit. Most agencies insisted upon seeing the questionnaire for staff and their drug using clients before they would agree to take part in the study. Therefore, the letter included a one page description of the research and copies of the questionnaires.

Sending the questionnaires before the visit did not influence how the drug workers or users responded. Usually it was at least 3 weeks and sometimes up to 10 weeks between sending the questionnaire and the visit to the agency. When the questionnaires were distributed, many of the staff said that they hadn’t seen them before and complained about their managers for not showing them! For the others, they remembered seeing them before but remembered little about them. There were no instances of any drug workers turning to a particular page of the questionnaire and asking questions before they reached that page by systematically completing the questionnaire. Also, by the time the agency was visited, they had not only forgotten the contents of the questionnaire and protocol but often required a reminder that they had previously agreed to take part in the research.

After writing to the director of the agency, a telephone call was made about 3 or 4 days after they received the letter. Frequently the director of the agency asked that the researcher ring again after they have had a chance to discuss
the research in a staff meeting. Contacting agencies and having them agree to a visit was a major administrative task. One agency insisted upon a visit just to discuss my proposed research. This entailed a drive of almost 300 miles for a discussion that took 20 minutes before they agreed with the proposal. In another instance it required over 30 telephone calls to reach a Consultant Psychiatrist to obtain permission to conduct the research. Two small agencies (one with 1 staff and the other with 3 staff) agreed to take part in the research but did not allow a visit. They were sent questionnaires with instructions and returned them by post. Telephone calls to the agencies gave them assurance about the following procedures:

1/ All questionnaires and taped interviews would be strictly confidential.
2/ The questionnaires, on average, required only 20 minutes to complete.
3/ The researcher would be available to come anytime that was convenient to the agency.
4/ When waiting for clients to ask them to complete a questionnaire or take part in a taped interview, the researcher would not interfere with the business of the agency.

Of the 56 agencies which fulfilled the criteria, 51 took part in the study. The five agencies which declined were, Blackburn Community Drug Team and Inward House in North Western Region and Kirkby Community Drug team, Artskill and Response in Merseyside Region. These 5 agencies employed a total of 18
drug workers. The reasons they felt that they could not take part in the study were:

   a/ Overwhelmed with work
   b/ Had recently taken part in research and were unhappy with the process
   c/ Felt that they were being threatened with closure and did not have the time

**THE STAFF**

Not all staff were asked to complete the questionnaire. Secretarial and administrative staff who did not face to face work with problem drug users were excluded. In some instances administrative staff were included if they also had some duties working with problem drug users, often in the form of helping in the Needle Exchange.

In most cases the weekly staff meeting was the most appropriate time to be introduced to the staff. During the meeting a brief explanation of the research was presented. The staff were then asked if they would be prepared to complete the questionnaire immediately. This allowed time to obtain a relatively large proportion of staff compliance within a short time.

For the most part, the interviews were completed in one day and for small agencies only 1/2 day was necessary. Most agencies had less than 10 members of staff (40 of the 52 agencies and all three of the agencies which responded by postal questionnaire). In some agencies though there was a need to return several times. The largest agencies (20 staff or more, of which there were 4) were given more time and
attention. For instance, sometimes up to 14 hours at a time was needed to see several shifts within a hospital setting. In order to enlist the cooperation of those staff who did not attend the staff meeting the researcher waited for them to return or returned at another time or day to ask them to complete my questionnaire. If this was not possible, a brief explanation of the research and a questionnaire with written instructions and a self address stamped envelope was left. Besides the questionnaire, 10 semi-structured taped interviews with staff and clients (5 each) were conducted. The purpose of these taped interviews was to allow clients and staff the opportunity to give more detailed explanations on how they understood problem drug use. The 12 questions were all open-ended and constructed in a similar way to the questionnaire. They had to do with which of three models of problem drug use were found to be the most helpful in understanding the origins and helping problem drug users. In 13 instances the researcher was asked by staff to explain the meaning of questions in the questionnaire. Two members of staff did not understand the meaning of "genetic" and this was explained to them. One question (question 16) required clarification for 4 staff who completed the questionnaire.

THE DRUG USERS

It was decided to aim for 100 to 150 completed questionnaires by problem drug users who attended drug agencies. As the number of agencies was relatively large (51) it was not necessary to obtain completed drug user questionnaires from every agency. A sample of two or three from each agency would
not have been representative of the drug users who attend that agency. In order to ensure a representative sample of problem drug users who came to specialist drug agencies for help, not more than 10% (i.e. 15) of my sample of problem drug users came from any one agency. This was to prevent any one agencies’ drug users from biasing the sample.

In practice, many of the agencies with different titles performed the same function. Drug Dependency Clinics and Community Drug Teams all claimed to provide counselling, information, referral, advice and for a large proportion of their clients or patients, access to a prescription for controlled drugs. In the case of Drug Dependency Clinics, the prescribing was carried out by a Consultant Psychiatrist with a special interest in drug misuse. Several Community Drug Teams also used a Consultant Psychiatrist but mainly they employed General Practitioners. Drug Dependency Clinics (DDCs) and Community Drug Teams (CDTs) were analyzed separately because DDCs usually included in-patient hospital facilities which CDTs did not. Also, DDCs had a Regional remit while CDTs, for the most part, only served the local District Health Authority.

Needle Exchanges and Advice and Information agencies were included as one agency. All Advice and Information agencies, except one, provided a Needle Exchange programme. They also provided some counselling, referral to other agencies, information on health issues, etc.

The tables below show what category of agency provided drug users for the study:
### TABLE 2
AGENCIES WHERE DRUG USERS COMPLETED QUESTIONNAIRES
MERSEYSIDE REGION

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
<th>Number of Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dep. Clinics</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Comm. Drug Team</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Advice/Infor &amp; Needle X</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Residential</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>82</strong></td>
</tr>
</tbody>
</table>

### TABLE 3
AGENCIES WHERE DRUG USERS COMPLETED QUESTIONNAIRES
NORTH WESTERN REGION

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
<th>Number of Drug Users</th>
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<tbody>
<tr>
<td>Drug Dep. Clinics</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Comm. Drug Team</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>Advice/Infor &amp; Needle X</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

### TABLE 4
AGENCIES WHERE DRUG USERS DID NOT COMPLETE QUESTIONNAIRES
MERSEYSIDE REGION

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dep. Clinics</td>
<td>0</td>
</tr>
<tr>
<td>Comm. Drug Team</td>
<td>2</td>
</tr>
<tr>
<td>Advice/Infor &amp; Needle X</td>
<td>2</td>
</tr>
<tr>
<td>Residential</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
Most of the drug users who completed questionnaires came from Community Drug Teams or Drug Dependency Clinics, as one would expect because they represented the largest number of agencies, 27 of the 51 agencies which took part in the study. They provided 81 of the 150 problem drug users who completed questionnaires.

It was more difficult to find problem drug users in Advice/Information agencies and Needle Exchanges. This is probably because of the nature of the agencies. Most drug users who came to Community Drug Teams or Drug Dependency Clinics had appointments with a member of staff and were waiting in the waiting room to be seen. Most of the drug users who came into Advice/Information Centres & Needle Exchanges came for needles and syringes. Some of them were in and out of the agency within a few minutes and were not as willing to take part in the research.

The drug users from the residential agencies were all drug free at the time they completed the questionnaire. Some of
them had been in the programme (and hence claimed to be drug free) for almost a year and others had been drug free for only a week or less.

As many drug users as possible were given the questionnaire on the day that the agency was visited. With the permission of the staff, the Waiting Room was used and each person who entered was asked to complete a questionnaire. A brief explanation of the purpose of the questionnaire was given. The researcher sat with them as they completed the questionnaire. In most cases, they were able to complete the questionnaire without asking for further clarification. However, in 5 cases it became apparent that the drug user had difficulty with reading and in those 5 cases he or she was escorted to another room where they could be helped in private. In total, there were 30 queries about specific questions in the questionnaire. One of the questions, question 2. (Genetic influence is an important factor in becoming a problem drug user.) was queried by 9 drug users. They did not understand the meaning of the word "genetic" and this had to be explained. The word "genetic" was difficult to replace in the pilot questionnaire. Several replacements such as "inherent" or "biological" were tried but they proved equally problematic and caused as many queries as "genetic".

In several instances, where more than one person was completing a questionnaire at a time, they began to talk about their answers. The researcher quickly intervened and asked them not to do so. In two cases, the questionnaire was completed so quickly that there were doubts that they were
read. These two questionnaires were excluded from the data. In four instances, the drug user was so heavily intoxicated that the data was excluded. In one of those cases the drug user lost consciousness three times before filling out the first page. The criteria used to judge whether a drug user was too intoxicated to use their data included heavily slurred speed, poor concentration, delusions, poor hand/eye coordination, and poor motor facilities. In one other case, the staff informed the researcher that the drug user had current and severe mental health problems and his questionnaire was excluded on this basis.

By the time 1/2 of the agencies were visited, 91 drug user questionnaires were completed. In order to balance the response rates from different agencies, several agencies provided drug workers only, especially those from categories of agencies which had already provided adequate numbers of problem drug users. The amount of time required to obtain completed questionnaires from problem drug users was variable. In one agency 10 questionnaires were completed in 2 1/2 hours. In another instance, 6 hours of waiting produced not even one completed questionnaire. There were few people who came to the agency that day and those that did not linger long enough to complete a questionnaire.

Each problem drug user was given a telephone card worth £2 when they returned the questionnaire. This procedure was established by previous researchers in the area and several agencies were not prepared to take part unless this procedure was followed. No doubt, it did help in finding a population
within a relatively short time. There is no indication that this procedure influenced the results. The staff mainly completed the questionnaire during work time and therefore they, in essence, were paid to take part. Six problem drug users agreed to be interviewed in the form of a semi-structured questionnaire. They were chosen randomly. With the permission of the agency they were taken to a room where the interview could be concluded. One of the six tape recorded interviews was discarded because the participant was clearly intimidated by the tape recorder and could not respond to most of the questions besides a yes or no. Considerable time and effort was made trying to make him at ease and to get him to talk about other things in order to get used to talking into a tape recorder. The researcher failed to make him sufficiently at ease to use his information.

The following list of agencies fulfilled the criteria to be included in the research.
TABLE 6
MERSEYSIDE REGIONAL HEALTH AUTHORITY

<table>
<thead>
<tr>
<th>NAME OF AGENCY</th>
<th>TYPE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ Regional Drug Dependency</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>2/ Maryland Clinic</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>3/ Liverpool Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>4/ Birchwood House</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>5/ Drug Free</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>6/ Phoenix House</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>7/ Outpost</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>8/ Countess of Chester Regional DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>9/ Turning Point, Chester</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>10/ Wirral DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>11/ Wirral Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>12/ Barnabos</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>13/ SHADO</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>14/ St. Helens Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>15/ Crewe CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>16/ Widnes DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>17/ Lifeline Warrington</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>18/ Southport Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>19/ South Knowsley CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>20/ South Sefton CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>21/ Warrington DDU</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>22/ Thomas Percival Trust</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>NAME OF AGENCY</td>
<td>TYPE OF SERVICE</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>1/ Lifeline</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>2/ Heathershaw</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>3/ Oldham Needle Exchange</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>4/ Rochdale CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>5/ Oldham CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>6/ Wigan CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>7/ Bolton CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>8/ Chatterton Hey</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>9/ Manchester Central CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>10/ Stockport CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>11/ North Manchester CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>12/ Prestwich Hospital Regional Drug Dependency Unit</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>13/ Bury CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>14/ Trafford CDT</td>
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<td>15/ Rochdale Needle Exchange</td>
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<td>16/ So. Manchester CDT</td>
<td>Community Drug Team</td>
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<td>17/ DASH</td>
<td>Advice/Information/Needle X</td>
</tr>
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<td>Community Drug Team</td>
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<td>19/ Chorley CDT</td>
<td>Community Drug Team</td>
</tr>
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<td>21/ Salford CDT</td>
<td>Community Drug Team</td>
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<td>22/ West Lancashire CDT</td>
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<td>23/ Lancaster CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>24/ Preston CDT</td>
<td>Community Drug Team</td>
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<td>25/ Burnley CDT</td>
<td>Community Drug Team</td>
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<td>26/ Burnley DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>27/ Lancaster Needle Exchange</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>28/ Blackburn Outreach</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>29/ Blackpool CDT</td>
<td>Community Drug Team</td>
</tr>
</tbody>
</table>
RESULTS

As stated in the introduction, the purpose of this study is to examine the models and assumptions about problem drug use held by problem drug users who attend drug agencies and compare and contrast them to those held by professionals in drug agencies. The results correspond to the aims of the study which are stated in the chapter on Methodology. The first part of the results cover the agencies in which the study was based.

THE INDIVIDUAL DRUG AGENCIES

These agencies are all located in either (what was) Merseyside Regional Health Authority or the North Western Regional Health Authority. They are all drug treatment agencies which provide services for problem drug users as their primary function. Other more generic services for problem drug users are not included. The agencies are divided into four types. The division of agencies into 4 basic types reflects the function of the agencies and also their names.

1/ Community Drug Teams (CDT) - with only one exception (Barnabos), all others were called Community Drug Teams and served several functions. They all deliver services to a District Health Authority and usually did not knowingly provide services to people who lived outside their catchment area. Perhaps some people from other health authorities came for information or advice but more time consuming and expensive services such as prescribing were reserved for residents of the health authority where they practised. In several areas problem drug users from outside of the health authority were treated but these were insignificant in number. All of the Community Drug Teams provided
access to a physician for drug prescriptions and other medical services, though one CDT was advertising for a physician to provide such a service when they were interviewed.

**Drug Dependency Clinics (DDC)** - were usually larger organisations than Community Drug Teams and provided services for referrals from the entire Regional Health Authority (and beyond). One DDC had 1000 patients on opiate prescriptions, another had 800. The others had smaller patient lists. A second feature of DDCs which distinguished them from Community Drug Teams is that they all had access to in-patient beds which were available (for a price in the form of Extra-Contractual Referrals) to District Health Authorities within their own region or others. Often they provided a wider range of prescribing options for patients and most of the DDCs prescribed a variety of drugs such as injectable Methadone, Amphetamines, Cocaine, and Heroin.

**Advice, information and Needle Exchanges** - made up the third category of agencies. These agencies were usually within the non-statutory field. On the whole, these were non-medical services. Few had direct access to a physician and they rarely provided prescriptions for Methadone or other drugs. They all, save two, provided needle and syringe exchange services. To varying degrees they provided education and training as well. Some of these agencies were very small, employing only one or two individuals who had a very specific task.

**Residential agencies** - were the fourth category. They were all distinguished by the fact that they provide beds for longer term (up to 18 months) rehabilitation. No drugs were provided by the agencies and all of them are abstinence orientated. All of the
residents should have been drug free except for those who had just arrived who may have still been experiencing varying degrees of withdrawal symptoms. A few of the residential programmes provided quick detoxification programmes while in the house but none of the residents who took part in the survey were receiving any drugs. All of the residential agencies are in the non-statutory sector.

As stated earlier in the chapter on Methodology, within the two regional health authorities five agencies declined to take part in the study. These five agencies were; Blackburn Community Drug Team and Inward House in North Western Region and Kirkby Community Drug team, Artskill and Response in Merseyside Region. These 5 agencies employed 18 staff. As far as could be determined, without visiting the agencies, they fulfilled the criteria for inclusion. The agencies gave a variety of reasons why they felt they were unable to take part. These included: being very busy and short staffed, recent participation in research, dissatisfaction with research in general, and one agency said it felt threatened with imminent closure.

On the following page are the agencies which took part in the study.
<table>
<thead>
<tr>
<th>NAME OF AGENCY</th>
<th>TYPE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ Regional Drug Dependency Clinic - Hope Street</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>2/ Maryland Clinic</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>3/ Liverpool Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
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<tr>
<td>12/ Barnabos</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>13/ SHADO</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>14/ St. Helens Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>15/ Crewe CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>16/ Widnes DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>17/ Lifeline Warrington</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>18/ Southport Merseyside Drug Council</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>19/ South Knowsley CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>20/ South Sefton CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>21/ Warrington DDU</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>22/ Thomas Percival Trust</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>NAME OF AGENCY</td>
<td>TYPE OF SERVICE</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>1/ Lifeline</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>2/ Heathershaw</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>3/ Oldham Needle Exchange</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>4/ Rochdale CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>5/ Oldham CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>6/ Wigan CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>7/ Bolton CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>8/ Chatterton Hey</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>9/ Manchester Central CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>10/ Stockport CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>11/ North Manchester CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>12/ Prestwich Hospital Regional Drug Dependency Unit</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>13/ Bury CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>14/ Trafford CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>15/ Rochdale Needle Exchange</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>16/ South Manchester CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>17/ DASH</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>18/ Tameside CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>19/ Chorley CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>20/ Westcliffe House</td>
<td>Residential Rehabilitation</td>
</tr>
<tr>
<td>21/ Salford CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>22/ West Lancashire CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>23/ Lancaster CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>24/ Preston CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>25/ Burnley CDT</td>
<td>Community Drug Team</td>
</tr>
<tr>
<td>26/ Burnley DDC</td>
<td>Drug Dependency Clinic</td>
</tr>
<tr>
<td>27/ Lancaster Needle Exchange</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>28/ Blackburn Outreach</td>
<td>Advice/Information/Needle X</td>
</tr>
<tr>
<td>29/ Blackpool CDT</td>
<td>Community Drug Team</td>
</tr>
</tbody>
</table>
Below are the agencies where drug users completed questionnaires.

### TABLE 10

**AGENCIES WHERE DRUG USERS COMPLETED QUESTIONNAIRES**

**MERSEYSIDE REGION**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
<th>Number of Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Clinics</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Community Drug Teams</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Advice, Information &amp; Needle Exchanges</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Residential Establishments</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>82</strong></td>
</tr>
</tbody>
</table>

### TABLE 11

**AGENCIES WHERE DRUG USERS COMPLETED QUESTIONNAIRES**

**NORTH WESTERN REGION**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
<th>Number of Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Clinics</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Community Drug Teams</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>Advice, Information &amp; Needle Exchanges</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential Establishments</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

### TABLE 12

**AGENCIES WHERE DRUG USERS DID NOT COMPLETE QUESTIONNAIRES**

**MERSEYSIDE REGION**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>No. of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Clinics</td>
<td>0</td>
</tr>
<tr>
<td>Community Drug Teams</td>
<td>2</td>
</tr>
<tr>
<td>Advice, Information &amp; Needle Exchanges</td>
<td>2</td>
</tr>
<tr>
<td>Residential Establishments</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
Most of the drug users who completed questionnaires came from Community Drug Teams or Drug Dependency Clinics, as one would expect. This is because, for the most part, they had appointments with key workers in the agency and did not come for a brief visit for the purpose of using the needle exchange (a major role of non-statutory agencies) or other brief services. They represented the largest number of agencies, 27 (52%) of the 52 agencies which took part in the study. They provided 97 (65%) of the 150 problem drug users who completed questionnaires.

It was more difficult to find problem drug users in Advice/Information and Needle Exchanges agencies. This is probably because of the nature of the agencies. Most drug users who came to Community Drug Teams or Drug Dependency Clinics had appointments with a member of staff and were waiting to be seen. Most of the drug users who came into Advice/Information Centres & Needle Exchange agencies came for needles and syringes. Some of them were in and out of the agency within a few minutes and were not as willing to take the time to complete a questionnaire.
The drug users from the residential agencies were, for all practical purposes, drug free at the time they completed the questionnaire. Some of them had been in the programme (and hence claimed to be drug free) for almost a year and others had been drug free for only a week or less.

Staffing

The total number of staff positions at all of the agencies within the two Regional Health Authorities was at the time of the recording 406. This total was divided almost evenly between the two Regional Health Authorities, 201 in Merseyside Regional Health Authority and 205 in North Western Regional Health Authority. Within the 406 staff at all of the above agencies, 16 sessional or part-time posts were filled by a total of just 6 doctors who worked in more than one drug agency. Most of these positions were for only 1 or 2 sessions a week (2-4 hours), 5 were in North Western Region and 11 in Merseyside Region. All of these individuals were doctors who worked in more than one agency. Often they worked in Regional Drug Dependency Clinics and provided sessional input to Community Drug Teams.

While there were fewer agencies in Merseyside Region compared to North Western Region (22 compared to 29) they employed, on average more staff. Within Merseyside Region, there were on average 9.1 staff members per agency compared to 7.1 in North Western Region. As stated before, this reflects the differing policies within the two regions. North Western Region had at least one Community Drug Team per District Health Authority (20 in 19 DHAs within the region) while Merseyside had no such
policy. Also, Merseyside had two large Drug Dependency Clinics which employed 57 staff while North Western had only one which employed 37.

THE DEMOGRAPHIC CHARACTERISTICS OF PROBLEM DRUG WORKERS AND USERS

This section will examine the following areas, as previously stated in the chapter on Methodology:

"2) To determine the characteristics of drug workers at those agencies and problem drug users who attend agencies which may influence those beliefs, such as gender, age, drug use patterns, education, training, experience. etc. .

a. What are the essential personal characteristics of problem drug users who use drug agencies?
b. What are the essential personal characteristics of drug worker employed at those agencies?"

CHARACTERISTICS OF THE PROBLEM DRUG USERS

Gender - There were a total of 150 problem drug user respondents to the questionnaire. As can be seen from the table below, the ratio of men to women was about 7 men to 2 women.

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>114</td>
</tr>
<tr>
<td>Women</td>
<td>33</td>
</tr>
<tr>
<td>Missing data</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
</tr>
</tbody>
</table>

Proportionately, there were more women from Merseyside Regional Health Authority than from the North West Regional Health Authority, though the differences were not statistically
significant.

---

**TABLE 15**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mersey RHA</th>
<th>North West RHA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>59 (74%)</td>
<td>55 (82%)</td>
<td>114</td>
</tr>
<tr>
<td>Women</td>
<td>21 (26%)</td>
<td>12 (18%)</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>67</td>
<td>147</td>
</tr>
</tbody>
</table>

\[ X^2 = 1.46 \]

level of significance = .227

df = 1

---

As can be seen from the table below, almost half of all respondents came from Community Drug Teams. Women were less likely to be found in residential facilities than in other agencies. This is partially explained by the fact that one residential facility was for men only. The others usually had a larger proportion of men to women. Mainly this has been because of the nature of residential establishments. Many referrals had been heavily involved in the criminal justice system and a large proportion were homeless. Women problem drug users were less likely to be involved in the criminal justice system and less likely to be homeless. Lack of child care facilities in most residential establishments may well have prevented more women from entering them. Finally, many women commented that the hostels were so dominated by men that they felt that they were intrusive and vulnerable.
TABLE 16
GENDER BY AGENCY TYPE

<table>
<thead>
<tr>
<th></th>
<th>CDT</th>
<th>Ad/inform</th>
<th>Residnt</th>
<th>DDC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>53</td>
<td>10</td>
<td>28</td>
<td>23</td>
<td>114</td>
</tr>
<tr>
<td>Women</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>17</td>
<td>33</td>
<td>29</td>
<td>147</td>
</tr>
</tbody>
</table>

\[ X = 4.49 \]
\[ \text{level of significance} = .213 \]
\[ df = 3 \]

Age

The Median age is 27 and the Mean age is 28. The youngest respondent was aged 18 and the oldest age 44. Within this range the distribution into gender and age groups is below.

TABLE 17
AGE BY GENDER AND AGE GROUPS

<table>
<thead>
<tr>
<th>Age</th>
<th>18-21</th>
<th>22-29</th>
<th>30-44</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>12</td>
<td>61</td>
<td>40</td>
<td>113</td>
</tr>
<tr>
<td>Women</td>
<td>7</td>
<td>15</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>76</td>
<td>51</td>
<td>146</td>
</tr>
</tbody>
</table>

\[ X = 2.59 \]
\[ \text{level of significance} = .274 \]
\[ df = 2 \]

A total of 3 respondents failed to record their age and another 3 failed to record their gender. Two of the above respondents failed to record both age and gender.

The distribution by age groups was roughly the same in the two Regional Health Authorities.
TABLE 18
AGE BY REGIONAL HEALTH AUTHORITY AND AGE GROUP

<table>
<thead>
<tr>
<th>Age</th>
<th>18-21</th>
<th>22-29</th>
<th>30-44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mersey</td>
<td>11</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>North West</td>
<td>8</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>77</td>
<td>51</td>
</tr>
</tbody>
</table>

\[X = .922\]
level of significance = .630
df = 2

The differences in age groups between the two Regional Health Authorities did not reach statistical significance.

TABLE 19
AGE BY AGENCY TYPE

<table>
<thead>
<tr>
<th>Age</th>
<th>CDT</th>
<th>Ad/inform</th>
<th>Residnt</th>
<th>DDC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-21</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>22-29</td>
<td>39</td>
<td>9</td>
<td>16</td>
<td>13</td>
<td>77</td>
</tr>
<tr>
<td>30-39</td>
<td>18</td>
<td>4</td>
<td>10</td>
<td>13</td>
<td>45</td>
</tr>
<tr>
<td>40-44</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>17</td>
<td>33</td>
<td>29</td>
<td>147</td>
</tr>
</tbody>
</table>

\[X = 5.69\]
level of significance = .458
df = 6

Community Drug Teams were more likely to attract a younger age group than Drug Dependency Units. This may reflect the fact that most of the DDCs were established before the Community Drug Teams and hence may have an older, ageing population.
Table 20

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afro/Caribbean</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Indian/Pakistani</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>12</td>
<td>10.0</td>
</tr>
<tr>
<td>White</td>
<td>106</td>
<td>80.7</td>
</tr>
<tr>
<td>Oriental</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Refused</td>
<td>17</td>
<td>11.3</td>
</tr>
<tr>
<td>Missing data</td>
<td>10</td>
<td>6.7</td>
</tr>
</tbody>
</table>

The majority of respondents described themselves as "White". A total of 18% of all responses were either "Refused" (11.3%) or the data was missing (6.7%), making it difficult to tell how representative this group is of the general population. Men were more likely to refuse to answer the question, 15 of 17 in that category were men. None of the women described themselves as anything but White, except 2 who described themselves as Mixed Race.

Drug Use

This question was used to determine which drugs problem drug users have used on a regular basis, now or in the past. As there were normative data from the Regional Data Bases in both Merseyside and North Western Health Authority this will not be considered in relation to problem drug users who attend agencies at this time.

However, patterns of drug use between the two regions were compared.
Past and current drug use.

The tables below show past and current drug use by drugs and region.

### TABLE 21
PAST AND CURRENT DRUG USE - OPIATES

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency</th>
<th>North Western Frequency</th>
<th>2 Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>79 (96%)</td>
<td>59 (87%)</td>
<td>4.63</td>
</tr>
</tbody>
</table>

df = 1

### TABLE 22
PAST AND CURRENT DRUG USE - STIMULANTS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency</th>
<th>North Western Frequency</th>
<th>2 Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulants</td>
<td>56 (68%)</td>
<td>53 (78%)</td>
<td>1.74</td>
</tr>
</tbody>
</table>

df = 1

### TABLE 23
PAST AND CURRENT DRUG USE - BARBITURATES

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency</th>
<th>North Western Frequency</th>
<th>2 Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbiturates</td>
<td>21 (26%)</td>
<td>23 (34%)</td>
<td>1.21</td>
</tr>
</tbody>
</table>

df = 1

### TABLE 24
PAST AND CURRENT DRUG USE - HALLUCINOGENICS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency</th>
<th>North Western Frequency</th>
<th>2 Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinog'c</td>
<td>46 (56%)</td>
<td>38 (56%)</td>
<td>.001</td>
</tr>
</tbody>
</table>

df = 1

### TABLE 25
PAST AND CURRENT DRUG USE - INHALANTS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency</th>
<th>North Western Frequency</th>
<th>2 Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalants</td>
<td>22 (27%)</td>
<td>9 (13%)</td>
<td>4.19</td>
</tr>
</tbody>
</table>

df = 1

178
Opiates were the most popular drugs. A Chi square test was used to see if particular drugs were more likely to be used in one Regional Health Authority rather than another. Respondents from both Regions preferred opiate drugs but those from Merseyside Region were statistically more likely to have used opiates compared to those from North Western region. There were no statistically significant differences between stimulant, barbiturate, hallucinogenic and cyclizine drug use between the two regions. Inhalants, however, were more likely to be used in Merseyside.

Gender and regular drug use

Gender was not a factor in past and drug use. The pattern of drug use by women was similar to that of men. Using a chi-square test there were no statistically significant differences between men and women.
TABLE 27
DRUG USE AND GENDER

<table>
<thead>
<tr>
<th>Drug</th>
<th>Men</th>
<th>Women</th>
<th>X value</th>
<th>level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
<td>104</td>
<td>31</td>
<td>.251</td>
<td>.616</td>
</tr>
<tr>
<td>Stimulants</td>
<td>85</td>
<td>22</td>
<td>.805</td>
<td>.370</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>35</td>
<td>8</td>
<td>.516</td>
<td>.473</td>
</tr>
<tr>
<td>Hallucinogenics</td>
<td>68</td>
<td>15</td>
<td>2.10</td>
<td>.148</td>
</tr>
<tr>
<td>Inhalants</td>
<td>23</td>
<td>8</td>
<td>.254</td>
<td>.614</td>
</tr>
<tr>
<td>Cyclizine</td>
<td>22</td>
<td>5</td>
<td>.294</td>
<td>.588</td>
</tr>
</tbody>
</table>

df = 1

Region and Preferred drug use

Problem drug users were also asked what specific drug they preferred (in contrast to the previous question where they were asked what drugs they had previously or currently used). They could only choose one drug in the list as their preferred drug.

TABLE 28
PREFERRED DRUGS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>Merseyside Frequency/%</th>
<th>North Western Frequency/%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>44 (63%)</td>
<td>25 (50%)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>5 (7%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>Methadone</td>
<td>6 (9%)</td>
<td>8 (16%)</td>
</tr>
<tr>
<td>Temazepam/Tranx</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>5 (7%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Diconal</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>6 (9%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Missing responses</td>
<td>12</td>
<td>8</td>
</tr>
</tbody>
</table>

180
Gender and drug preference

Women were more likely to prefer Methadone than men (17% to 10%) but men were more likely to prefer amphetamines than women (12% compared to 3%). On the other hand, women were more inclined to prefer Cocaine than men, 10% to 7%. Heroin was the preferred drug by both men (59%) and women (55%).

Prescribed drugs

Just over half of the sample, 79 (53%) were receiving a prescription for drugs from the agency where they were visited and 71 (47%) were not receiving a prescription from the agency. Another 26 (17%) said they were receiving a prescription from their General Practitioner or another agency, while 124 (83%) said were not. It is entirely possible that some drug users were receiving prescriptions from more than one agency.

Women were somewhat more likely to be receiving a prescription from the agency than men (61% compared to 51%). Those from North Western Region were more likely to be receiving a prescription from the agency where they were interviewed (65%) than those from Merseyside Region (43%). This difference could simply reflect the types of agencies where respondents were interviewed, i.e. in Merseyside only 39 of 82 (48%) respondents came from agencies which prescribed drugs while in North Western Region 59 of 68 (87%) came from agencies where drugs were prescribed.

Education

"0" Levels and GCSE examinations

The mean number of "0" level or GCSE examination results was 2.0. The range was from 0 to 9. Nearly half, 71 (47%), of the problem drug users had no "0" level or GCSE examination results while 26
had achieved 5 or more. In order to test whether there was a statistically significant difference between the number of "0" level or GCSE examinations between men and women, the unpaired "t" test was used. The data fits the criteria for a parametric test.

-----

**TABLE 29**
GENDER AND "0" LEVELS AND GCSE EXAMINATIONS

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean number of &quot;0&quot; levels and GCSE examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>2.0</td>
</tr>
<tr>
<td>Women</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**t-test value** = -.30
**Level of significance** = .761
**df** = 125

There was no statistical difference between men and women in their mean number of "0" level and GCSE results.

In order to test whether there was a statistically significant difference between the number of "0" level or GCSE examinations between problem drug users from the two Regional Health Authorities, the unpaired "t" test was used. The data fit the criteria for a parametric test.

-----

**TABLE 30**
REGION AND "0" LEVELS AND GCSE EXAMINATIONS

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean number of &quot;0&quot; levels and GCSE examinations by Regional Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside problem drug users</td>
<td>2.2</td>
</tr>
<tr>
<td>North Western problem drug users</td>
<td>1.9</td>
</tr>
</tbody>
</table>

**t-test value** = -.68
**Level of significance** = .499
**df** = 1

-----
There was no statistical difference between problem drug users from the two regions in their mean number of test results. Ethnic origin and "O" levels and GCSE examinations

In order to test whether there was a statistically significant difference between the number of "O" level or GCSE examinations between white and non-white problem drug users, the "t" test was used. The data fit the criteria for a parametric test.

-----

TABLE 31
MEAN NUMBER OF "O" LEVELS AND GCSE EXAMINATIONS
BY WHITE AND NON-WHITE PROBLEM DRUG USERS

White problem drug users = 2.5
Non-white problem drug users = 0.6

t-test value = 2.35
level of significance = .021
df = 1

There was a statistical difference between white and non-white problem drug users in their mean number of "O" level and GCSE results. Non-white problem drug users had achieved, on average .6 "O" level or GCSE examination results compared to 2.5 for white problem drug users. It is difficult explain why non-white problem drug users had significantly less "O" level and GCSE results than white problem drug users. Perhaps their problem drug use was more associated with deprivation than white problem drug users and educational achievement is just one indicator of that.

A total of 21 problem drug users did not answer this question. With the high number of problem drug users who did not respond to this question, or answer questions about their racial origin, it is not safe to draw firm conclusions despite the significant level of the results.
A Level examinations
Only 10 (8%) problem drug users claimed to have achieved at least one A level examinations. A total of 8 of the 10 who had achieved at least 1 A level were male. With such small numbers, it was not meaningful to submit the data to further statistical analysis.

Certificates of Further Education
There were a total of 7 (6%) problem drug users who recorded having at least one Certificate of Further Education.

University degrees
Only 3 problem drug users had a university degree, 2 came from Merseyside and all three were men.

Post graduate degrees
Only 3 problem drug users had a post-graduate degree.

A PORTRAIT OF PROBLEM DRUG USERS
The problem drug users in the population are overwhelming male, especially in North Western Region. Their mean age is 27 and there is little difference between women and men in this respect. Over half are between 22-29 and another third are between 30-39. Those from North Western Region are slightly older but not significantly. Over 80% categorised themselves as being "White", but a large proportion either neglected to provide information about their ethnic background or refused to answer this question (18%).

The great majority of problem drug users had previously or currently used opiates, 87% in North Western Region, 96% from Merseyside. Opiates were also the preferred drug as well. Adding together the three kinds of opiates (Heroin, Methadone, and
Diconal), 72% preferred opiate drugs. Many other drugs were widely used, including stimulants, hallucinogens and barbiturates. There were few differences between women and men in their pattern and preference of drug use. A total of 70% were receiving a prescription for controlled drugs, mostly from the agency where they were interviewed but some from their General Practitioner or another agency. Just under 1/2 of the sample came from Community Drug Teams.

There are important differences between this population of problem drug users and drug users in general. Most recent surveys (Leitner, et al., 1994, Mott, and Mirrlees, 1994) suggest that cannabis was the by far the most widely used illicit drug. Heroin was only used by very few, usually 1 or 2% (Leitner, et al., 1993, Mott, and Mirrlees-Black, 1995). Compared to Leitner, et al. and Mott and Mirrlees-Black, this group of problem drug users were largely male, while their samples were more evenly divided. Mostly they were in receipt of prescribed controlled drugs. This also suggests that they had been involved with drugs problematically for many years.

In many important ways this population are homogeneous, i.e. they regularly use opiates, are male, in their late 20s, white, and in receipt of a prescription for controlled drugs. Other surveys of drug users (rather than problem drug users) suggest a much more heterogeneous group in terms of age, racial origin, gender, and pattern and choice of drugs. In the conclusion, they will be compared to other problem drug users within the regions.

THE DRUG WORKERS
Not counting the physicians who worked in more than one agency
(or in 2 cases, in three agencies), there were a total of 398 staff positions within the two regions, 200 in North Eastern Region and 198 in Merseyside Region. Of those 398, 317 (again, not counting the physicians who worked in more than one agency twice or three times) took part in the study. The regional breakdown is below.

TABLE 32
DRUG WORKERS IN MERSEYSIDE AND NORTH WESTERN REGIONAL HEALTH AUTHORITIES

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Staffing</th>
<th>Number interview</th>
<th>Percent interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside RHA</td>
<td>198</td>
<td>169</td>
<td>85.3%</td>
</tr>
<tr>
<td>North Western RHA</td>
<td>200</td>
<td>148</td>
<td>74.0%</td>
</tr>
<tr>
<td>Total</td>
<td>398</td>
<td>317</td>
<td>79.6%</td>
</tr>
</tbody>
</table>

Gender

TABLE 33
GENDER OF DRUG WORKERS

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>146</td>
<td>(46%)</td>
</tr>
<tr>
<td>Women</td>
<td>169</td>
<td>(54%)</td>
</tr>
<tr>
<td>Total</td>
<td>315</td>
<td></td>
</tr>
</tbody>
</table>

* Data was missing from 2 respondents

Of the 317 drug workers who completed the questionnaire, 146 (46%) were men and 169 (53%) were women. Two (1%) refused to divulge their gender.
TABLE 34
GENDER OF DRUG WORKERS BY REGION

<table>
<thead>
<tr>
<th></th>
<th>North Western</th>
<th>Merseyside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>70</td>
<td>76</td>
</tr>
<tr>
<td>Female</td>
<td>77</td>
<td>92</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>169</td>
</tr>
</tbody>
</table>

$X^2 = 1.876$
level of significance = .910
df = 2

There was no significant difference in the types of agencies where men and women found employment. All 4 categories of agencies employed slightly more women than men.

TABLE 35
GENDER OF DRUG WORKERS BY AGENCY

<table>
<thead>
<tr>
<th>Type of agency</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>65</td>
<td>71</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Drug Dependency Units</td>
<td>32</td>
<td>44</td>
</tr>
</tbody>
</table>

$X^2 = 2.165$
level of significance = .9038
df = 6

AGE

Gender and Age

The mean age of all drugs workers was 36.8 years. There were small differences between men and women but those differences were not significant.
TABLE 36
GENDER AND AGE

<table>
<thead>
<tr>
<th></th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>36.4</td>
</tr>
<tr>
<td>Women</td>
<td>37.1</td>
</tr>
</tbody>
</table>

"t" test = -.64
level of significance = .523
df = 307

Regional Health Authority and Age

TABLE 37
AGE AND REGION

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside</td>
<td>36.6</td>
</tr>
<tr>
<td>NorthWestern</td>
<td>37.0</td>
</tr>
</tbody>
</table>

"t" test = -.35
level of significance = .729
df = 309

The mean age of drug workers was 36.8 years of age. The oldest was 62 and the youngest was 22. Only 65 (21%) of the drug workers were under the age of 30. The mean age of women was slightly older than that of men, 37.1 years of age compared to 36.4 years of age. There was no statistically significant difference between the mean age of women and men. Also, there was no statistically significant difference between workers from the two regions (see above). A total of 6 participants refused or neglected to record their age.

Ethnicity

The ethnic characteristics of the drugs workers were as follows.
A total of 4 out of 5 drugs workers classified themselves as "White" and only a small minority classified themselves as Afro/Caribbean or Indian/Pakistani. A relatively large minority either refused to answer or the response was missing. There was little difference between the two Regional Health Authorities in regard to the ethnic composition of their drug workers. North Western Region had a much lower rate of "Refused" and "Missing", as said earlier, compared to Merseyside (7% compared to 19%). Most of the non-white workers were employed in Community Drug Teams, where they represented 8% of the drug workers, and Advice Centres, where they were 15%.
TABLE 39
DRUG WORKERS AND AGENCIES

<table>
<thead>
<tr>
<th>Agencies</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Clinic</td>
<td>76 (24%)</td>
</tr>
<tr>
<td>Community Drug Team</td>
<td>137 (43%)</td>
</tr>
<tr>
<td>Advice/Information/Needle Exchange</td>
<td>70 (22%)</td>
</tr>
<tr>
<td>Residential</td>
<td>34 (11%)</td>
</tr>
<tr>
<td>Total</td>
<td>317 (100%)</td>
</tr>
</tbody>
</table>

Community Drugs Teams employed nearly 50% of all staff in drugs agencies and together with Drug Dependency Clinics provided 67% of all drugs workers in the two regions. All of these agencies were service providers within the NHS, leaving less than 33% of drug workers in the non-statutory sector. In part, this represented the structure of the North Western Regional Health Authority where 18 of 29 agencies were Community Drug Teams.

Professions
Most drugs workers were professionally qualified as doctors, social workers, or nurses. There were a small number of other professions, such as psychologists or occupational therapists.

TABLE 40
PROFESSIONALLY QUALIFIED DRUG WORKERS

<table>
<thead>
<tr>
<th>Professionally qualified</th>
<th>162 (62%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Professionally qualified</td>
<td>121 (38%)</td>
</tr>
</tbody>
</table>
TABLE 41
DRUG WORKERS PROFESSIONS

<table>
<thead>
<tr>
<th>PROFESSIONS</th>
<th>Numbers &amp;% of all drug workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>36 (18%)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>38 (19%)</td>
</tr>
<tr>
<td>Nurses</td>
<td>116 (59%)</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Psychologists</td>
<td>4 (2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>196</td>
</tr>
</tbody>
</table>

Of the 317 drug workers, 196 (62%) were professionally qualified. Not all of the professionals were employed in a job which required professional qualifications. Some nurses and social workers were employed as drug counsellors or outreach workers and managers.

TABLE 42
PROFESSIONALLY QUALIFIED BY REGION

<table>
<thead>
<tr>
<th>Region</th>
<th>Prof. Qualified</th>
<th>Not Prof. Qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merseyside Region</td>
<td>82 (49%)</td>
<td>87 (51%)</td>
</tr>
<tr>
<td>North Western Region</td>
<td>105 (71%)</td>
<td>43 (29%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>187 (59%)</td>
<td>130 (41%)</td>
</tr>
</tbody>
</table>

\[ X^2 = 12.52 \]
level of significance = .000
\[ df = 1 \]

Drug workers from the North Western Region were much more likely to be professionally qualified compared to those from Merseyside Region. This reflected the much larger proportion of statutory agencies which required professional qualifications as compared
to the large number of non-statutory agencies in Merseyside which do not require professional qualification as often.

\[\begin{array}{|c|c|c|}
\hline
 & Prof. Qualified & Not Prof. Qualified \\
\hline
Men & 98 (67\%) & 48 (33\%) \\
Women & 94 (56\%) & 75 (44\%) \\
\hline
\end{array}\]

2 cases missing
\[X = 7.43\]
level of significance = .024
df = 1

Men were significantly more likely to possess a professional qualification compared to women. Most of the professionally qualified were nurses and they were usually women (67 of 116, 58\%). However, men were far more likely to be doctors (23 of 36, 64\%) or social workers (26 of 38 58\%).

Mean Length of Time Drug Workers Had Been Employed at the Agency

The mean length of time that drug workers were employed at the agency where they worked was 3 years & 2 months.

\[\begin{array}{|c|}
\hline
DRUG WORKERS MEAN LENGTH OF EMPLOYMENT AT THE AGENCY BY REGION \\
\hline
mean length of time employed (Merseyside HA) - 37.0 months \\
mean length of time employed (North West HA) - 38.4 months \\
\hline
\end{array}\]

t-test = .10
level of significance .922
range - 1 month to 31 years
The longest serving drug worker had been employed at the agency for 31 years. There was some difference when comparing women to men, women worked on average 35.4 months compared to men who worked for the same agency for 41.2 months. Drug workers with professional qualifications had, on average, been working at the agency for 38.0 months while those with no qualifications had worked at the agency for 38.5 months.

Mean Length of Time Drug Workers Had Worked with Problem Drug Users

The mean length of time working with problem drug users was 5.0 years.

---

TABLE 46
MEAN LENGTH OF TIME EMPLOYED WORKING WITH PROBLEM DRUG USERS BY REGION

mean length of time employed (Merseyside HA) - 62.0 months
mean length of time employed (North West HA) - 58.2 months

t-test = .67
level of significance .502
range - 1 month - 36 years
df = 309
Drug workers, on average had just over 5 years (60.2 months) experience working with problem drug users. The longest serving drug worker had been working with problem drug users for 36 years. Relatively few were new to the field. Only 48 (15%) had been working with problem drug users for less than 12 months and 81 (26%) for two years or less. There was no statistical significant difference between Regional Health Authorities, though drug workers from Merseyside Region were somewhat more experienced than those from North Western (Table 46).

The mean number of months for men was 69.1 months, while for women it was 52.3 months. There was a statistically significant difference between men and women when considering how long they had been working with problem drug users. This could be explained by taking into account many of the women workers having time off to have children.

Drug workers with professional qualifications had, on average, been working with problem drug users for 5 years and 4 months while those with no qualifications had been working with problem drug users for 4 years and 7 months.
TABLE 48
GENDER AND PREVIOUS PROBLEM ALCOHOL OR DRUG USE

<table>
<thead>
<tr>
<th></th>
<th>Previous alc./drug problem</th>
<th>No previous alc./drug problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>20 (13.7%)</td>
<td>126 (86.3%)</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>9 (5.3%)</td>
<td>160 (94.7%)</td>
</tr>
</tbody>
</table>

2 cases missing data

\[ X = 10.27 \]
level of significance = .006

df = 1

previous problem alcohol or drug use by drug workers was not uncommon. A total of 30 (one of whom failed to indicate their gender) drug workers claimed that they had been problem alcohol or drug users, just under 10% of the population of 317. Men were more than twice as likely, 20 of 146 (13.7%) to have been problem alcohol or drug users than women, 9 (5.3%) of 169 and this was statistically significant. This could simply reflect higher rates of alcohol and drug problems in men when compared to women.

There was little age difference between those with previous alcohol and drugs problems those without. The mean age of those with previous alcohol or drug problems was 36.1 years old while those who had no previous problem, 36.8 years old.

Problems with drugs alone accounted for 21 (70%) of the 30. Those who reported problems with alcohol alone (4) accounted for 13%, and another 5 (17%) claimed to have had problems with both alcohol and drugs.

problems with drugs alone accounted for 21 (70%) of the 30. Those who reported problems with alcohol alone (4) accounted for 13%, and another 5 (17%) claimed to have had problems with both alcohol and drugs.

Previous alcohol or drug problems
Previous problems with alcohol or drugs was claimed by 1 doctor, 2 nurses, and 4 social workers. None of the Occupational
Therapists or clinical psychologists claimed to have had problems with alcohol or drugs.

The most commonly held jobs for those with alcohol or drug problems was that of drug counsellor where 14 (19%) of 74 drug counsellors answered yes to this question. Of 30 outreach workers, 7 (23%) claimed to have previously had problems with alcohol or drugs. This was followed by 5 (12%) of Managers. Chi-square and levels of significance could not be calculated because the numbers in some professions (i.e psychologists and occupational therapists was too low).

Education and previous problem alcohol or drug use

---

TABLE 49
MEAN NUMBER OF "O" LEVEL OR GCSE EXAMINATION RESULTS BY PREVIOUS EXPERIENCE OF PROBLEM ALCOHOL OR DRUG USE

Mean Number of "O" Level or GCSE Examination Results of Drug Workers with Previous Problem Alcohol or Drug Use - 4.4

Mean Number of "O" level or GCSE Examination Results of Drug Workers with No Previous Problem Alcohol or Drug Use - 5.4

t-test = -1.62
level of significance = .107
df = 306

---

Most, 25 (83%) of 30 of those who have had problems with drugs, alcohol or both categorised themselves as "white". On the whole, those with alcohol or drug problems were less qualified than those who did not previously have problems. Those who had problems in the past were awarded on average 4.4 "O" level or GCSE awards while those who had no such previous problems had been awarded, on average, 5.4 "O" level or GCSE awards. The difference, however, was not statistically significant. A total
of 11 of 30 (37%) claim to have a degree compared to 42% of drug workers who have not had drug or alcohol problems.

Full or Part Time

Of the 317 drug workers, 52 (16%) were employed part-time. Of 169 women, 34 (20%) were part-time while only 18 (12%) of 146 men were part-time. Merseyside had far fewer part-time staff (12%) compared to North Western Region (22%).

Education

In the questionnaire, it is not possible to distinguish those who refused or forgot to record information on their education such as "O" level or GCSE examinations, "A" levels, degree, or postgraduate degree from those who had not obtained these qualifications. If no mark of any kind, such as a line or a "0" was made, this was treated as missing information. Where a profession was indicated with a tick or check mark, it was assumed they belonged to no other profession unless another profession was also indicated. No problem drug worker claimed to be professionally qualified in more than one profession.

GCSE or "O" Level Awards

TABLE 50

GCSE OR "O" LEVEL AWARDS BY REGION

Mean number of "O" level or GCSE awards of drug workers in Merseyside Region = 4.9.
Mean number of "O" level or GCSE awards of drug workers in North Western Region = 5.8.

$t$-test = 2.50
Level of significance = .013
$df = 270$

Drug workers had been awarded, on average (mean) 5.3 "O" level
or GCSE awards. A total of 60 (19%) had no "O" level or GCSE examinations and 88 (28%) had 8 or more such examinations. Drug workers from the North Western Region had a mean of 5.8 "O" levels or GCSE examinations while those from Merseyside had a mean of 4.9. This difference can be accounted for by the much larger proportion of statutory agencies in the North West region which would require higher educational qualifications than most non statutory agencies.

-----

TABLE 51
GCSA OR "O" LEVEL AWARDS BY GENDER

Mean number of "O" level or GCSE awards of male drug workers = 5.4.
Mean number of "O" level or GCSE awards of female drug workers = 5.3.

t-test = .30
level of significance = .763
df = 304

-----

There were no statistical differences between men and women regarding the average number of GCSE or "O" level examinations acquired. Men had been awarded, on average, 5.4 "O" levels or GCSE examinations and women, 5.3.

-----

TABLE 52
"O" LEVEL OR GCSE AWARDS BY PROFESSION

<table>
<thead>
<tr>
<th>Profession</th>
<th>Average &quot;O&quot; level or GCSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>7.47*</td>
</tr>
<tr>
<td>Nurses</td>
<td>5.09</td>
</tr>
<tr>
<td>Social Workers</td>
<td>5.45</td>
</tr>
</tbody>
</table>

-----

Using a One-way ANOVA, the mean number of "O" level or GCSE examinations were compared across professions. Using a Scheffe
test of significance at 0.05 level, Physicians had statistically significant more "0" level or GCSE examinations compared to the rest of the population. This is not surprising as Medical School acceptance usually requires 8 "0" levels or GCSE as a minimum entrance requirement. The average was reduced by the inclusion of several physicians who were foreign born and educated who were medically qualified but had no "0" levels or GCSE's. Nurses had achieved a mean of 5.1 results, just under the overall mean (5.3) of examinations while Social Workers had just over the mean.

A level awards
Community Drug Teams claimed the largest proportion of staff with "A" Level examinations. In total, 78 (57%) of 137 staff claimed to have at least one "A" level. All of the remainder of agencies had less than 1/2 of their staff qualified with "A" level examinations. These results need to be read with some caution because several professionally qualified staff with University Degrees had no "A" level examinations because they were educated abroad.

-----

TABLE 53
"A" LEVEL RESULTS OF DRUG WORKERS BY REGION

<table>
<thead>
<tr>
<th>Region</th>
<th>Workers with at least 1 &quot;A&quot; level</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Western</td>
<td>83 (58%)</td>
</tr>
<tr>
<td>Merseyside</td>
<td>75 (46%)</td>
</tr>
</tbody>
</table>

\[ X^2 = 4.36 \]
level of significance = .113
\[ df = 2 \]

-----

There is a difference between the two Regional Health Authorities in "A" achievements. A total of 83 (58%) of 145 (3 missing) North
Western Regional Health Authority drug workers had at least one "A" Level result compared to only 75 (46%) of 164 Merseyside drug workers (5 missing). The difference though was not statistically significant.

Those with professional qualifications were more likely to have at least one A level result, 99 of 191 (52%), than those with no professional qualifications 59 of 118 (50%).

Further Education Certificates
In total, 66 drug workers had been awarded Certificates of Further Education, proportionately they were equally divided between those from the two Regional Health Authorities.

University Degrees
Over 1/3 (119) of drug workers had a university degree. Community Drug Teams were more likely to employ staff with a degree. A total of 65 (48%) out of 136 (1 was missing) claimed to have earned a degree. This is not surprising when one considers the high proportion of professionally qualified staff which work for Community Drug Teams. Residential establishments were almost as likely to employ staff with a degree 11 of 23 (44 %) and Drug Dependency Clinics were not far behind with 22 (43%) of 51 (3 missing). Information/Advice/Needle Exchanges employed the fewest proportion of staff with degrees, 20 (32%) of 63 staff, with 4 missing. Those with professional qualifications were more likely to have a degree, 75 of 191 (39%), than those with no professional qualifications 44 of 118 (37%).

Post Graduate Degrees
More staff at Community Drug Teams had acquired post graduate degrees, 41 (31%) of 136 (1 missing) than at other categories of
agencies. This was followed by advice/information/needle exchanges 15 (27%) of 56 staff (4 missing), Drug Dependency Clinics 16 (21%) of 76 (3 missing) and residential establishments where no staff had post graduate degrees. Like other educational qualifications, more North Western Region drugs workers 39, (27%) had post graduate degrees than Merseyside drug workers 33 (20%).

Other Qualifications

Besides professional qualifications such as "Registered Mental Nurse" (RMN), "State Enrolled Nurse" (SEN), "Certificate of Qualification in Social Work" (CQSW), "Membership of the Royal College of Psychiatry" (MRCPsych), etc., drug workers held a variety of different qualifications. Nurses sometimes held "English National Board" (ENB) qualifications. The most relevant is the ENB 612 (Substance Misuse) which was held by 4 nurses in Merseyside Region and 8 nurses in North Western Region. There were a total of 24 other ENB qualification held by nurses, 18 by nurses in North Western Region and 6 by nurses in Merseyside Region.

Other qualifications mentioned were Diplomas or Certificates in Counselling, which were more popular in Merseyside (15) than in North Western Region (5), Youth and Community Certificates and various teaching qualifications.

A PORTRAIT OF DRUG WORKERS

There were 317 drug workers who took part in the study, representing 80% of all drug workers within the geographical area of the study. There were slightly more (169 compared to 148) from Merseyside RHA than North Western RHA. There were somewhat more women than men employed as drug workers, 169 (54%) compared to
148 (46%) men. The mean age of drug workers was 36.8 years with little difference between women and men or between Regional Health Authorities. Only 65 (21%) were under the age of 30. Their ethnic origin was primarily described as "white" (80%). Only 21 (6%) claimed to be Afro/Caribbean, Indian/Pakistani, or Oriental. There were 43 who either refused to give this information or left the space missing.

A majority, 196 (62%) were qualified in a profession (Medicine, Nursing, Occupational Therapist, Psychologist or Social Worker). Nursing was far the most common profession, 116 (37%). This was followed by Physicians, 36 (11%) and Social Workers (12%). On the whole they were a very experienced group of drug workers. The mean number of months working in the agency was 38 and the mean amount of time they had been working with problem drug users was just over 5 years. Only 26% had been working with problem drug users for under 2 years.

Just under 1 in 10 (30) claimed problems with alcohol, drugs or both in the past. A total of 5 of those were professionally qualified. Nearly 50% (14) of those with previous alcohol or drug problems were employed as "drug counsellors".

As a group the drugs workers were well educated, especially compared to problem drug users. A total of 62% were professionally qualified. They had, on average, 5.3 "O" or GCSE examinations. Under 1 in 5 (60) had no "O" level or GCSE qualifications. While those who were professionally qualified had a mean of 5.7 "O" level or GCSE examinations, even those who had no professional qualification still had a mean of 4.7.

Over a third had a university degree while 72 (23%) had a post
graduate qualification.
This portrait of drug workers is consistent between the two Regional Health Authorities. They are, as a group, experienced, professionally qualified, and have worked in their employing agency for several years. Most are women and many have qualifications in nursing. Less than 1 in 10 claims to have had previous problems with alcohol or drugs. How these characteristics influence their beliefs about the origin and preferred treatment or help for problem drug users will be considered in the next chapter.

DIFFERENCES BETWEEN DRUG USERS AND DRUG WORKERS
A major aim of this study is to examine the differences between problem drug users and drug workers in how they view and understand problems of problem drug use. At this stage, it may be of benefit to compare the two groups in demographic terms.

The first obvious difference is how the populations which took part in the study were found. Drug workers who took part in the study represented about 4 out of 5 of all drug workers within the two Regional Health Authorities. It is not possible to estimate what proportion the 150 drug users were of all problem drug users who attended those agencies. This is because all of the agencies provided their own statistics and usually did not define "a case" in the same way as another agency. Though all of the agencies involved in the study reported to the Regional Data Bases in Manchester and Liverpool, some (like the Needle and Syringe Exchanges) did not report markers (i.e. initials and dates of birth) which would enable double counting to be avoided. Also, it was unclear how many physicians, especially those who worked
for Community Drug Teams, reported problem drug users, as coming from the agency or their own surgeries. Whatever the proportion of all problem drug users the 150 who took part in the study were, it was very small compared to the nearly 80% of drug workers who participated. The 150 chosen to take part were chosen randomly in the sense that they, by chance, attended the agency on the day or days on which they were visited. A few agencies did not wish to allow access to their clients or patients. The only problem drug users who were excluded were those who were too intoxicated (or in one case suffering from florid symptoms of what may have been mental illness) to give a reliable response. All of the problem drug users, by definition, had used illicit drugs in a way which necessitated them seeking help from an agency. They used a variety of drugs. Only about 10% of drug workers reported problematic drug or alcohol use at any time in their lives. More men than women drug workers had problematically used alcohol or drugs (2.2 to 1) but this is a similar ratio of men to women in the population of problem drug users (3.5 to 1). A major difference between the two groups was that of gender. A slight majority of drug workers were women (1.2 women to 1 man) while the ratio of women to men amongst the drug users was .3 women to 1 man, a ratio of 3 to 1. The mean age of problem drug users was 28.0 years, ranging from 18 to 44. The mean age of drug workers was 36.8, ranging from 22 to 62. While they were, on average 8.8 years older, the difference was not so great that they came from different generations. In terms of ethnicity, the two groups were very similar. A total of 80% of drug workers described themselves as "white", compared
to 80.7% of drug users. The high numbers of refused or missing data was also similar, 13.5% for the drug workers and 18% for the drug users. The numbers of both drug workers who categorised themselves as Afro-Caribbean was 1.6% for drug workers and 1.3% for drug users. The only major difference was that 12 (3.8%) of drug users described themselves as being of "mixed race" while 12 (10%) of drug workers described themselves similarly.

THE BELIEFS OF PROBLEM DRUG USERS AND DRUG WORKERS

This section examines the beliefs about the preferred interventions and origins of problem drug use held by problem drug users and drug workers. The results in this chapter relate to the third question of the purpose of this research, as previously stated from the Introduction:

"(3) To determine the beliefs about the preferred interventions and origins of problem drug use held by problem drug users who attend drug agencies and the drug workers in those agencies.

  a. What are the beliefs of problem drug users who attend agencies about the origins and preferred interventions to help problem drug use?
  b. What are the beliefs of drug workers who are employed at agencies about the origin and preferred interventions of problem drug use?
  c. To determine the influence of personal characteristics, education, experience, drug use patterns for problem drug users and drug workers on those beliefs."

THE BELIEFS OF PROBLEM DRUG USERS AND DRUG WORKERS

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b. What are the beliefs of drug workers who are employed at agencies about the origin and preferred interventions of problem drug use?

c. To determine the influence of personal characteristics, education, experience, drug use patterns for problem drug users and drug workers on those beliefs."

The same questionnaire was used for both problem drug users who attend agencies and drug workers. The first 18 questions tested the belief in one of three models about problem drug use held by problem drug users and drug workers. The three models are derived from a review of the literature on problem drug use. The three main models which attempt to explain problem drug use have been referred to as:

1/ The Medical/Biological Model - This model attempts to explain the phenomenon of problem drug use in terms of biological and/or genetic causes as being the main
component of the model. Most problem drug users would be seen as suffering from forms of "Personality Disorder" which is a recognised Psychiatric condition, even if it is not an illness. Probably the most appropriate form of treatment would be seen as pharmacological rather than counselling or help with social problems.

2/ The Psychological Model - This model attempts to explain the phenomenon of problem drug use in terms of learning theory, especially learning which takes place in childhood and adolescents. Problem drug use is seen as a response to the discomfort generated by unresolved emotional difficulties. The most relevant treatment would be seen as counselling or psychotherapy. Learning theory would suggest that habits could be "unlearned" given the right circumstances and drug using habits could be altered.

3/ The Social/Economic Model - This model attempts to explain the phenomenon of problem drug use in terms of the individuals response to social problems such as unemployment, poor housing, deviant life style, boredom, etc. This model suggests that some people are denied legitimate access to jobs, education, housing, status, etc. so they respond to their social condition by using drugs in a problematic way. It may also reflect the influence of alternative cultural values held by the social groups which problem drug users belong. The most suitable form of helping would be to either alter society or help the individual gain
access to better social conditions and opportunity. These models contain influences from other models. For example, the Psychological model may well accept that unemployment may make drug users more vulnerable to problem drug use by lowering their self esteem. Each model, however, has at its foundation a definable source of the problem, i.e genetic or biochemical abnormalities, insufficient or incomplete learning, or unequal social opportunity. It would be unrealistic to expect anyone to believe entirely in only one of the three models. Most people appreciate that problem drug use is a complex issue which is influenced by a variety of factors. Often it is a matter of emphasis as to which model is held to be most important. The models are not mutually exclusive though, in many ways, the "Medical/Biological" model is the opposite of the "Social/Economic" model. This is because the first holds the source of problem drug use to be within the individual while the second holds the source of the problem within another party (i.e. society).

It is the intention of the author to use the questionnaire to ascertain to what degree the drug worker and the problem drug user who attends a drug agency base their beliefs on one of the three models and how consistent these beliefs are within those models. The models can be divided into 2 parts:

1/ The origins of problem drug use.
2/ What treatment or help is the most affective in facilitating change.

Methods of analysis

Each questionnaire was coded in order to ease the process of
recording the data into a data base. A Delta V Data Base was used to record the information. Delta V was used because it is compatible with SPSS software and lends itself readily to the format of the questionnaire. The software used to analyse the data are SPSS for Windows.

Several decisions had to be made before analysing the results. The first decision was how to deal with "Don't Know" answers and missing data. Several options were available. The first was to simply count "Don't Know" and missing data as "Neutral" within the Likert Scale. This had the advantage of simplicity and consistency but was rejected because the meaning of "Don’t Know" and "Neutral" are not the same. Also, it would be presumptuous to assume missing data as the same as "Neutral". The second option was to simply count "Don’t Know" as missing data. This was logically more acceptable than counting it as "Neutral" but had the disadvantage in that for some questions, "Don’t Know" and missing data accounted for up to 18% of the responses. In other questions, however, they accounted for only 2 or 3%.

The third alternative was to take the average of the other two answers in order to fill in the missing data from "Don’t Know" or missing data. This option was chosen because it made no assumptions about the meaning of missing data and "Don’t Know" and allowed the use of all of the information in the questionnaire. This was particularly important when the populations were sub divided into smaller groups for analysis. This option was only possible if there was a high correlation between the 6 questions within any one set (i.e. those that tested belief in one of the three models), and more importantly -
if there was a high correlation between the three statements within the subset of "origin" and "treatment". Fortunately there was a strong correlation between the 6 questions within each set. (See next sub section.)

One statement did not produce a high level of correlation within the set - question 16. This statement (which was meant to test belief in a "Medical/Biological Model" about treatment) said,

"Prescribing Methadone is important because it helps reduce cravings, controls withdrawals and makes drug use less enjoyable."

There were a high level of "missing" answers and the statement produced a relatively large number of comments which suggested that many drug workers and problem drug users found it difficult to rate this statement in terms of "agree or disagree". Several of the drug workers and one of the problem drug users rightfully pointed out that the statement had more than one part. It does not necessarily follow that reducing cravings and controlling withdrawals makes drug use less enjoyable. Prescribing is such an emotive issue that it would have been better to leave it out altogether. There was insufficient attention paid to the structure of the statement or understanding that those believing in other models could also find favour with the statements but for other reasons.

Reliability and Correlation between statements within the subset of each model

The correlation between the questions testing each model was high, especially for drug workers. A Spearman Correlation Coefficient was used to test statistical significance which could
be a measure of reliability. This test was used because the data were Ordinal. The nature of the variable was non-categorical and called for a non-parametric test. This was used as a test of reliability. Recently the use of correlation as a test of reliability has been called into question (Bland & Altman, 1996) but few accepted alternatives have been proposed.

The Social/Economic Model

Drug Workers

For those statements which tested belief in the "Social Economic" model, the correlations were particularly high. There were 6 statements which were included in this section, statements 1, 4, 6, 10, 12, and 14. The resulted show there was a significant correlation between all of the statements (See Appendix). In total there were 15 possible correlations. The range of positive correlations is below.

Range of correlations between questions: .3985 - .1250
Range of Levels of Significance: .000 - .029

All statements positively correlated and had a level of significance at less than a .05 level, using a 1-tailed test. A total of 13 of 15 possible levels of significance were less than .001.

Problem drug users

For problem drug users 6 of the possible correlations were less than significant (See appendix).

Range of correlations between questions: .3187 - -.0783
Range of Levels of Significance: .000 - .424

The Medical/Biological Model

Drug Workers

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Within this subset Question 16 was rejected (see previous page), leaving 5 questions. These 5 questions were questions 2, 5, 7, 8, and 11. In total there were 10 possible correlations. For drug workers, there was a significant level of correlation between all of the questions (See appendix).

Range of correlations for statements testing the belief in the "Medical/Biological Model".

- Range of correlations between questions: .5770 - .1102
- Range of levels of significance: .000 - .030

A total of 8 of the 10 correlations were significant at less than .001.

Problem drug users

For problem drug users, 3 of the possible correlations were less than significant.

- Range of correlations between questions: .2484 - -.0037
- Range of levels of significance: .005 - .485

The Psychological Model

Drug Workers

Within this subset there was a high correlation for all 15 possible relationships. The 6 questions were questions 3, 9, 13, 15, 17, and 18 (See appendix).

Range of correlations between statements testing the belief in the "Psychological Model"

- Range of correlations between questions: .5288 - .0974.
- Range of levels of significance: .000 - .080

A total of 10 of the 15 correlations were significant at a .001 level.
Problem drug users

For problem drug users, 7 of 15 possible correlations were statistically significant at a .05 level. (See appendix). Range of correlations between questions: .4803 - .0421.

Range of levels of significance: .000 - .080

The levels of significance were lower for problem drug users than for drug workers. For drug workers it is probable that many of them were introduced to theories of problem drug use (or "addiction", "dependence", etc) which were consistent models. Through their training and education they were probably made aware of consistency as an issue. Problem drug users, with less education, may have been working at a less theoretical (though not necessarily a less valid) level but a more personal level, where they recognised the various influences on their lives which may not have readily fit into a consistent model.

Validity of the three theories

There are several ways to measure the validity of the statements in relation to the three models which were used in the questionnaire. One way to look at the validity of the statements was to compare the scores achieved on each of the three models from the first 18 statements to the answers in questions 29 and 30 later in the questionnaire. These questions asked drug workers what they talked about with their clients and drug users what they talked about with their key worker. The questions were structured so there were three possible answers which correspond to each of the three models. There should have been a high correlation between those answers and the scores achieved on the three models from the first 18 statements.
While there was a positive correlation between the answers on questions 29 & 30 and the scores achieved on the three models from the first 18 statements, they did not reach statistical significance. The reasons for this became obvious when considering the role of harm reduction. It soon became apparent that when the survey was carried out the overwhelming majority of drug workers and problem drug users saw harm reduction as the primary goal of their interaction rather than abstinence. Treatment (with the exception of workers and users in residential rehabilitation agencies) was aimed at harm reduction rather than abstinence. Therefore, no matter what drug workers and users believed about the origin of their problem or the best way to achieve abstinence, what they tried to do was to achieve harm reduction.

The importance of harm reduction was reflected in the answers to statement 24 ("Harm reduction is an important part of this agency's work.") and statement 26 ("Harm reduction is an important part of my work."). The mean answer for drug workers was 1.71 and 1.78 respectively (within a scale of 1 = Strongly agree and 5 = Strongly disagree). These scores represented the strongest beliefs for the whole questionnaire. There was little variation in their answers. The standard deviation was 1.23 and 1.31 respectively, the second and third lowest standard deviations within the survey.

Another way of considering validity was to compare the answers of professional groups who should believe in one of the three theories to the rest of the population. Physicians, for instance, should have had a stronger belief in the "Medical/Biological
Model" than the rest of the population of drug workers. In practice this was the case. Using a Mann-Whitney U test comparing physicians to the rest of the population, they had a lower score, i.e. more strongly agree than the rest of the drug workers. The level of significance was .0017 for the "origins" questions of the "Medical/Biological Theory" and .0014 for the "treatment" aspect. Just as physicians should have had a stronger belief in the "Medical/Biological" model, social workers should have had a stronger belief in the "Economic/Social" model. Social workers scored a lower score (a--stronger belief) than the rest of the drug workers. In the origins subset, the score was significantly lower (.0390) but in the treatment subset the score did not quite reach significance (.078).

The same exercise is not possible in considering the "Psychological" model because there were only 4 "Psychologists" within the population. There were many unfilled posts for psychologists within the agencies.

VARIABLES IN THE BELIEFS IN THE THREE MODELS OF PROBLEM DRUG USE

The first 18 statements.

This section corresponds to the 4th aim of this study, "4/ To determine the influence of personal characteristics, education, experience, drug use patterns for problem drug workers users and drug workers on those beliefs.

a. Which personal characteristics are most influential?"

In this subsection, the variables which may effect the beliefs about problem drug use within the three models will be considered. This comprises the first 18 statements of the
questionnaire. When comparing the responses by subgroups within the population (i.e. gender, age, job title, professional qualification) The Mann-Whitney U test was used where the Likert statements testing belief in one of the three models is divided between nominal groups such as gender, job title, occupation, etc. When referring to the degree that subgroups believe in the three models a similar convention to the questionnaire when reporting the results was used. That is using a scale of 1 to 5:

1 = Strongly agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree

At the end of the analysis of the questionnaires, the results from the semi-structured interviews are considered.

THE SEMI-STRUCTURED INTERVIEWS

A total of 12 semi-structured interviews (6 problem drug users and 6 drugs workers) were carried out in the course of the study. The same questions were asked of the problem drug users and the drug workers. Each was tape recorded and later transcribed. The participants came from a total of 11 different agencies (one agencies provided two interviews). The drug workers included doctors, social workers, nurses and drug counsellors. There were 3 women and 3 men drug workers who took part in the interviews and 4 men and two women who took part in the problem drug user interviews. The purpose of the semi-structured interviews was to give another dimension to views about the origins and best
treatment for problem drug use. The questions were structured in a way so as not to be repetitive of the questionnaire but to allow the respondents the opportunity to express their views in response to open ended questions.

The following questions were asked of the drug workers.

1/ Why do you think problem drug users use drugs in a way which causes themselves and others problems?

2/ Are problem drug users different from people who do not use drugs problematically? If so, how?

3/ What prevents problem drug users from changing their drug using habits? From becoming abstinent?

4/ What are the best way for agencies to help problem drug users reduce the harm from their drug use? Become abstinent?

5/ Do the aims and objectives of the agency which you work for correspond to your own? What are they and how are they different?

6/ Do you see the needs of problem drug users as being in conflict with the larger interests of society?

7/ What is more important to you as a goal, harm reduction or abstinence? What is more important for your agency?

8/ Do most of your clients/patients share your goals? If not, how do they differ?

9/ If you could change what your agency does, what would you do?

10/ If you could change Health Authority, Regional or National policy, how would you change it?

The questions for the problem drug users were the same, except
for questions:

5/ Do the aims and objectives of this agency correspond to your own? What are they and how are they different?

8/ Does your key worker or the person you see most often at this agency share your personal goals? If not, how do they differ?

Only the first 4 questions are relevant to this section of the results, i.e. beliefs in models of problem drug use. The remainder of the questions will be integrated into the text of the appropriate results from the quantitative questionnaire.

Drug Workers

The scores, as described above for the three models are presented below. These are the mean scores, on the scale of 1 - 5, of the questions in the subset. For instance, for the Social/Economic model - origins, the score is the mean of the three questions on the origins of problem drug use within the Social/Economic model. Lower scores indicate stronger agreement.

---

TABLE 54
DRUG WORKERS SCORES ON THE THREE MODELS OF BELIEFS

<table>
<thead>
<tr>
<th>Name of the models</th>
<th>Mean score on origin</th>
<th>Mean score on treatment</th>
<th>Average on both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Economic Model</td>
<td>3.27</td>
<td>2.87</td>
<td>3.07</td>
</tr>
<tr>
<td>Med/Biological Model</td>
<td>4.10</td>
<td>3.46</td>
<td>3.78</td>
</tr>
<tr>
<td>Psychological Model</td>
<td>3.50</td>
<td>2.72</td>
<td>3.11</td>
</tr>
</tbody>
</table>

---

The most favoured model was the Social/Economic while the psychological model came a close second. A Medical/Biological model was the least favoured.

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Gender

There were slightly more women drug workers than men (167 to 146) within the population.

The Social/Economic Model - The following table shows the Mann-Whitney test applied to gender as a variable when considering the belief held in the social/economic model as stated on page 2 of this chapter.

----

TABLE 55
SOCIAL/ECONOMIC SCORES MODEL BY GENDER

<table>
<thead>
<tr>
<th>Origin</th>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>161.3</td>
<td>3.28</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>153.3</td>
<td>3.26</td>
<td></td>
</tr>
</tbody>
</table>

Mann Whitney U value = 11568
Level of significance = .429

----

TABLE 56
SOCIAL/ECONOMIC MODEL SCORES BY GENDER

<table>
<thead>
<tr>
<th>Preferred Treatment</th>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>153.3</td>
<td>2.85</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>158.4</td>
<td>2.90</td>
<td></td>
</tr>
</tbody>
</table>

Mann Whitney U value = 22227
Level of significance = .616

----

The above statistical analysis suggested that men had a slightly stronger belief in a social/economic origin of problem drug use but women had a slightly stronger belief in social/economic treatment compared to men. Neither difference reached statistical significance.

The Medical/Biological Model - The following table shows the Mann-Whitney test applied to gender as a variable when
considering the belief held in the medical/biological model stated on page 2 of this chapter.

---

**TABLE 57**

MEDICAL/BIOLOGICAL MODEL SCORES BY GENDER

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>170.5</td>
<td>4.20</td>
</tr>
<tr>
<td>Women</td>
<td>144.3</td>
<td>4.02</td>
</tr>
</tbody>
</table>

Mann Whitney U value = 10075  
Level of significance = .010

---

**TABLE 58**

MEDICAL/BIOLOGICAL MODEL SCORES BY GENDER

Preferred Treatment

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>159.9</td>
<td>3.48</td>
</tr>
<tr>
<td>Women</td>
<td>154.5</td>
<td>3.44</td>
</tr>
</tbody>
</table>

Mann Whitney U value = 11775  
Level of significance = .600

---

The above statistical analysis suggest that women had a stronger belief in a medical/biological origin of problem drug use and a slightly stronger belief in medical/biological treatment compared to men. Only the first reached statistical significance.

The Psychological Model - The following table shows the Mann-Whitney test applied to gender as a variable when considering the belief held in the psychological model stated on page 2 of this chapter.
TABLE 59

PSYCHOLOGICAL MODEL SCORES BY GENDER

<table>
<thead>
<tr>
<th>Origin</th>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>154.2</td>
<td>3.48</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>154.8</td>
<td>3.51</td>
<td></td>
</tr>
</tbody>
</table>

Mann Whitney U value = 11767
Level of significance = .958

TABLE 60

PSYCHOLOGICAL MODEL SCORES BY GENDER

<table>
<thead>
<tr>
<th>Preferred Treatment</th>
<th>Gender</th>
<th>Mean Rank</th>
<th>Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>166.6</td>
<td>2.80</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>147.6</td>
<td>2.66</td>
<td></td>
</tr>
</tbody>
</table>

Mann Whitney U value = 10640
Level of significance = .060

The above statistical analysis suggests that there was virtually no difference between women and men in their beliefs in the psychological origin of problem drug use and women had a stronger belief in psychological treatment compared to men, just missing statistical significance.

In conclusion, there was little difference in the beliefs of women and men in the three models stated above. Only in the belief of the medical/biological origins of problem drug use did the difference reach statistical significance.

Age
The age range of the study group was 22 to 62. The mean age was 36.8 years of age and the median age was 35. In order to see if
age had an influence on the beliefs of the study group in the three theories, the study group was divided into two parts - those aged 22-35 (n= 159, 50.2%) and those aged 36-62 (n=152, 47.9%). A total of 6 (1.9%) respondents did not record their age.

-----

TABLE 61
MEAN SCORES ON THREE MODELS BY AGE GROUPS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Orig</td>
<td>Treat</td>
<td>Orig</td>
</tr>
<tr>
<td>problem drug workers age 22-35</td>
<td>3.24</td>
<td>2.89</td>
<td>4.19</td>
</tr>
<tr>
<td>problem drug workers age 36-62</td>
<td>3.31</td>
<td>2.84</td>
<td>4.02</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by Age Groups - Levels of significance between those the ages of 22 to 35 and those aged 36 to 62

Economic/Social Model - Origin .231
Economic/Social Model - Treatment .644
Medical/Biological Model - Origin .054
Medical/Biological Model - Treatment .056
Psychological Model - Origin .136
Psychological Model - Treatment .727

-----

The results indicate that older drug workers have a stronger belief in the medical/biological model in both the origins and preferred treatment sections, but in both cases the differences do not quite reach statistical significance.

Education

The influence of education on beliefs about problem drug use can be found in two ways. Firstly, there is the issue of general
educational level which has been achieved by the individual. This will include GCSE, A Level, Certificates of Higher Education, degrees and post-graduate degrees. The second issue will be about professional qualifications for certain categories of jobs. These professions include Medical Practitioners, Social Workers, Probation Officers, Clinical Psychologists, and Occupational Therapists.

"0" Level or GCSE results

The mean number of "0" level or GCSE results was 5.33 and the range was between 0 - 15. The curve was heavily skewed at the bottom end of the scale. A total of 52 drug workers had no "0" level or GCSE results. The sample was divided into two groups, those who achieved 5 or less (143) and those who achieved 6 or more (155) "0" level or GCSE results. This method divided the sample, as near as possible in half. The two groups were then compared using a Mann-Whitney U test to see if there were significant differences between them in the mean scores of their belief in the three models The results are below. The three models are, again, divided into "Origin" and "Preferred Treatment".
TABLE 62
MEAN SCORES ON 3 MODELS BY "0" LEVEL, GCSE RESULTS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Theory</th>
<th>Med/Biological Theory</th>
<th>Psychological Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Origin</td>
<td>Treat.</td>
<td>Origin</td>
</tr>
<tr>
<td>5 or less &quot;0&quot; level</td>
<td>3.31</td>
<td>2.86</td>
<td>4.06</td>
</tr>
<tr>
<td>or GCSE results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 or more &quot;0&quot; level</td>
<td>3.23</td>
<td>2.86</td>
<td>4.11</td>
</tr>
<tr>
<td>or GCSE results</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by "0" Level, GCSE Results - Levels of significance between those with 5 or less "0" levels or GCSE results and those with 6 or more "0" levels or GCSE results

Economic/Social Model - Origin .311
Economic/Social Model - Treatment .934
Medical/Biological Model - Origin .806
Medical/Biological Model - Treatment .102
Psychological Model - Origin .121
Psychological Model - Treatment .375

From the above tables it is clear that the number of "0" level or GCSE results was not a factor in the beliefs of drug workers in the three models about the origins or preferred treatment of problem drug use. As a further test, the group was divided into those with no "0" levels or GCSE results (52) from those with at least one result (256). The data was analyzed to compare those drug workers to problem drug users, who for the most part, have not achieved "0" level or GCSE results. Below that the levels of significance were calculated between the two groups.

224
### TABLE 63
**MEAN SCORES ON THREE MODELS BY "0" LEVEL, GCSE RESULTS**

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Medical/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>No &quot;0&quot; level or GCSE results</td>
<td>3.44 3.02</td>
<td>4.11 3.31</td>
<td>3.58 2.66</td>
</tr>
<tr>
<td>1 or more &quot;0&quot; level or GCSE results</td>
<td>3.23 2.83</td>
<td>4.09 3.49</td>
<td>3.47 2.73</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by "0" Level, GCSE Results - Levels of significance (using a Mann-Whitney U test) between those with no "0" levels or GCSE results and those with 1 or more "0" levels or GCSE results

- Economic/Social Model - Origin: .029
- Economic/Social Model - Treatment: .077
- Medical/Biological Model - Origin: .481
- Medical/Biological Model - Treatment: .076
- Psychological Model - Origin: .247
- Psychological Theory - Treatment: .580

In conclusion, the results suggest that there was little difference in beliefs about the origins or preferred treatment between those drug workers with less than 5 "0" level or GCSE results and those with 6 or more. However, those with no "0" level or GCSE examinations were less likely to belief in the "Economic/Social" Model for both origins and treatment. The differences reached statistical significance when considering the origin portion of the model.
A Level qualifications

When describing the influence of educational qualifications the models was split into two parts. The first part refers to the origins of the problem while the second part refers to the preferred treatment. Just over half of the population of drug workers achieved at least one A Level qualification. A total of 158 drug workers (51%) have achieved this level while 151 (49%) have not. There are missing data for 6 (2%) drug workers.

Mean Scores on Three Models by "A" Level examination - Levels of significance (using a Mann-Whitney U test) between those with no "A" level examinations and those with 1 or more "A" level examination

<table>
<thead>
<tr>
<th>Economic/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origin</td>
<td>Treatment</td>
<td>Origin</td>
</tr>
<tr>
<td>No &quot;A&quot; level exams</td>
<td>3.35</td>
<td>2.96</td>
</tr>
<tr>
<td></td>
<td>4.01</td>
<td>3.44</td>
</tr>
<tr>
<td></td>
<td>3.52</td>
<td>2.68</td>
</tr>
<tr>
<td>One or more &quot;A&quot;</td>
<td>3.18</td>
<td>2.77</td>
</tr>
<tr>
<td>level exams</td>
<td>4.18</td>
<td>3.48</td>
</tr>
<tr>
<td></td>
<td>3.47</td>
<td>2.76</td>
</tr>
</tbody>
</table>

The results suggest that there were significant differences in beliefs about the origins or preferred treatment between those...
drug workers with "A" level examinations and those without. Those with no "A" level examinations were less likely to believe in the "Economic/Social" theory for both origins and treatment. The differences reached statistical significance in both instances. Those with no "A" level results also were more likely to believe in the origin section of the Medical/Biological Model.

Certificates of Further Education

A total of 309 of the population of 317 drug workers answered the question about Certificates of Further Education. There are only 66 drug workers with Certificates in Further Education, this represents 21% of those who answered this question.

-----

**TABLE 65**

**MEAN SCORES ON THREE MODELS BY FURTHER EDUCATION CERTIFICATES**

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Further Education Certif.</td>
<td>3.26</td>
<td>2.85</td>
<td>4.07</td>
</tr>
<tr>
<td>One or more Further Education Certif.</td>
<td>3.26</td>
<td>2.88</td>
<td>4.18</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by Further Education Certificates - Levels of significance (using a Mann-Whitney U test) between those with no Further Education Certificates and those with one or more Further Education Certificates.

- Economic/Social Model - Origin .975
- Economic/Social Model - Treatment .728
- Medical/Biological Model - Origin .305
- Medical/Biological Model - Treatment .312
- Psychological Model - Origin .682
- Psychological Model - Treatment .919
There is no statistical difference in their scores on origin or treatment in any of the three models when comparing those with a Certificate of Further Education and those without.

University Degrees

Out of a population of 311 drug workers (there was no data for 6 drug workers), 119 (38%) had been awarded a degree and 190 (61%) had not.

---

**TABLE 66**

MEAN SCORES ON THREE MODELS BY UNIVERSITY DEGREE

<table>
<thead>
<tr>
<th>Drug workers with no degree</th>
<th>Drug workers with a degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Econ/Social Model</td>
<td>Med/Biological Model</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>3.33</td>
<td>2.92</td>
</tr>
<tr>
<td>3.16</td>
<td>2.76</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by University degree - Levels of significance (using a Mann-Whitney U test) between those with no University degree and those with a university degree

Economic/Social Model - Origin | .020
Economic/Social Model - Treatment | .038
Medical/Biological Model - Origin | .228
Medical/Biological Model - Treatment | .903
Psychological Model - Origin | .061
Psychological Model - Treatment | .378

---

Those who have earned a University degree were more likely to hold views supporting a Social/Economic model. The differences were statistically significant for both the origin and treatment sections of the model. There was no difference between those with
a degree and those without when considering the Medical/Biological model. Those with a degree were more likely to agree with the origin section of the Psychological model (and this approached statistical significance) but less likely to agree with the treatment section. Note the similarity with the mean scores from "A" level results.

Post Graduate degrees

There were a total of 72 drug workers who claimed to have earned a post graduate degree, 237 had not earned a post graduate degree. A total of 8 responses were missing.

---

TABLE 67
MEAN SCORES ON THREE MODELS BY POST GRADUATE UNIVERSITY DEGREE

<table>
<thead>
<tr>
<th>Drug workers with no postgrad. degree</th>
<th>Econ/Social Origin</th>
<th>Med/Biological Origin</th>
<th>Psychological Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug workers with a postgrad. degree</td>
<td>3.29</td>
<td>2.88</td>
<td>4.10</td>
</tr>
<tr>
<td></td>
<td>3.17</td>
<td>2.78</td>
<td>4.05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug workers with no postgrad. degree</th>
<th>Econ/Social Treat.</th>
<th>Med/Biological Treat.</th>
<th>Psychological Treat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug workers with a postgrad. degree</td>
<td>2.88</td>
<td>3.45</td>
<td>2.68</td>
</tr>
<tr>
<td></td>
<td>2.78</td>
<td>3.49</td>
<td>2.84</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by Post Graduate University degree - Levels of significance (using a Mann-Whitney U test) between those with no University postgraduate degree and those with a post graduate university degree

- Economic/Social Model - Origin .178
- Economic/Social Model - Treatment .283
- Medical/Biological Model - Origin .359
- Medical/Biological Model - Treatment .341
- Psychological Model - Origin .733
- Psychological Model - Treatment .085
There were no significant differences between those with a post graduate degree and those without this qualification. Those with no post graduate degree were more likely to agree with the preferred treatment section of the Psychological model but this difference was not statistically significant.

The Influence of professional qualifications

The influence of professional qualifications for medicine, nursing and social work/probation will be analyzed together because their training is similar in a number of ways. Each profession not only has a body of knowledge but also a code of ethics and professional standards.

The analysis for social work and probation is combined because their professional training was the same. The other two professions, psychologist (n = 4) and occupational therapist (n = 2) were too few in number to analyze in a meaningful way, so for the purpose of analysing each profession they were dropped.
Physicians

There were a total of 36 qualified physicians in the study group.

TABLE 68
MEAN SCORES ON THREE MODELS BY PHYSICIANS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Physician drug workers</td>
<td>3.27  2.95</td>
<td>3.77  3.10</td>
<td>3.17  2.69</td>
</tr>
<tr>
<td>Drug workers not qualified as physicians</td>
<td>3.27  2.86</td>
<td>4.14  3.50</td>
<td>3.54  2.72</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by Physicians - Levels of significance (using a Mann-Whitney U test) between qualified physicians and those with no medical qualifications

- Economic/Social Model - Origin: .813
- Economic/Social Model - Treatment: .489
- Medical/Biological Model - Origin: .002
- Medical/Biological Model - Treatment: .001
- Psychological Model - Origin: .006
- Psychological Model - Treatment: .690

Physicians were far more likely to believe in both the aspects (origin and preferred treatment) of the Medical/Biological model than their non medically qualified colleagues. They were also more likely to believe in the psychological origins of problem drug use but no more likely to believe in psychological treatments.

Nurses

There were a total of 116 nurses in the study group. They were
by far the largest profession and accounted for 37% of all drug workers who took part in the study.

---

TABLE 69
MEAN SCORES ON THREE MODELS BY NURSES

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nurses</td>
<td>3.35</td>
<td>2.91</td>
<td>4.15</td>
</tr>
<tr>
<td>Drug workers</td>
<td></td>
<td></td>
<td>3.51</td>
</tr>
<tr>
<td>not qualified as</td>
<td></td>
<td></td>
<td>3.56</td>
</tr>
<tr>
<td>nurses</td>
<td></td>
<td></td>
<td>2.59</td>
</tr>
<tr>
<td>Drug workers</td>
<td>3.23</td>
<td>2.84</td>
<td>4.07</td>
</tr>
<tr>
<td>not qualified as</td>
<td></td>
<td></td>
<td>3.42</td>
</tr>
<tr>
<td>nurses</td>
<td></td>
<td></td>
<td>3.46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.79</td>
</tr>
</tbody>
</table>
Mean Scores on Three Models by Qualified Nurses - Levels of significance (using a Mann-Whitney U test) between nurses and those with no nursing qualifications:

Economic/Social Model - Origin: 0.091
Economic/Social Model - Treatment: 0.402
Medical/Biological Model - Origin: 0.319
Medical/Biological Model - Treatment: 0.237
Psychological Model - Origin: 0.207
Psychological Model - Treatment: 0.014

Nurses were less likely to believe in the origin section of the Economic/Social model than their colleagues but the differences were not statistically significant. Only in the treatment section of the Psychological model was the difference between nurses and those with no nursing qualifications statistically significant. Here nurses believed more strongly in psychological treatments than their colleagues.
Social Work

There were 38 qualified social workers within the study group.

-----

TABLE 70
MEAN SCORES ON THREE MODELS BY SOCIAL WORKERS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Social Work drug workers</td>
<td>3.02 2.67</td>
<td>4.32 3.62</td>
<td>3.07 3.61</td>
</tr>
<tr>
<td>Drug workers not qualified as Social Workers</td>
<td>3.31 2.89</td>
<td>4.07 3.43</td>
<td>2.67 3.48</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by Social Workers - Levels of significance (using a Mann-Whitney U test) between social workers and those with no social work qualifications

- Economic/Social Model - Origin: .039
- Economic/Social Model - Treatment: .078
- Medical/Biological Model - Origin: .029
- Medical/Biological Model - Treatment: .091
- Psychological Model - Origin: .396
- Psychological Model - Treatment: .001

-----

Social workers were stronger believers in a Economic/Social model than their colleagues and this reached statistical significance in the origins section but not quite in the treatment section. They were also less likely to believe in the Medical/Biological model and this reached statistical significance in the origin section but not in the treatment section. They also were far more likely to believe in the use of
psychological treatments than their colleagues and this difference was statistically significant.

The Influence of Working Full or Part Time

Just under 17% of drug workers were employed on a part-time basis.

---

TABLE 71
MEAN SCORES ON THREE MODELS BY DRUG WORKERS WORKING FULL TIME COMPARED TO THOSE WORKING PART-TIME

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time drug workers</td>
<td>3.29</td>
<td>2.88</td>
<td>4.13</td>
</tr>
<tr>
<td>Part time drug workers</td>
<td>3.18</td>
<td>2.80</td>
<td>3.91</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by full and part time Drug Workers - Levels of significance (using a Mann-Whitney U test) between those working full time and those working part time.

Economic/Social Model - Origin .201
Economic/Social Model - Treatment .362
Medical/Biological Model - Origin .028
Medical/Biological Model - Treatment .415
Psychological Model - Origin .034
Psychological Model - Treatment .123

---

Drug workers working part time were more likely to agree with statements suggesting a biological influence in the origin of drug problems rather than statements suggesting preferred medical treatment but their answers were not statistically different from the population of full-time drug workers. They were also more
likely to agree to statements suggesting a psychological origin of problem drug use but not when considering preferred psychological treatments, where there was no statistical difference between full and part time workers.

It should be noted that physicians constituted a relatively large proportion of part-time drug workers. While they only account for 11% of all drug workers, they account for 35% of part-time staff, by far the largest group of part-time workers.

The influence of the length of time the drug worker has been working with problem drug users

The median length of time that drug workers have worked with problem drug users is 56 months. The study group was divided into two, those who worked 56 months or less with problem drug users (n=159) and those who worked 57 months or more with problem drug users (n=152). A total of 6 drug workers did not respond to this question.
### Table 72

Mean scores on three models by drug workers who have experience working 56 months or less compared to those working 57 months or more

<table>
<thead>
<tr>
<th>Economic/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origin</td>
<td>Treat.</td>
<td>Origin</td>
</tr>
<tr>
<td>Drug workers at agency 56 months or less</td>
<td>3.29</td>
<td>2.85</td>
</tr>
<tr>
<td>Drug workers at agency 57 months or more</td>
<td>3.24</td>
<td>2.87</td>
</tr>
</tbody>
</table>

Mean scores on three models drug workers who have experience working 56 months or less compared to those working 57 months or more - Levels of significance (using a Mann-Whitney U test) between the two groups.

- Economic/Social Model - Origin: 0.650
- Economic/Social Model - Treatment: 0.856
- Medical/Biological Model - Origin: 0.895
- Medical/Biological Model - Treatment: 0.730
- Psychological Model - Origin: 0.750
- Psychological Model - Treatment: 0.849

There was no significant difference in the beliefs of any of the three models between those who have worked with problem drug users for less than 56 months and those who have worked for more than 57 months. From the above results, there was no influence on belief in any of the three models and the length of time worked with problem drug users.
The influence of the length of time the drug worker has been working for the agency

The median length of time that drug workers have worked for the agency that employs them is 30 months. In order to analyze the data it was divided into two groups, those who worked in the agency for 30 months or less and those who worked in the agency for 31 months or more.

---

**TABLE 73**

MEAN SCORES ON THREE MODELS BY DRUG WORKERS EMPLOYED AT THE AGENCY FOR 30 MONTHS OR LESS COMPARED TO THOSE WORKING 31 MONTHS OR MORE

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug workers at agency 30 months or less</td>
<td>3.20</td>
<td>2.83</td>
<td>4.09</td>
</tr>
<tr>
<td>Drug workers at agency 31 months or more</td>
<td>3.35</td>
<td>2.91</td>
<td>4.10</td>
</tr>
</tbody>
</table>

Mean Scores on Three Models Drug Workers Who Have Worked for 30 Months or Less and those Who Have Worked 31 Months or More - Levels of significance (using a Mann-Whitney U test).

- Economic/Social Model - Origin: .063
- Economic/Social Model - Treatment: .240
- Medical/Biological Model - Origin: .877
- Medical/Biological Model - Treatment: .347
- Psychological Model - Origin: .811
- Psychological Model - Treatment: .014

---

Drug workers, working at the agency more than 31 months were less likely to believe in the treatment section of the psychological
model than those working less than 30 months. They were also less likely to believe in the origins section of the economic/social model than their colleagues who had worked for less time, but this difference was not quite statistically significant.

The Influence of race

Excluding the large numbers of those who did not respond to questions of racial origins (21, nearly 7%) and those who responded by marking the "refused" category (again 21, nearly 7%), 92% of drugs workers considered themselves to be White. No single non-white group constituted more than 12 (4%). With such small groups of non-white drug workers it was not possible to consider the issue of racial groups. However, aggregating together all four non-white groups (Afro-Caribbean, Indian/Pakistani, Other/Mixed Race, and Oriental there were only 21 (nearly 7%) in total. The results are below.
Mean Scores on Three Models by full and part time Drug Workers -
Levels of significance (using a Mann-Whitney U test) between
those working full time and those working part time.

Economic/Social Model - Origin  .388
Economic/Social Model - Treatment .254
Medical/Biological Model - Origin  .077
Medical/Biological Model - Treatment .746
Psychological Model - Origin  .116
Psychological Model - Treatment .682

Non-white drug workers shared the same beliefs as white drug
workers, except within the origin section of the
Medical/biological model was concerned. They agreed with this
section of the theory slightly more but not to the point where
it reached statistical significance.

The influence of previous problem alcohol or drug use
The majority (21) of those drugs workers (30, nearly 10% of the
population) who considered that they had, at one time, a problem
with alcohol or drugs, felt they had a drug problem. Only 4

240
believed they had an alcohol problem while 5 believed they had problems with both alcohol and drugs. No details of their alcohol or drug problem were solicited and no reference was made to help they may have had about their problem. There was no indication how long ago they had their problem or the extent or types of difficulties they had.

---

**TABLE 75**

MEAN SCORES ON THREE MODELS BY WORKERS WITH PREVIOUS PROBLEMS WITH ALCOHOL OR DRUG USE

<table>
<thead>
<tr>
<th>Drug workers with previous substance problem</th>
<th>Econ/Social Model Origin</th>
<th>Med/Biological Model Origin</th>
<th>Psychological Model Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.26</td>
<td>4.37</td>
<td>3.52</td>
</tr>
<tr>
<td></td>
<td>2.66</td>
<td>2.89</td>
<td>3.46</td>
</tr>
<tr>
<td></td>
<td>4.37</td>
<td>4.07</td>
<td>2.82</td>
</tr>
<tr>
<td>Drug workers with no previous substance problem</td>
<td>3.27</td>
<td>3.45</td>
<td>2.70</td>
</tr>
<tr>
<td></td>
<td>2.89</td>
<td>3.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.07</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mean Scores on Three Models by previous problems with alcohol or drugs. Levels of significance (using a Mann-Whitney U test) between those drug workers who have had previous problems and those who have not had previous problems.

- Economic/Social Model - Origin . 881
- Economic/Social Model - Treatment . 120
- Medical/Biological Model - Origin . 026
- Medical/Biological Model - Treatment . 574
- Psychological Model - Origin . 822
- Psychological Model - Treatment . 477

From the above results it can be seen than drug workers with previous problems of alcohol or drug use were slightly more in
favour of the treatment section of the Economic/Social Model and significantly less in favour of a Medical/Biological Model.

The influence of the agency on the drug worker and problem drug user

In this section the influence of the agency will be considered as a factor in the beliefs of drug workers in the three models of problem drug use. In order to be able to compare the influence of agency on beliefs the Mann-Whitney U test was used. The data was non parametric and ordinal. Each agency was separately compared to the other 3 agencies than the group of 4 agencies as a whole. This is because the Mann-Whitney U test can only be used when comparing 2 variables, not 3 or more where other tests would be appropriate. By using the Mann-Whitney U test throughout the results were more readily comparable with other variables (such as gender, race, etc.).

There were 4 different types of agencies within the two Regional Health Authorities. They were:

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of workers surveyed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>137</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>70</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td>Regional Drug Dependency Units</td>
<td>76</td>
</tr>
</tbody>
</table>

There is no missing data.
The mean scores on the three models from the groups of agencies are listed in the table below.

### TABLE 77
MEAN SCORES OF THE SOCIAL/ECONOMIC THEORY BY AGENCIES

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>3.21</td>
<td>2.74</td>
<td>2.97</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.25</td>
<td>2.83</td>
<td>3.04</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.33</td>
<td>3.27</td>
<td>3.30</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>3.38</td>
<td>2.95</td>
<td>3.17</td>
</tr>
</tbody>
</table>

Scoring  
1 = strongly agree  
2 = agree  
3 = neutral  
4 = disagree  
5 = strongly disagree

### TABLE 78
MEAN SCORES OF THE MEDICAL/BIOLOGICAL THEORY BY AGENCIES

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>4.05</td>
<td>3.52</td>
<td>3.78</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>4.14</td>
<td>3.56</td>
<td>3.85</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>4.33</td>
<td>3.42</td>
<td>3.88</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>4.04</td>
<td>3.25</td>
<td>3.65</td>
</tr>
</tbody>
</table>

Scoring  
1 = strongly agree  
2 = agree  
3 = neutral  
4 = disagree  
5 = strongly disagree
### TABLE 79

**MEAN SCORES OF THE PSYCHOLOGICAL THEORY BY AGENCY**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>3.45</td>
<td>2.83</td>
<td>3.14</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.66</td>
<td>2.80</td>
<td>3.23</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.21</td>
<td>2.56</td>
<td>2.89</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>3.56</td>
<td>2.50</td>
<td>3.03</td>
</tr>
</tbody>
</table>

Scoring  
1 = strongly agree  
2 = agree  
3 = neutral  
4 = disagree  
5 = strongly disagree

Using a Mann Whitney U test, the mean model scores were compared. One agency was tested against the other three agencies to see if there were any statistically significant differences between them.

### TABLE 79

**COMMUNITY DRUG TEAMS VS. THE THREE OTHER AGENCIES**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>2.97</td>
<td>3.78</td>
<td>3.14</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>3.14</td>
<td>3.77</td>
<td>3.04</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .005
- Medical/biological model: .714
- Psychological model: .399

Those workers from Community Drug Teams were much more likely to believe in an economic/social model than those workers from the
other agencies. The differences in the other scores were not statistically significant.

---

**TABLE 80**  
**ADVICE CENTRES VS. THE THREE OTHER AGENCIES**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice Centres</td>
<td>3.04</td>
<td>3.85</td>
<td>3.23</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>2.97</td>
<td>3.78</td>
<td>3.14</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .580
- Medical/biological model: .125
- Psychological model: .051

Those workers from Advice Centres were less likely to believe in a psychological model than those workers from the other agencies, though the differences did not quite reach statistical significance. The differences in the other scores were not statistically significant.

---

**TABLE 81**  
**RESIDENTIAL REHABILITATION VS. THE THREE OTHER AGENCIES**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Rehab.</td>
<td>3.30</td>
<td>3.88</td>
<td>2.89</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>3.04</td>
<td>3.76</td>
<td>3.14</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .019
- Medical/biological model: .376
- Psychological model: .032

245
Drug workers from residential rehabilitation agencies were less likely to agree with an economic/social model but more likely to agree with a psychological model than workers in the other types of agencies.

Another statistical method of analyzing the data is to use a One-Way ANOVA to compare agencies beliefs in the three theories. Using a Scheffe test of significance at a 0.05 level, drug workers from the four agencies did not have statistically different scores in their beliefs in the medical/biological model or the psychological model. When considering the social/economic model, however, there was a statistically significant difference.

---

**TABLE 82**

**BELIEF IN THE ECONOMIC/SOCIAL THEORIES BY AGENCIES**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean score in belief in the Economic/Social Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>2.97</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.04</td>
</tr>
<tr>
<td>Drug Dependency Units</td>
<td>3.30*</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.16</td>
</tr>
</tbody>
</table>

Drug workers in Needle Exchanges were statistically less likely (using a Scheffe test at a .05 level of significance in One-way ANOVA) to belief in the Economic/social theory compared to those from other agencies.

**Validation of drug workers beliefs**

In the last section of the questionnaire drug workers and drug users were asked two basic questions, how often they talked (question 29) about issues related to psychological problems (i.e. relationships, emotions, coping with anxiety or
depression), socio/economic problems (i.e. welfare rights, housing problems, education or work) or medical problems (unprescribed drug use, injecting, safer sex). In question 30, their views were sought about what help their clients or patients needed the most.

The following table contains the mean scores from question 29 and transformed into the three models. Similar to the other analysis, the model score was by taking the mean score on the three questions which comprised the model score. For example, in order to derive the economic/social model score for question 29 (When you see your client or patient, how often do you talk about the following areas: welfare rights "score 1-3", housing problems "score 1-3", and education or work "score 1-3"), the mean score for the three questions which comprise the model were calculated. See the following table.

Question 29 - "When you see your patient or client, how often do you talk about the following problems?"

-----

**TABLE 83**

<table>
<thead>
<tr>
<th>Drug workers</th>
<th>1.79</th>
<th>1.45</th>
<th>1.37</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic/Social Model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Biological Model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Model</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The scoring for question 29 ranged from:

1 = talked often
2 = talked sometimes
3 = talked never

-----

Clearly, psychological problems were the most common areas to be
discussed by drug workers with their clients or patients. This was followed by medical problems and economic/social problems last.

Below are the scores for each of the three models by profession. The levels of significance are calculated by comparing the professional group against the remainder of the study group.

Question 29 - "When you see your clients/patients face to face, how often do you talk about the following problems?"

Physicians

<table>
<thead>
<tr>
<th></th>
<th>Physicians mean score</th>
<th>Drug workers mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic/social</td>
<td>1.85</td>
<td>1.78</td>
</tr>
<tr>
<td>Medical/biological</td>
<td>1.25</td>
<td>1.47</td>
</tr>
<tr>
<td>Psychological theory</td>
<td>1.44</td>
<td>1.36</td>
</tr>
</tbody>
</table>

The scoring for question 29 ranged from:

1 = talked often
2 = talked sometimes
3 = talked never

Mean Scores on 3 Models by drug workers - professions. Levels of significance (using a Mann-Whitney U test) between physicians and drug workers who are not physicians.

Economic/Social Model .372
Medical/Biological Model .003
Psychological Model .262

Physicians indicated that they mainly talked about medical
problems with their clients or patients and this was significantly more frequent compared to their colleagues. There was not much difference when considering economic/social problems or psychological problems.

Social Workers

---

**TABLE 85**

**HOW OFTEN SOCIAL WORKERS TALK TO THEIR CLIENTS ABOUT ECONOMIC/SOCIAL, MEDICAL/BIOLOGICAL, OR PSYCHOLOGICAL PROBLEMS**

<table>
<thead>
<tr>
<th></th>
<th>Social workers mean score</th>
<th>Drug Workers mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic/social theory</td>
<td>1.70</td>
<td>1.80</td>
</tr>
<tr>
<td>Medical/biological theory</td>
<td>1.52</td>
<td>1.44</td>
</tr>
<tr>
<td>Psychological theory</td>
<td>1.50</td>
<td>1.35</td>
</tr>
</tbody>
</table>

The scoring for question 29 ranged from:

1 = talked often
2 = talked sometimes
3 = talked never

Mean Scores on 3 Models by drug workers - professions. Levels of significance (using a Mann-Whitney U test) between social workers and those in the study group who were not social workers.

- Economic/Social Model . 261
- Medical/Biological Model . 217
- Psychological Model . 058

---

Social workers, surprisingly, said that they talked to their clients about psychological problems and medical problems more than they talked to them about economic or social problems, though they were less likely (not quite statistically significant) to talk about psychological problems than their
Nurses were more likely to talk to their clients/patients about psychological and economic/social problems than their colleagues. This difference was statistically significant for both economic/social and psychological problems and nearly significant when dealing with medical problems. Psychological problems were the most commonly type of problems talked about.

Question 30 - "When you see your clients/patients face to face, which issues do you feel they need the most help with:
Psychological problems (i.e. relationships, emotions, coping with anxiety or depression), socio/economic problems (i.e. welfare rights, housing problems, education or work) or medical problems (unprescribed drug use, injecting, safer sex).

The analysis of question 30 was calculated in a similar way as question 29.

---

TABLE 87
WHICH ISSUES DO DRUG WORKERS THINK THEIR CLIENTS NEED THE MOST HELP WITH: ECONOMIC/SOCIAL, MEDICAL/BIOLOGICAL, OR PSYCHOLOGICAL

<table>
<thead>
<tr>
<th></th>
<th>Econ/soc Model</th>
<th>Med/biolog Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug workers</td>
<td>2.17</td>
<td>2.34</td>
<td>2.33</td>
</tr>
</tbody>
</table>

The scoring for question 30 ranged from:
1 = no help
2 = some help
3 = most help

---

Drug workers felt that their clients or patients needed the most help with medical problems, followed by psychological and economic/social problems.

The analysis of question 30 was conducted in the same way as the analysis of question 29.
Physicians

-----

TABLE 88
WHICH ISSUES DO PHYSICIANS THINK THEIR CLIENTS NEED THE MOST HELP WITH: ECONOMIC/SOCIAL, MEDICAL/BIOLOGICAL, OR PSYCHOLOGICAL

<table>
<thead>
<tr>
<th>Model</th>
<th>Physicians mean score</th>
<th>Drug Workers mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic/social model</td>
<td>2.17</td>
<td>2.17</td>
</tr>
<tr>
<td>Medical/biological model</td>
<td>2.51</td>
<td>2.31</td>
</tr>
<tr>
<td>Psychological model</td>
<td>2.14</td>
<td>2.36</td>
</tr>
</tbody>
</table>

The scoring for question 30 ranged from:

1 = no help
2 = some help
3 = most help

Mean Scores on 3 Models by drug workers - physicians. Levels of significance (using a Mann-Whitney U test) between physicians and other drug workers who are not physicians.

Economic/Social Model           .946
Medical/Biological Model        .020
Psychological Model             .006

-----

Physicians scored the same as their colleagues when considering the economic/social needs of their clients/patients but, not surprisingly, that they required more medical help than their colleagues. They also felt that they required less psychological help than their colleagues, the last two differences were statistically significant.
TABLE 89
WHICH ISSUES DO SOCIAL WORKERS THINK THEIR CLIENTS NEED THE MOST HELP WITH: ECONOMIC/SOCIAL, MEDICAL/BIOLOGICAL, OR PSYCHOLOGICAL

<table>
<thead>
<tr>
<th>Economic/social model</th>
<th>Social Workers mean score</th>
<th>2.22</th>
<th>Drug Workers mean score</th>
<th>2.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/biological model</td>
<td>2.26</td>
<td>2.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological model</td>
<td>2.24</td>
<td>2.35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The scoring for question 30 ranged from:

1 = no help
2 = some help
3 = most help

Mean Scores on 3 Models by drug workers - social workers. Levels of significance (using a Mann-Whitney U test) between social workers and those in the study group who are not social workers.

- Economic/Social Model .350
- Medical/Biological Model .238
- Psychological Model .117

There was little difference in the mean scores of social workers when considering the economic/social, medical and psychological needs of their clients. None were statistically different from their colleagues.
Nurses

### TABLE 90

**WHICH ISSUES DO NURSES THINK THEIR CLIENTS NEED THE MOST HELP WITH: ECONOMIC/SOCIAL, MEDICAL/BIOLOGICAL, OR PSYCHOLOGICAL**

<table>
<thead>
<tr>
<th>Model</th>
<th>Nurses mean score</th>
<th>Drug Workers mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic/social model</td>
<td>2.16</td>
<td>2.17</td>
</tr>
<tr>
<td>Medical/biological model</td>
<td>2.38</td>
<td>2.30</td>
</tr>
<tr>
<td>Psychological model</td>
<td>2.39</td>
<td>2.30</td>
</tr>
</tbody>
</table>

The scoring for question 30 ranged from:

1 = no help  
2 = some help  
3 = most help

Mean Scores on 3 Models by drug workers - nurses. Levels of significance (using a Mann-Whitney U test) between nurses and those in the study group who are not nurses.

- Economic/Social Model: .659  
- Medical/Biological Model: .211  
- Psychological Model: .069

Nurses felt that their clients/patients required medical and psychological help equally and economic/social help came a poor third. They felt that the clients/patients required more psychological help than their colleagues but this difference did not quite reach statistical significance.

**What drug workers say they talk to drug users about and what help they think they need**

This section was about what drug workers talk about when they see problem drug users and what kind of help they believe they need.
Drug workers said that they talked to their clients about psychological problems but that they needed the most help with medical problems, which was only slightly ahead of psychological problems. There were differences between professions as to what they talked to problem drug users about. Physicians spoke to problem drug users more about medical problems than other professions. However, social workers were not more concerned about economic/social problems than their colleagues. Physicians felt that problem drug users required both more medical help and psychological help than nurses or social workers. This was consistent with their preference in models as well. Even though physicians said they preferred an economic/social model, they also preferred psychological and medical treatment.

Nurses, however, claimed to talk to their clients more than other professionals and that they talked to them about psychological problems more than economic/social problems or medical problems. This was consistent with their preference for treatment. Like physicians, they preferred an economic/social model overall, they also preferred a psychological model for treatment.

Social workers were perhaps the least consistent of the three professions. They say they talk to their clients mostly about psychological problems and medical problems and about economic/social problems the least. They, however, say that treatment of economic and social problems were their preference.

What drug workers say drug users most need.

Previously in the questionnaire, drug workers indicated that they believed more in a social/economic model than in the other two models. However, in this section of the questionnaire, they
indicated that they needed more help with psychological and medical problems than they needed with economic/social problems. Most physicians feel that problem drug users mainly required medical help and most nurses suggested that they mostly required psychological and medical help. Social workers indicated little preference for any of the three models, which scored about the same.

Overall, the results of the analysis of these two questions were reasonably consistent with the first part of the questionnaire. The main differences were in the belief of an economic and social model for the origins of drug problems, but the simultaneous belief in psychological and medical treatment for that problem. These findings will be considered more thoroughly in the conclusion.

SUMMARY
The influence of the agency on drug workers was significant in several agencies. Community Drug Team workers were more likely to favour an economic/social model compared to the workers from the other agencies. Advice Centre workers had less faith in a Psychological Model than workers from other agencies but this did not quite reach statistical significance (Level of significance = .051). Finally, workers in residential rehabilitation agencies had far more faith in a Psychological model (Level of significance = .019) and far less faith in an Economic/Social Model (Level of significance = .032). This result was consistent with the type of treatment which was offered, i.e. group therapy concentrating on the individual pathology of the residents. Drug Dependency Units also had less faith in a Economic/Social Model
compared to the other three types of agencies (Level of significance = .034) but also had more faith in a Medical/biological Model (Level of significance = .011). Again, this was consistent with the type of treatment available at this type of agency - mainly prescribed drugs. When using a One Way ANOVA, Scheffe test, the only statistically significant result suggested that drug workers in Needle Exchanges were less likely to belief in an Economic/Social model.

The Influence of Working Full or Part Time

Just under 17% of drug workers were employed on a part-time basis. Their belief in the three models of problem drug use was not statistically different when considering the Social/Economic Model. In relation to the Medical/Biological Model, however, they were more likely to agree with statements suggesting a biological influence in the origin (using a Mann-Whitney U test, it was significant, .028, for a 2-tailed test) of the problem rather than statements suggesting preferred medical treatment where their answers were not statistically different from the population of full-time drug workers. They were also more likely to agree to statements suggesting a psychological origin of problem drug use (significant at a .034 level, using a 2-tailed test) but not when considering preferred psychological treatments, where there was no statistical difference between full and part-time workers (see page 240).

Differences between the two Regional Health Authorities

There were no differences between the drug workers from Merseyside Regional Health Authority and the North West Regional Health Authority when considering either the origins or preferred
treatment aspects of the Medical/Biological Model or the Social/Economic/ Model. However, drug workers from Merseyside showed a strong preference for both the origins and preferred treatment aspects of the Psychological Model. Using a 2-tailed Mann-Whitney U the level of significance was .0002 for the origins aspect and .0381 for the treatment aspects.

THE SEMI-STRUCTURED INTERVIEWS
The drug workers comprised two doctors, one nurse, one drug counsellor, one manager (of a small service) and one social worker. They came from Drug Dependency Centres, a Community Drug Team and two voluntary agencies (a residential project and an information/advice centre).

The semi-structured interviews gave substance and detail to the quantitative questionnaire. The questions related to the origins and best treatment of problem drug use. They delved deeper into what makes problem drug users different from others who do not use drugs problematically.

1/ Why do you think problem drug users use drugs in a way which causes themselves and others problems?

Four of the six respondents suggested that socio/economics were a key causal factor in why some people become problem drug users and others don’t. None thought that it was the only factor. One physician listed a whole range of factors including personality and psychopathology. She went on to say,

"My clinical experience had led me to feel that the environmental and socio-economic factors seem to be extremely important in maintaining problem drug use and in relapse following admission for detoxification."
A drug counsellor in a residential establishment pointed out the way economic and social factors can be interrelated.

"There are no jobs in this area and there is a lot of unemployment. The drug use gives them a sense of belonging, it gives them a peer group in which to go round with....Drugs gives them something to do and given them a glamorous life in their eyes - it's an achievement, exciting."

One manager felt that there were any number of reasons and that, possibly, problem drug users didn't have enough in common as a group to say anything of importance.

"I think it is difficult when you start lumping together problem drug users. I don't think there is a homogenized group. You've probably got as many reasons as there are problem drug users."

2/ Are problem drug users different from people who do not use drug problematically? If so, how?

Most of the respondents had difficulties distinguishing between the effects of the drug on the individual (and the problems that caused) from an inherent difference between problem drug users before they began to use drugs and their peers who do not use drugs problematically.

One manager and one doctor readily perceived this problem and gave strikingly similar answers. The physician said,

"Yes they are or they wouldn't be problem drug users as opposed to non-problem drug users."

Later on, in response to a direct question asking if that means that the initial problem is within their personality, he said,
"......... it must be something about their personality or perhaps their level of understanding, knowledge, ignorance."

the manager said,

"Again it is asking the question of whether they are different because of their drug use or whether their drug use somehow makes them different before they started. Certainly problem drug users are different at the point that they are problem drug users."

Another two respondents said that problem drug users are not very much different from those that do not use drugs problematically.

A drug counsellor from an information and advice centre said,

"The point I am trying to make is that simply being a drug user doesn’t mean that your problems are necessarily any different from people who don’t take drugs."

Another drug worker said,

"Not necessarily. I think where someone is using drugs because of some underlying problem (relationships, housing) I would guess that they are not fundamentally different to other people."

3/ What prevents problem drug users from changing their drug using habits? From becoming abstinent?

In trying to answer this question a number of issues arose. The two most common were issues around the difficulties in changing social circumstances and those around learning to cope with life and emotional problems without the aid of drugs. Some gave equal weight to the two issues. An example of the first comes from a drug counsellor,
"One of the things is that they find it difficult to change their circumstances or change their behaviour. If, for example, they have things like offers of better housing, better employment prospects, better relationships in their family or with friends, they can sometimes make positive changes as they must see it to become abstinent."

One physician gave more weight to the psychological problems of problem drug users. She said,

"...difficulties in facing up to unresolved issues without reliance on drugs to deal with these issues and lives problems."

Most of the answers gave a variety of reasons why problem drug users find it difficult to change. Several pointed out that it is much easier to help problem drug users practice harm reduction measures than achieve abstinence. A physician who at first implied it had something to do with pain thresholds and the capacity to delay gratification later gave up and said,

"I don't know what the answer to that one is really. I suspect it's one of those multi-factorial things which are different to different people."

4/ What are the best ways for agencies to help problem drug users reduce the harm from their drug use? Become abstinent?

Two types of answers to this question were given. On the one hand, nearly several of the respondents suggested that their roles were educational. They felt that they could teach problem drug users to use drugs less harmfully, develop interests that did not include drug use, etc. One manager said,

"In terms of reducing harm, there is a lot we can do -
advice, information. I don't think there is a need or desire amongst the large majority of drug users for intensive therapeutic counselling."

This approach suggests a social/economic model. Problem drug users were seen as rational participants rather than suffering from emotional difficulties which prevented them from acting in their own self interest.

Other respondents, however, suggested a therapeutic role was the primary way to help problem drug users. They felt that the main focus of helping was through building a positive relationship with the problem drug user rather just simply supply information and advice. One drug counsellor from a therapeutic community said,

"If you can build up a trust with an individual you can ask them about that and show that you obviously care and you are going some way to help them with what they need."

This approach suggests a psychological model. The drug counsellor implied that dealing with the users psychological needs are paramount and that this is best done by forming a good relationship.

Most of the respondents felt that a combination of the two approaches was the best way forward, i.e. practical help and counselling. None indicated that there was an inherent difficulty (i.e. a medical/biological approach) which had to be addressed or at least taken into account.

CONCLUSION - WHAT ARE THE VARIABLES IN DETERMINING DRUG WORKERS BELIEFS IN THE ORIGIN AND PREFERRED TREATMENT OF PROBLEM DRUG USE?
Using the three models of the origins and preferred treatment of problem drug use it is apparent that drug workers hold reasonably consistent beliefs. That is, if a drugs worker believes that social and economic factors are important in the origins of problem drug use they are likely to prefer social and economic interventions. There was greater consistency in the beliefs (and a higher correlation) in the Economic/Social model than in the other two models.

---

TABLE 91
CORRELATIONS AND LEVELS OF SIGNIFICANCE BETWEEN THE ORIGINS AND PREFERRED TREATMENT SECTIONS OF THE THREE MODELS OF PROBLEM DRUG USE

<table>
<thead>
<tr>
<th>THEORY</th>
<th>Mean Score Origin</th>
<th>Mean Score Treatment</th>
<th>Combined Score</th>
<th>Correlation</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECONOMIC/SOCIAL MODEL</td>
<td>3.27</td>
<td>2.87</td>
<td>3.07</td>
<td>.503</td>
<td>.000</td>
</tr>
<tr>
<td>MED/BIOLOGICAL MODEL</td>
<td>4.10</td>
<td>3.46</td>
<td>3.78</td>
<td>.288</td>
<td>.000</td>
</tr>
<tr>
<td>PSYCHOLOGICAL MODEL</td>
<td>3.50</td>
<td>2.72</td>
<td>3.11</td>
<td>.383</td>
<td>.000</td>
</tr>
</tbody>
</table>

The economic/social model was preferred overall but in terms of preferred treatment, the psychological theory was the most popular.

The semi-structured interviews allowed drug workers to expand upon the differences between problem drug users and their peers who are not problem drug users. Several drug workers suggested that once they developed a drug problem, that alone made them different from others of their same age, gender and class. There was disagreement though when considering if they were different before they began to have drug problems, rather than after their
drug problems developed.

Gender was a factor in that women drug workers were more likely than men to favour a medical/biological model in terms of origin of the problem and were more likely to favour (but not quite statistically significant - .060) psychological treatments. Age was only a factor in relation to beliefs in one model - the medical/biological. Older drug workers were more likely to believe in the medical/biological model than younger drug workers but the differences did not quite reach statistical significance. General educational levels (measured by the number of "0" level or GCSE examinations) were not influential except for those with no "0" level or GCSE examinations who were less likely to believe in the economic/social origin of problem drug use. This difference was confirmed when comparing those with at least one "A" level examination to those with no "A" level examination. Those with "A" level results were much more likely to believe in the economic/social model in both origins (level of significance = .005) and preferred treatment (level of significance = .007). They were also more likely to believe in the medical/biological model (level of significance = .039) than those with no "A" level results. Education, at all levels from "0" level and GCSE results to degrees influenced drug workers beliefs. Overall, the more educational qualifications the drug worker had, the more he or she believed in a social/economic model. The exception to this rule was physicians.

Professional qualifications were also influential. Not surprisingly, physicians were much more likely to believe in both the origin and treatment sections of the medical/biological
models (levels of significance were .002 and .001 respectively). Also, they were more likely to favour psychological treatments (level of significance = .006) than those without medical qualifications. Nurses, however, had no such preferences for medical/biological models of origin or treatment. Like their medical colleagues though, they did have a stronger preference than those without nursing qualifications for psychological treatments. Social Workers were the most likely professional group to believe in the economic/social model in both origins and treatment terms. Unlike their medical colleagues, they did not favour psychological treatments (level of significance = .001).

A number of other factors were shown to have no significant effect on beliefs in the three models. These included, the length of time the drug worker had been working at the agency, how much experience they had in working with problem drug users, and racial origins. Previous problems with alcohol or drugs only influenced the origins section of belief in the medical/biological model. Drug workers with a history of previous alcohol or drug problems believed less in a medical/biological origins section than those without previous problems with alcohol or drugs (level of significance = .026).

The most striking result, however, is how robust the economic/social model was amongst drug workers. All professional groups (even physicians) preferred this model over other theories of problem drug use. This held true regardless of education, experience, gender, race, etc. While this was the preferred theory overall, many drug workers preferred a treatment model which was consistent with a Psychological model. Perhaps this was
because they believe that they could have little impact on the social/economic condition of their clients or patients but may be of some use for their psychological problems. This was reflected in several of the semi-structured interviews. Change in social or economic conditions was seen by several drug workers as of great importance, but they did not suggest that they could influence that change.

Finally, there was a marked influence from the type of agency where the drug worker was employed. Workers from agencies which strongly advocated and used psychological treatments such as group therapy (i.e. residential rehabilitation agencies) were much more likely to favour that model. The same was true for prescribing agencies such as Community Drug Teams and Drug Dependency Units, which favoured a more medical/biological approach. This is not evidence that the relationship is cause and effect. It is also possible that drug workers who favoured certain models and treatments went to work for agencies which employed those models and treatments.

The results of the semi-structured interviews allowed those interviewed to express their beliefs in models within their own terms rather than be constrained by the limited choice of answers with a more quantitative questionnaire.

**Problem Drug Users**

Problem Drug Users as a group.

Below are the scores which problem drug users registered for the three models of problem drug use. Like the drug workers, they are derived from the mean score of the first 18 questions, of which 6 (3 for origins and 3 for treatment) are for each of the models.
Similar to the drug workers, question 16, has been eliminated and the mean scores for the two remaining questions were used.

-----

**TABLE 92**

BELIEFS IN THE THREE MODELS BY PROBLEM DRUG USERS

<table>
<thead>
<tr>
<th>Name of the model</th>
<th>Mean score origin</th>
<th>Mean score treatment</th>
<th>Combined mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Economic Model</td>
<td>3.19</td>
<td>2.74</td>
<td>2.97</td>
</tr>
<tr>
<td>Medical/Biological Model</td>
<td>3.23</td>
<td>2.75</td>
<td>2.99</td>
</tr>
<tr>
<td>Psychological Model</td>
<td>3.19</td>
<td>2.25</td>
<td>2.72</td>
</tr>
</tbody>
</table>

-----

For problem drug users, it is apparent that the Psychological Model is the most favoured followed by the Social/Economic and finally the Medical/Biological.

**Gender**

Within the study group of 150 problem drug users there were 114 men (78%) and 33 women (22%). A total of 3 individuals did not respond to this question.
TABLE 93

PROBLEM DRUG USERS MEAN SCORES ON THREE MODELS BY GENDER

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men problem drug users</td>
<td>3.17</td>
<td>2.78</td>
<td>3.30</td>
</tr>
<tr>
<td>Women problem drug users</td>
<td>3.20</td>
<td>2.61</td>
<td>2.98</td>
</tr>
</tbody>
</table>

Mean Scores on 3 Models by gender. Levels of significance (using a Mann-Whitney U test) between men and women.

Economic/Social Model - Origin . 641
Economic/Social Model - Treatment . 310
Medical/Biological Model - Origin . 186
Medical/Biological Model - Treatment . 010
Psychological Model - Origin . 813
Psychological Model - Treatment . 393

From the above results it can be seen that women problem drug users had a stronger belief in a Medical/Biological Model than men problem drug users. Within the treatment section, the difference was statistically significant.

Age

For the initial analysis the drug users study group was divided into two. The first group was aged 18 - 27 (n=79, 53%) and the second group was aged 28 - 44 (n=68, 45%). There were 3 (2%) respondents who did not record their age. Their mean scores were then analyzed by age group and tested for levels of significance using the Mann-Whitney U test.
Mean Scores on 3 Theories by age groups. Levels of significance (using a Mann-Whitney U test) between drug users aged 18-27 and those aged 28-44.

<table>
<thead>
<tr>
<th>Drug users aged 18-27</th>
<th>Drug users aged 28-44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Econ/Social Model</td>
<td>Medical/Biological Model</td>
</tr>
<tr>
<td>Origin Treat.</td>
<td>Origin Treat.</td>
</tr>
<tr>
<td>3.12</td>
<td>3.24</td>
</tr>
<tr>
<td>2.80</td>
<td>2.68</td>
</tr>
<tr>
<td>3.17</td>
<td>3.28</td>
</tr>
<tr>
<td>2.66</td>
<td>2.86</td>
</tr>
<tr>
<td>3.18</td>
<td>3.16</td>
</tr>
<tr>
<td>2.22</td>
<td>2.30</td>
</tr>
</tbody>
</table>

From the results it is clear that age is not a significant factor in beliefs about the origins and preferred treatment of problem drug use.

**Ethnicity**

Excluding the relatively large proportion of "missing" (6.7%) data and "refused" (11.3%), 86% of problem drug users considered themselves to be "White". The category "Other/Mixed" constituted 8% of the total, while the three other non-white categories constituted only 3% combined. By aggregating all the "Non-white" (n=17) responses it was possible to test the difference between
white and non-white problem drug users.

-----

TABLE 95
MEAN SCORES ON THREE MODELS, "WHITE" PROBLEM DRUG USERS AND "NON-WHITE" PROBLEM DRUG USERS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>White problem drug user</td>
<td>3.16</td>
<td>2.72</td>
<td>3.22</td>
</tr>
<tr>
<td></td>
<td>2.82</td>
<td>3.18</td>
<td>2.28</td>
</tr>
<tr>
<td>Non-white problem drug users</td>
<td>3.21</td>
<td>3.04</td>
<td>3.52</td>
</tr>
<tr>
<td></td>
<td>2.56</td>
<td>3.12</td>
<td>2.19</td>
</tr>
</tbody>
</table>

Mean scores on 3 Theories by "White" and "Non-white" problem drug users. Levels of significance (using a Mann-Whitney U test) between "White" and "Non-white" problem drug users aged.

Economic/Social Model - Origin .859
Economic/Social Model - Treatment .179
Medical/Biological Model - Origin .314
Medical/Biological Model - Treatment .252
Psychological Model - Origin .661
Psychological Model - Treatment .847

-----

There was no statistical difference between "White" and "Non-white" problem drug users in their beliefs about the origins and preferred treatment of problem drug use.

Drug Preference

Few of the drug using respondents claimed to be using one drug. This is not surprising as most studies of problem drug users suggest that polydrug use is common (Donmall & Miller, 1993). That is not to say that problem drug users are indiscriminate in their drug use. Most have a preference for one drug or another (Hartnoll, 1992).
In the first instance the mean scores of opiate users were calculated (n=85,576) and compared to problem drug users who used other drugs. Opiate users were the majority in this cohort of problem drug users. No doubt this reflects the nature of the agencies in the studies. Community Drug Teams and Drug Dependency Units all prescribed Methadone and in some cases other opiates. It is therefore not surprising that opiate users represent a majority.

Opiate users had usually sampled a variety of all the other illicit drugs and there is ample evidence that opiates are the last group of drugs to be used. It is often assumed that opiate users have longer and more problematic drug histories than other drug users.
TABLE 96
MEAN SCORES ON THREE MODELS BY PROBLEM DRUG USERS WHO PREFER
OPIATE DRUGS VS THOSE WHO PREFER OTHER DRUGS

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem drug users</td>
<td>3.26</td>
<td>2.76</td>
<td>3.23</td>
</tr>
<tr>
<td>who prefer opiates</td>
<td></td>
<td></td>
<td>2.69</td>
</tr>
<tr>
<td>Problem drug users</td>
<td>3.15</td>
<td>2.75</td>
<td>3.18</td>
</tr>
<tr>
<td>who prefer non opiate</td>
<td></td>
<td></td>
<td>2.97</td>
</tr>
<tr>
<td>drugs</td>
<td></td>
<td></td>
<td>3.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.27</td>
</tr>
</tbody>
</table>

Mean Scores on 3 Models for problem drug users who prefer opiate
drugs compared to those who prefer other drugs. Levels of
significance (using a Mann-Whitney U test) of opiate preferring
drug users vs non opiate preferring drug users.

Economic/Social Model - Origin .534
Economic/Social Model - Treatment .719
Medical/Biological Model - Origin .702
Medical/Biological Model - Treatment .091
Psychological Model - Origin .894
Psychological Model - Treatment .694

Broadly speaking, most drug users preferred opiate drugs such as
Heroin, Methadone, Diconal, etc. The remainder preferred a
variety of drugs such as Cocaine, Amphetamine, Cannabis, etc. In
the sample of problem drug users in this survey 85 of 130 problem
drug users (57%) preferred opiates while 35 (23%) preferred
stimulants. With no statistically significant differences between
opiate users and other drug users, the mean scores of opiate
users and stimulant users were calculated. A total of 30 (20%)
had missing data.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem drug users who prefer opiates</td>
<td>3.26</td>
<td>2.76</td>
<td>3.23</td>
<td>2.69</td>
<td>3.21</td>
<td>2.23</td>
</tr>
<tr>
<td>Problem drug users who prefer stimulants</td>
<td>3.25</td>
<td>2.67</td>
<td>3.23</td>
<td>3.01</td>
<td>2.97</td>
<td>2.41</td>
</tr>
</tbody>
</table>

Mean scores on 3 models for problem drug users who prefer opiate drugs compared to those who prefer stimulants. Levels of significance (using a Mann-Whitney U test) of opiate preferring drug users vs stimulant preferring drug users:

- Economic/Social Model - Origin: .914
- Economic/Social Model - Treatment: .585
- Medical/Biological Model - Origin: .976
- Medical/Biological Model - Treatment: .085
- Psychological Model - Origin: .409
- Psychological Model - Treatment: .187

The mean scores of opiate users and stimulant users were similar and the only one which approached, but did not reach statistical significance was the treatment section of the Medical/Biological Theory, where opiate users had a stronger preference. This was not surprising as many of those opiate users were receiving prescriptions for opiates while few of the stimulant users were receiving stimulant prescriptions.
TABLE 98
MEAN SCORES ON THREE MODELS BY PROBLEM DRUG USERS WHO HAVE A PRESCRIPTION FOR DRUGS VS THOSE WHO DO NOT

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem users on a prescription</td>
<td>3.27 2.61</td>
<td>3.17 2.82</td>
<td>3.26 2.34</td>
</tr>
<tr>
<td>Problem users w/ no prescription</td>
<td>3.03 2.97</td>
<td>3.34 2.62</td>
<td>3.07 2.09</td>
</tr>
</tbody>
</table>

df = 148 for all models

Mean scores on 3 models for problem drug users who prefer opiate drugs compared to those who prefer stimulants. Levels of significance (using a Mann-Whitney U test) of opiate preferring drug users vs stimulant preferring drug users:

- Economic/Social Model - Origin: .123
- Economic/Social Model - Treatment: .011
- Medical/Biological Model - Origin: .306
- Medical/Biological Model - Treatment: .126
- Psychological Model - Origin: .307
- Psychological Model - Treatment: .043

Problem drug users who were in receipt of a prescription had a stronger belief in a Social/Economic treatment option and less belief in a Psychological treatment option compared to those who were not receiving a prescription. They had a greater belief in a Medical/Biological treatment option (which could be described as a prescription for a drug) but the difference did not reach statistical significance.

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Education
The relationship between education and belief were analysed by models of problem drug use in three ways. Firstly the correlation between those who had achieved "A" level examinations against those who did not was considered. As there were only 10 problem drug users who had achieved "A" level examinations it is not surprising that they were not statistically different from the other 140 problem drug users. There were so few problem drug users with Further Education Certificates, Degrees, or Post Graduate degrees that no analysis was possible:
The number of "O" level or GCSE pass results was considered by dividing those who had achieved at least one "O" level or "GCSE" examination pass and those who had none. This divided the group into two nearly equal sub groups.
Problem drug users who achieved 1 or more "O" level or GCSE examination and those who achieved none
There were 58 (39%) problem drug users who achieved at least 1 "O" level or GCSE examination and 71 (47%) who achieved none. Missing data accounted for 21 (14%) responses. There was no statistical difference in the beliefs in any of the three models and passing one or more examination.
TABLE 99
MEAN SCORES ON THREE THEORIES BY PROBLEM DRUG USERS WHO ACHIEVED AT LEAST ONE "0" LEVEL OR GCSE EXAMINATION AND THOSE WHO ACHIEVED NONE

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Model</th>
<th>Med/Biological Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem drug users</td>
<td>3.12</td>
<td>2.71</td>
<td>3.14</td>
</tr>
<tr>
<td>with no &quot;0&quot; level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or GCSE exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem drug users</td>
<td>3.22</td>
<td>2.78</td>
<td>3.44</td>
</tr>
<tr>
<td>with at least 1 &quot;0&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>level or GCSE exam</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mean Scores on 3 Models for problem drug users who have achieved at least 1 "0" level or GCSE and those who have not. Levels of significance (using a Mann-Whitney U test) of those who have achieved at least 1"0" level result and those who have not.

- Economic/Social Model - Origin: .440
- Economic/Social Model - Treatment: .528
- Medical/Biological Model - Origin: .118
- Medical/Biological Model - Treatment: .650
- Psychological Model - Origin: .765
- Psychological Model - Treatment: .819

There was little difference in the beliefs in the three models between those with "0" level or GCSE results and those without. None of the above values approached or reached statistical significance.

The influence of agencies

In this section the influence of the agency will be considered as a factor in the beliefs of problem drug users in the three
models of problem drug use. In order to be able to compare the influence of agency on beliefs the Mann-Whitney U test was used. The data is non parametric and ordinal. Each agency was separately compared to the other 3 agencies than the group of 4 agencies as a whole. This is because the Mann-Whitney U test can only be used when comparing 2 variables, not 3 or more where other tests would be appropriate. By using the Mann-Whitney U test throughout the results are more readily comparable with other variables (such as gender, race, etc.).

There are 4 different types of agencies within the two Regional Health Authorities.

---

TABLE 100
PROBLEM DRUG USERS BY AGENCIES

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of problem drug users surveyed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>69</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>18</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td>Regional Drug Dependency Units</td>
<td>29</td>
</tr>
</tbody>
</table>

There is no missing data.

---
The mean scores on the three models from the groups of agencies are listed in the tables below.

### TABLE 101
**THE MEAN SCORES ON THE SOCIAL/ECONOMIC MODEL BY AGENCY**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>3.13</td>
<td>2.53</td>
<td>2.83</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.31</td>
<td>2.77</td>
<td>3.04</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.14</td>
<td>3.18</td>
<td>3.16</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>3.30</td>
<td>2.71</td>
<td>3.01</td>
</tr>
</tbody>
</table>

Scoring   
1 = strongly agree  
2 = agree  
3 = neutral  
4 = disagree  
5 = strongly disagree

### TABLE 102
**THE MEAN SCORES ON THE MEDICAL/BIOLOGICAL MODEL BY AGENCY**

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>3.16</td>
<td>2.68</td>
<td>2.92</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.21</td>
<td>3.17</td>
<td>3.19</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.50</td>
<td>2.67</td>
<td>3.09</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>3.09</td>
<td>2.74</td>
<td>2.92</td>
</tr>
</tbody>
</table>

Scoring   
1 = strongly agree  
2 = agree  
3 = neutral  
4 = disagree  
5 = strongly disagree

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TABLE 103
THE MEAN SCORE ON THE PSYCHOLOGICAL MODEL BY AGENCY

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Mean response re: origin</th>
<th>Mean response re: treatment</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>3.29</td>
<td>2.33</td>
<td>2.81</td>
</tr>
<tr>
<td>Advice Centres</td>
<td>3.44</td>
<td>2.14</td>
<td>2.79</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.09</td>
<td>2.13</td>
<td>2.61</td>
</tr>
<tr>
<td>Reg. Drug Dependency Units</td>
<td>2.90</td>
<td>2.26</td>
<td>2.58</td>
</tr>
</tbody>
</table>

Scoring:
1 = strongly agree
2 = agree
3 = neutral
4 = disagree
5 = strongly disagree

Using a Mann Whitney U test, the mean model scores between the one agency and the other three agencies were compared to see if there was any statistically significant differences between the agencies, see tables below:

TABLE 104
MEAN SCORES ON THREE MODELS, COMMUNITY DRUG TEAMS VS THE THREE OTHER AGENCIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Teams</td>
<td>2.83</td>
<td>2.90</td>
<td>2.79</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>3.08</td>
<td>3.06</td>
<td>2.64</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .031
- Medical/biological model: .177
- Psychological model: .214

Those problem drug users from Community Drug Teams were much more
likely to believe in an economic/social model than those from the
other agencies. The differences in the other scores were not
statistically significant.

---

**TABLE 105**

MEAN SCORES ON THREE MODELS, ADVICE CENTRES VS THE THREE OTHER AGENCIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice Centres</td>
<td>3.04</td>
<td>3.19</td>
<td>2.80</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>2.96</td>
<td>2.96</td>
<td>2.70</td>
</tr>
</tbody>
</table>

Levels of significance

Economic/Social model .635

Medical/biological model .179

Psychological model .051

---

Those workers from Advice Centres were less likely to believe in
a psychological model than those workers from the other
agencies, though the differences did not quite reach statistical
significance. The differences in the other scores were not
statistically significant.
### TABLE 106
MEAN SCORES ON THREE MODELS, RESIDENTIAL REHABILITATION VS THE THREE OTHER AGENCIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Rehab.</td>
<td>3.16</td>
<td>3.11</td>
<td>2.61</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>2.91</td>
<td>2.96</td>
<td>2.73</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .064
- Medical/biological model: .248
- Psychological model: .355

Problem drug users from residential rehabilitation agencies were less likely to agree with an economic/social model compared to problem drug users from the other agencies, but the differences were not statistically significant.

### TABLE 107
MEAN SCORES ON THREE MODELS, DRUG DEPENDENCY UNITS VS THE THREE OTHER AGENCIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean econ/soc score</th>
<th>Mean Med/bio score</th>
<th>Mean Psych. score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Units</td>
<td>3.01</td>
<td>2.91</td>
<td>2.59</td>
</tr>
<tr>
<td>3 other agencies</td>
<td>2.95</td>
<td>3.00</td>
<td>2.73</td>
</tr>
</tbody>
</table>

Levels of significance

- Economic/Social model: .716
- Medical/biological model: .532
- Psychological model: .309

There were little differences between the beliefs of problem drug
users from Drug Dependency Units compared to other agencies. In addition, the data (the mean numerical scores representing the beliefs in the three models by agencies) was analyzed using a One-Way ANOVA and a Scheffe test of significance at a .05 level. The results were similar to the three tables above, except that there were no statistically significant differences between the problem drug users from the four agencies in their beliefs in the three models instead of just one (Table 103).

Validation of drug users beliefs

In the last section of the questionnaire drug workers and drug users were asked two questions about their counselling sessions at the agencies. In question 29 they were asked how often they talked about issues related to psychological problems (i.e. relationships, emotions, coping with anxiety or depression), socio/economic problems (i.e. welfare rights, housing problems, education or work) or medical problems (unprescribed drug use, injecting, safer sex). In question 30 they were asked about what help their clients or patients needed the most, utilising the same questions related to psychological, socio/economic, and medical problems as in question 29.

The purpose of these questions was to gather data on what drug workers and drug users talked about when they met and what they felt was important to pursue. In part it was a check on the validity of the previous questions and also it serves as an indicator of how drug users and workers perceive their interaction.

The following table contains the mean scores from question 29 and transformed into the three models. Similar to the other analysis,
the model score was calculated by taking the mean score on the three questions which comprised the model score. For example, in order to derive the economic/social model score for question 29 (When you see your key worker, at this agency, how often do you talk about the following areas: welfare rights "score 1-3", housing problems "score 1-3", and education or work "score 1-3"), the mean score for the three questions which comprise the model were calculated.

**Question 29 - "When you see your key worker, at this agency, how often do you talk about the following problems?"**

---

**TABLE 108**

MEAN SCORES ON THREE MODELS USED IN QUESTION 29, PROBLEM DRUG USERS - HOW OFTEN DO YOU TALK ABOUT ECONOMIC/SOCIAL PROBLEMS, MEDICAL PROBLEMS AND PSYCHOLOGICAL PROBLEMS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Econ/soc Model</th>
<th>Med/biolog Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug users</td>
<td>2.30</td>
<td>2.11</td>
<td>1.80</td>
</tr>
</tbody>
</table>

The scoring for question 29 ranged from:

1 = talked often  
2 = talked sometimes  
3 = talked never  

---

Clearly, psychological problems were the most common areas to be discussed with key workers.

Drug users were then divided into those who were receiving a prescription for drugs and those who were not.
TABLE 109
MEAN SCORES ON THREE MODELS USED IN QUESTION 29, PROBLEM DRUG USERS BY TREATMENT WITH PRESCRIBED DRUGS - HOW OFTEN DO YOU TALK ABOUT ECONOMIC/SOCIAL PROBLEMS, MEDICAL PROBLEMS AND PSYCHOLOGICAL PROBLEMS

<table>
<thead>
<tr>
<th></th>
<th>Econ/soc Model</th>
<th>Med/biol Model</th>
<th>Psych Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug users w/ prescription</td>
<td>2.30</td>
<td>2.03</td>
<td>1.91</td>
</tr>
<tr>
<td>Drug users w/ no prescription</td>
<td>2.29</td>
<td>2.24</td>
<td>1.61</td>
</tr>
</tbody>
</table>

level of significance

econ/soc model = .922 df = 128
med/biolog model = .075 df = 127
psycholog model = .007 df = 133

Drug users without a prescription claimed to talk more frequently about psychological problems than those who had a prescription. This could simply reflect the treatment which drug users in residential rehabilitation programmes received.

Question 30 - "What issues do you feel you need the most help with (economic/social, medical, psychological)?"
The analysis of question 30 was calculated in a similar way as question 29.

TABLE 110
MEAN SCORES ON THREE MODELS USED IN QUESTION 30, PROBLEM DRUG USERS - HOW MUCH HELP DO YOU NEED WITH ECONOMIC/SOCIAL PROBLEMS, MEDICAL PROBLEMS AND PSYCHOLOGICAL PROBLEMS

<table>
<thead>
<tr>
<th></th>
<th>Econ/soc Model</th>
<th>Med/biolog Model</th>
<th>Psychological Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem drug users</td>
<td>1.77</td>
<td>1.60</td>
<td>2.14</td>
</tr>
</tbody>
</table>

The scoring for question 30 ranged from:

1 = no help
2 = some help
3 = most help

284
Problem drug users felt that they needed the most help with psychological problems, followed by economic/social problems and medical problems. While it may have been predictable that they feel they need the most help with psychological problems (from their answers on question 29), they feel that they need more help with economic and social problems than they do medical problems (the opposite of question 29).

Drug users were then divided into those who were receiving a prescription for drugs and those who were not.

-----

**TABLE 111**

<table>
<thead>
<tr>
<th></th>
<th>Econ/soc Model</th>
<th>Med/biolog Model</th>
<th>Psycholog. Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug users w/ prescription</td>
<td>1.71</td>
<td>1.63</td>
<td>2.07</td>
</tr>
<tr>
<td>Drug users w/ no prescription</td>
<td>1.88</td>
<td>1.55</td>
<td>2.24</td>
</tr>
</tbody>
</table>

level of significance

econ/soc model = .138  
df = 125
med/biolog model = .494  
df = 106
psycholog model = .150  
df = 129

There were no statistically significant differences between problem drug users with a prescription and those without in terms of their stated need for help with problems falling into one of three models.

**SUMMARY**

This section concentrates upon what problem drug users talk about when they see drug workers and what they feel their needs are when they talk with drug workers. Problem drug users indicated
that they needed the most help with psychological problems and received the most help with those problems. On the other hand, they felt they needed more help with economic/social problems and least help with medical problems but talked to their key workers more about medical problems than economic/social problems.

Drug users were more consistent than drug workers in what models they said they preferred (psychological model) and what they said they talked about to their drug worker about when they met, i.e. psychological problems. There was even more consistency in that they felt that this was the help that they most needed.

Overall, there was good agreement between problem drug users and drug workers over what help they received (i.e. mainly psychological) but less agreement on what they need. Perhaps this suggests less consistency amongst drug workers than amongst problem drug users. Drug workers indicated that they believe more in a social/economic model than in the other two models yet feel that this is where their clients require the least help.

Problem drug users believe more strongly in a psychological model than the other two models and also say that they need most help with psychological problems. Drug users with no prescription felt they needed more help with psychological problems than those receiving a prescription. The difference was statistically significant and expected. Those with no prescription would require more help with psychological problems as a result of being drug free, or at least attempting to become drug free. These findings will be considered more thoroughly in the conclusion.
THE SEMI-STRUCTURED INTERVIEWS

The results of the semi-structured interview confirmed the results of the quantitative questionnaire. Below are the first 4 questions which are relevant to beliefs.

1/ Why do you think problem drug users use drugs in a way which causes themselves and others problems?

The answers to this question were varied but it was possible to find at least one theme which ran through them all. This theme (stated one way or another by 4 of the 6 respondents) was that drugs made you feel good and later, when problems arose from drug use or other sources, it offered a means of escape. They also felt that it had something to do with childhood experience. These answers would fit well with the psychological theory of problem drug use.

One woman and one man, thought that childhood experience was a key issue in the origins of their own and other peoples problem drug use.

"First of all, I think, in my case, it was problems that I couldn't face up to so I used drugs which initially I didn't realise would give me more problems."

Two respondents felt it had something to do with not having a job and being bored. One drug user felt that in his own case there was a direct cause and effect,

"When I was working, I wasn't interested in drugs. As soon as I came out of work I went really heavy into Heroin. I got another job and got off the Heroin. Then I lost the job and was back on the Heroin because I was bored."

These two answers fit well with the social/economic theory.
None of the respondents were sure about the reasons and most realised that it could have different origins in different people. While they seemed happy to discuss the origins, none of them seemed to feel the need to come to some sort of decision about the origins of their own problem drug use.

"I was in personal problems myself. Things happen in people’s lives that they can’t handle, their parents as well. My friends take it for a load of different reasons. I take it because I’ve been abused and I’ve been raped and I’ve lost one of my children - a load of things rolled into one, really, that I’ve never sorted out."

2/ Are problem drug users different from people who do not use drugs problematically? If so, how?

Perhaps this question was not stated clearly because 3 of the 6 respondents explained how being a problem drug user made them different because of their "need" to obtain drugs. This is somewhat different from the intention of the question which is about if problem drug users were different from others before they began using drugs problematically. Therefore, the question had to be rephrased in several of the interviews.

Most problem drug users who were interviewed felt that in many ways, problem drug users were similar to those who did not use drugs. One user said,

"I would say they are not different, meself." , another said,

"I don’t think that they’ve got more problems." .

Another problem drug user held the polar opposite view,

"A person who has used drugs may have had one particular
problem to deal with and has used drugs to block that problem out because they can't cope with dealing with it."
This was confirmed by yet another user.

"The people that use drugs just can't seem to sit down and work things out. They escape by using the drugs".

One drug user suggested that it was the drugs which changed him for the worse, not that he was using drugs because he had a particular personality or more problems. He said,

"Drugs make you what you are. Before I took drugs I was nothing like I am now."

Despite the above, all of those interviewed declared that in other ways problem drug users are different. One user said,

"I think it just might be something in the personality where they are weaker or they just don't have the capacity to deal with certain problems."

None of those interviewed suggested that differences were biological or genetic. Another objected to the idea that problem drug users are simply responding to their social situation,

"It is easy blaming society and the classic of 'I hate the world' sort of thing. I think it's on the individual..."

Later on he said that maybe he was a "potential user" from the start but did not elaborate further.

Those from therapeutic communities were more likely to feel that their drug use stemmed from the inability to cope with the normal stresses and strains of everyday life. Whether they absorbed this particular line of reasoning from the therapeutic programme or they felt this way before they entered the programme and this is why they chose to attend the programme is difficult to say. In
the same way, a problem drug user from a street agency felt that drug use was not necessarily harmful or wrong.

3/ What prevents problem drug users from changing their drug using habits? From becoming abstinent?

Here the differences between those in a therapeutic community and those from community agencies are not so marked. Nearly all of the problem drug users felt that the key problems are in changing their lifestyle and coping with problems without the help of drugs. One user said,

"I feel it’s fear of the unknown. The fear of emotions and feelings coming back for them and they find the problems they been running from and I think they realise that if they are drug free they will have to deal with these problems."

Another respondent from a therapeutic community said,

"I think it’s people are scared of change. Not knowing what they will get into if they do change."

Stated in this way, it is not surprising that both of these problem drug users were drug free in a therapeutic community. Another user who was receiving a prescription for controlled drugs had a similar answer.

"It’s the things you’ve got to handle. You can’t block things out - everything comes back. It’s the feelings that are there - you’ve got to learn how to control them."

Yet another respondent from an advice centre felt it was because they would miss the pleasure of drug use and would miss the identity of being a drug user without having an alternative.

"I think they enjoy it. When that stops, they’ve got nothing to do and they think what am I going to do cos I’m
used to going out and shoplifting and burglarizing........

While most of those who were interviewed were dissatisfied with their current lifestyles, it was the fear of change and the unknown which was uppermost in their minds and the greatest barrier to change. When physical withdrawals were mentioned they turned out to be less of a problem than originally thought. One drug user suggested it was a barrier at the time but in retrospect looks at it differently.

"Initially, I would say the withdrawals because they can be very difficult to go through." later he went on to say, "...when you look back on it, once you’ve had the withdrawal, it hasn’t been as bad."

Another problem drug user from an advice centre said,

"Withdrawals are nothing to your emotions that come back."

In summary, physical withdrawals, while a barrier at the time are less of a problem than learning to live drug free and having to face problems without the help of chemical assistance.

4/ What are the best ways for agencies to help problem drug users reduce the harm from their drug use? Become abstinent?

In answering this question, there was a clear division amongst the problem drug users who were interviewed. One group said that agencies should simply ask their clients what they want and then try to provide it.

"It’s just by giving them what they want really."

Another said,

"I think the best way for agencies to help people with drug problems is just to be there to listen and to provide the help that addict requires."
Like the respondent above, another problem drug users felt that counselling was the best way for agencies to help,

"I can come down here and talk about all my problems. I feel better when I leave because a lot of them are psychiatrists and those things. They help me talk."

The provision of prescriptions for controlled drugs was another key element for several of those who were interviewed.

"They’ve been compassionate towards me. They got me the Methadone and I’m detoxing myself on the Methadone."

Another said,

"If an addict requires a Methadone script and the agency has the authority to prescribe then that is what they should do."

The provision of Methadone or other substitute drugs was not universally accepted as a good way to help problem drug users.

".... they do have, like, the maintenance prescriptions but I don’t feel that’s solving anything. I just feel it’s making another black market for prescribed drugs whereas addicts will be meeting and swopping drugs, etc."

SUMMARY - WHAT ARE THE VARIABLES IN DETERMINING PROBLEM DRUG USERS BELIEFS IN THE ORIGIN AND PREFERRED TREATMENT OF PROBLEM DRUG USE?

Using the three models of the origins and preferred treatment of problem drug use, it is clear that problem drug users hold consistent beliefs but not quite as consistent compared to drug workers.
TABLE 112
CORRELATIONS AND LEVELS OF SIGNIFICANCE BETWEEN
THE ORIGINS AND PREFERRED TREATMENT SECTIONS OF
THE THREE MODELS OF PROBLEM DRUG USE

<table>
<thead>
<tr>
<th>MODEL</th>
<th>Mean Origin Score</th>
<th>Mean Treatment Score</th>
<th>Combined Score</th>
<th>Correlation of Level Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECON./SOCIAL MODEL</td>
<td>3.19</td>
<td>2.74</td>
<td>2.97</td>
<td>.295</td>
</tr>
<tr>
<td>MED./BIOLOG. MODEL</td>
<td>3.23</td>
<td>2.75</td>
<td>2.99</td>
<td>.194</td>
</tr>
<tr>
<td>PSYCHOLOG. MODEL</td>
<td>3.19</td>
<td>2.25</td>
<td>2.72</td>
<td>.287</td>
</tr>
</tbody>
</table>

The psychological model was the clear preference amongst problem drug users.

Unlike the drug workers, education was not a significant factor in the beliefs of problem drug users about the origins or preferred treatment.

There was no statistical difference in the beliefs of problem drug users from the two regions, North West Region and Merseyside Region, except in the Social/Economic Model, where those from the North West Region more strongly agreed with the treatment section of this theory than those from Merseyside (at a level of .0046 using a 2-tailed Mann-Whitney U test).

The semi-structured interviews and the quantitative questionnaires were consistent in giving preference to a psychological model for problem drug users. In the semi-structured interviews this was expressed in two ways, seeking the euphoria from drug use and escaping the negative feelings from problems, some of which are caused by problem drug use but others which are simply a part of life. Most problem drug users
interviewed for the semi-structured questionnaire also felt that they were different from those who did not use drugs problematically. As a group, they were split however in the beliefs as to the source of those problems, i.e. whether the problems were there before they started to use drugs problematically or only arose after and as a result of their drug use. Psychological issues, feelings, and emotions were given more weight than social/economic issues or inherent biological/medical issues when considering the barriers to changing to a drug free life. Women were more likely to believe in a medical/biological model than men and this difference was statistically significant. Age and race, however, were not factors in the belief of problem drug users in any of the three models. Drug preference did not seem to make any difference in beliefs in models. However, those who were in receipt of a prescription for drugs have a stronger belief in the origins section of a social economic model than those without a prescription. Those with a prescription had a stronger belief in the treatment section of a medical/biological model (prescribing could be seen as a legitimate treatment within this model) but the differences were not statistically significant. Education did not seem to be an important variable in determining beliefs but this could be because, for the most part, educational achievement was quite uniform.

There were differences according to which agency the problem drug user attended. Those from residential establishments had less belief in a social/economic model than those from other agencies but these differences did not hold when submitted to another
statistical test (i.e. the Scheffe). This could reflect the treatment which emphasises personal responsibility. Those from Community Drug Teams had a stronger belief in a social/economic model than those from the other agencies.

**THE DIFFERENCE IN BELIEF BETWEEN PROBLEM DRUG USERS AND DRUG WORKERS**

The first and most obvious difference between problem drug users and drug workers is simply in the preference of models. Problem drug users preferred a psychological model while drug workers preferred a social/economic model. Perhaps this difference is not so important in that both drug workers and problem drug users preferred the treatment section of the psychological model over the other options.

Age did not seem to be a factor in determining the beliefs of problem drug users but did for drug workers. This could simply reflect the difference in the range of ages between the two groups. For drug workers, their age range was between was between 22 - 64. The age range for problem drug users was much smaller, between 18 - 44. Older drug workers were more likely to believe in a medical/biological model compared to their younger colleagues.

A major variable for drug workers was education. Professional training correlated positively with the beliefs of professional groups for the appropriate models, i.e. doctors were more likely to believe in a medical/biological model than their colleagues, social workers were more likely to believe in an economic/social model. The correlations, however, did not always reach statistical significance. The largest group, nurses, did not have
a preference for medical/biological model but did prefer the treatment section of the psychological model, making their beliefs the closest to problem drug users. The more education the drug workers completed, the more likely they were to believe in the economic/social model. This was not the case for problem drug users. Their beliefs were much more uniform regardless of educational achievement. This could also be an artifact of a much smaller range in educational attainment. For problem drug users, the average number of "0" level or GCSE examinations was 2.2. Almost 1/2 had no "0" level or GCSE results and only 17% had 5 or more. A total of 8% had at least one "A" level. For drug workers, there was a much greater range and hence more opportunity for differences to become apparent.

Drug workers with a previous problem of alcohol or drug use were similar in their beliefs (except that they had even less belief in the origin section of the medical/biological model) compared to their colleagues. Their beliefs were not similar to problem drug users.

There was a correlation for both drug user and drug worker between their belief in a model of problem drug use and the agency from where they came. For both, the agency with the most influence were the residential rehabilitation agencies. This is not surprising as these are drug free and require a great deal of commitment from both residents and staff. Staff were required to work unsocial hours and had a particularly intimate relationship with their clients in that they lived together for an extended period, i.e up to 18 months. The residents required a much greater commitment than those who attend other agencies.
They were required to be drug-free (not a requirement of treatment for the other agencies) and lived in a hostel where they may have been sharing a room and facilities with others. Their movements, communications and associations were all restricted. The main form of therapy was group work which was often confrontative in nature and again required great commitment. With all of this in mind it is not surprising that both residents and staff had a greater commitment to the psychological model than do other drug users or workers.

Both drug workers and problem drug users who came from Community Drug Teams both had a higher commitment to the social/economic model than those from other agencies.

The implications of the differences and similarities in belief between drug workers and problem drug users will be considered in the conclusion.

DRUG WORKERS AND DRUG USERS RELATIONSHIP TO THE AGENCY AND TO GOVERNMENT POLICY - QUESTIONS 19-28

Questions 19 - 28 were directed at the fifth aim of this research, in particular, sub aims 5/ b and 5/d. That aim was:

"5/ To determine the influence of national, regional, district and agency policy on those beliefs.

a/ What are the current national, regional, district and agency policies within the geographical area where the research is conducted?

b/ Do problem drug users and drug workers understand and agree with their agencies policies, regional, and national policies?

c/ What are the goals of drug workers in drug agencies? How
do these goals relate to the work of the agency?

d/ Do the goals of problem drug users and drug workers coincide? Do problem drug users feel satisfied with the service they receive and identify with the goals of the agency they attend."

Drug workers and drug users were asked the same questions. Broadly the questions rated:

1/ the relationship of the drug user and the drug worker to the agency
2/ agreement with local, agency and national policy
3/ the relationship of the agency to national policy

**Drug Workers**

The analysis of the questionnaires completed by drug workers considered the variables which may be significant in answering the questions. For drug workers these were:

1/ gender
2/ age
3/ agency
4/ professional qualification
5/ educational attainment
6/ length of time working at agency
7/ length of time with problem drug users

The statistical tests which were used for these variables are stated below.

Mann-Whitney U test -

Gender

Spearman Correlation Coefficients -

length of time working w/ problem drug users
length of time working at agency
"O" Level, GCSE attainment
Age
One Way ANOVA (Scheffe test for significance) -
Professional Qualification
Agency
The Mann-Whitney test was used for the first group because they are nominal scales with only two variables in each, while the scale used in the 10 questions are ordinal. In the second group, Spearman Correlation Coefficients, the group is ordinal. In the third group, One-Way ANOVA, the data is again ordinal but each has more than two variables. The Scheffe test was then used to determine statistical significance between the scores of the groups. Psychologists and Occupational Therapists were not considered because the numbers in each of these professions was too small (4 psychologists and 2 occupational therapists) to submit to statistical analysis. In the case of probation officers, they were added to the category "social workers" because they both require the same professional qualification, i.e. CQSW or Dip. S.W.
Similar to the other questions in the survey, a Likert scale was used which ranged between 1 - Strongly Agree, 2 - Agree, 3 - Neutral, 4 - Disagree, 5 - Strongly Disagree.
PROBLEM DRUG USERS
As in the previous section, the variables which may have related to the answers provided by problem drug users will be examined when responding to these statements. These variables will include:
Drug user were divided into those who are received a prescription and those who did not. Educational attainment divided problem drug users into those who had no "0" level or GCSE examination results and those who had 1 or more.

The following tests were applied to the above variables.

Mann-Whitney U test -
- Gender
  - Receiving a prescription or not
  - Attainment of "0" level or GCSE or not

Spearman Correlation Coefficients -
- Age

One-Way ANOVA -
- Agency
PROBLEM DRUG USERS

-----

TABLE 113

QUESTION 19 - My goals are the same as the agency I come to for help.

The mean response to this statement was 2.44.

VARIABLES

<table>
<thead>
<tr>
<th>Age</th>
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<th>level of significance = .736</th>
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<table>
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<th>Gender</th>
<th>Women mean response</th>
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<th>Men mean response</th>
<th>2.59</th>
<th>Mann-Whitney U value 1393</th>
<th>Level of sig.014</th>
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<table>
<thead>
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<table>
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<th>Prescription</th>
<th>2.33</th>
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<th>Level of sig.260</th>
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</thead>
</table>

<table>
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<th>2.33</th>
<th>Residential Rehab</th>
<th>2.85</th>
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<tbody>
<tr>
<td></td>
<td>Drug Dependency Unit</td>
<td>1.90</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

No statistical difference at a 0.05 level

Overall, most drug users agreed with this statement. Women were more likely to agree with this statement than men and the difference was statistically significant. There was little difference between drug users who received a prescription and those who do not, and also little difference between drug users who had acquired "0" level or GCSE results and those who had not. Those from drug dependency units were in stronger agreement with this statement than those from other agencies, but the differences between agencies did not reach statistical significance.
TABLE 114

Question 20 - The government and authorities are more interested in controlling problem drug users than in helping them.

The mean response to this statement was 2.05.

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Women mean response</th>
<th>Men mean response</th>
<th>Mann-Whitney U value</th>
<th>Level of sig</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>2.03</td>
<td>2.05</td>
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<tr>
<td>Women</td>
<td>2.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>2.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mann-Whitney U</td>
<td>1821</td>
<td></td>
<td></td>
<td>765</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No &quot;0&quot; level exams</td>
<td>2.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or more exams</td>
<td>2.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mann-Whitney U</td>
<td>2024</td>
<td></td>
<td></td>
<td>860</td>
</tr>
<tr>
<td>Prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Prescription</td>
<td>1.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription</td>
<td>2.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mann-Whitney U</td>
<td>2351</td>
<td></td>
<td></td>
<td>312</td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comm. Drug Team</td>
<td>2.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice Centre</td>
<td>2.22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Rehab</td>
<td>1.82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Dependency Unit</td>
<td>2.34</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most drug users agreed with this statement. There was little correlation with age and no statistically significant relationship to education, being in receipt of a prescription or being treated by a particular agency.
TABLE 115

Question 21 - I feel that I have an influence over how this agency uses resources and develops policy.

The mean response to this statement was 3.71.

VARIABLES

<table>
<thead>
<tr>
<th>Age</th>
<th>Correlation of .033</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>level of significance = .693</td>
</tr>
</tbody>
</table>

| Gender | Women mean response | 3.24 |
|        | Men mean response   | 3.78 |
|        | Mann-Whitney U value | 1497 |
|        | Level of sig. 0.068 |

| Education | No "0" level exams | 3.85 |
|           | One or more exams  | 3.41 |
|           | Mann-Whitney U value | 1786 |
|           | Level of sig. 0.186 |

| Prescription | No Prescription | 3.61 |
|              | Prescription    | 3.72 |
|              | Mann-Whitney U value | 2404 |
|              | Level of sig. 0.453 |

| Agency       | Comm. Drug Team | 3.72 |
|             | Advice Centre   | 3.28 |
|             | Residential Rehab | 3.47 |
|             | Drug Dependency Unit | 4.07 |
|             | No statistical difference at a 0.05 level |

Most drug users disagreed with this statement. The level of disagreement was significant and may have reflected a sense of alienation from the agency.

Men disagreed more strongly than women but the difference was not statistically significant. Those from Drug Dependency Units disagreed the most with this statement, but the differences with those from other agencies were not statistically significant. This could have reflected dissatisfaction with the content of the treatment but may not have had anything to do with receiving a prescription or not.
Table 116

Question 22 - Most problem drug users see this agency as too controlling.

The mean response to this statement was 3.69.

VARIABLES

Age Correlation of -.137
level of significance = .097

Gender
Women mean response 4.10
Men mean response 3.60
Mann-Whitney U value 1560 Level of sig.127

Education
No "O" level exams 3.69
One or more exams 3.90
Mann-Whitney U value 1864 Level of sig.343

Prescription
No Prescription 3.81
Prescription 3.63
Mann-Whitney U value 2360 Level of sig.352

Agency
Comm. Drug Team 3.54
Advice Centre 4.17
Residential Rehab 3.80
Drug Dependency Unit 3.66
No statistical difference at a 0.05 level

The mean response to this statement suggested a mild disagreement with the suggestion that most problem drug users find the agency too controlling. Women were more likely to disagree with this statement than men but the difference was not statistically significant. There were no statistical differences according to "O" level or GCSE attainment or receiving a prescription.
TABLE 117
Question 23 - There are no major differences in the aims and objectives of this agency and those of the Department of Health and the Home Office.

The mean response to this statement was 4.27.

VARIABLES

Age  Correlation of -.019
level of significance = .823

Gender  Women mean response  4.45
         Men mean response  4.23
         Mann-Whitney U value 1662 Level of sig 297

Education No "0" level exams  4.25
           One or more exams  4.38
         Mann-Whitney U value 1954 Level of sig 609

Prescription No Prescription  4.46
                      Prescription  4.16
         Mann-Whitney U value 2296 Level of sig 236

Agency  Comm. Drug Team  4.04
         Advice Centre  4.67
         Residential Rehab  4.32
         Drug Dependency Unit  4.52
         No statistical difference at a 0.05 level

Drug users believed the agency was in opposition to government policy on drugs. The level of disagreement was significant (keeping in mind this was a negative statement). Women were more likely to be in disagreement than are men but the difference was not significant. There were no statistical differences according to "0" level or GCSE attainment or receiving a prescription. Those from Advice Centres were the most likely to disagree but their responses were not statistically different from other groups. Perhaps drug users had not appreciated the level of
control practised by the state over these agencies or they may take the anti-drug advertising (as opposed to the harm reduction model practised by most agencies) on the media as sign of state policy. Also, many drug users may not have known what the policies of the state were and may have taken their view from drug workers.

-----

**TABLE 118**

**Question 24 - Harm reduction is an important part of this agency's work.**

The mean response to this statement was 2.67.

**VARIABLES**

- **Age**  
  Correlation of -.083  
  level of significance = .320

- **Gender**  
  Women mean response 2.09  
  Men mean response 2.84  
  Mann-Whitney U value 1443 Level of sig.033

- **Education**  
  No "0" level exams 2.77  
  One or more exams 2.63  
  Mann-Whitney U value 1969 Level of sig.654

- **Prescription**  
  No Prescription 2.78  
  Prescription 2.60  
  Mann-Whitney U value 2229 Level of sig.137

- **Agency**  
  Comm. Drug Team 2.45  
  Advice Centre 2.06  
  Residential Rehab 3.18  
  Drug Dependency Unit 2.97  
  No statistical difference at a 0.05 level

There was mild agreement with this statement. Women were much more in agreement with this statement than were men. There were no statistical differences according to "0" level or GCSE attainment or receiving a prescription. Those from Advice Centres were the most likely to agree but there were no statistical differences.
differences between those from any two agencies. There were statistically significant differences between the responses of drug users from the 4 agencies. The more neutral stance from those from residential rehabilitation projects was predictable because they were all abstinence based and did not advocate safer drug use, they advocate no drug use.

Table 119

Question 25 - *I see this agency as too controlling.*

The mean response to this statement was 3.95.

**Variables**

- **Age**
  - Correlation of -0.095
  - Level of significance = .252

- **Gender**
  - Women mean response 4.03
  - Men mean response 3.94
  - Mann-Whitney U value 1744 Level of sig.507

- **Education**
  - No "0" level exams 3.79
  - One or more exams 4.34
  - Mann-Whitney U value 1654 Level of sig.046

- **Prescription**
  - No Prescription 4.17
  - Prescription 3.82
  - Mann-Whitney U value 2224 Level of sig.134

- **Agency**
  - Comm. Drug Team 3.67
  - Advice Centre 4.50
  - Residential Rehab 4.44
  - Drug Dependency Unit 3.69
  - No statistical difference at a 0.05 level

There was consistent disagreement with this statement. There was no correlation with age and gender had not influenced the results significantly. Those with more education more strongly disagreed than those with less and this difference was statistically significant. Those from advice centres and residential
rehabilitation programmes disagreed the most, but the differences were not statistically significant. This is not surprising for advice centres, because they make the least demand on their clients (i.e. they do not prescribe controlled drugs and attendance is always voluntary). It was a surprising result for residential rehabilitation programmes because they made many demands on their residents, i.e., being drug free, restrictions on associating with people outside of the programme, limited access to telephones.

-----

**TABLE 120**

**Question 26 - Harm reduction is an important part of what I hope to achieve.**

The mean response to this statement was 2.55.

**VARIABLES**

<table>
<thead>
<tr>
<th>Age</th>
<th>Correlation of -.140</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>level of significance = .090</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Women mean response 2.42</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men mean response 2.60</td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 1847 Level of sig.866</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>No &quot;0&quot; level exams 2.80</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One or more exams 2.33</td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 1730 Level of sig.097</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription</th>
<th>No Prescription 2.85</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prescription 2.39</td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 2088 Level of sig.036</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency</th>
<th>Comm. Drug Team 2.38</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advice Centre 2.39</td>
</tr>
<tr>
<td></td>
<td>Residential Rehab 3.11</td>
</tr>
<tr>
<td></td>
<td>Drug Dependency Unit 2.41</td>
</tr>
<tr>
<td></td>
<td>No statistical difference at a 0.05 level</td>
</tr>
</tbody>
</table>

There was mild agreement with this statement but the mean drifts
towards a neutral answer. There was little difference between men and women and those with "0" level of GCSE results agreed more strongly than those with none, though the difference had not reach statistical significance. Those in receipt of a prescription had agreed significantly more than those without a prescription and those from residential rehabilitation programmes were much less likely to agree, again this is probably because the ethos of the programmes was abstinence.

TABLE 121

Question 27 - Government policy often pays lip service to harm reduction but in reality fails to carry it through.

The mean response to this statement was 2.50

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Response</th>
<th>Mann-Whitney U Value</th>
<th>Level of Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Correlation of -0.205</td>
<td>Level of significance = 0.013</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Women: 2.85, Men: 2.83</td>
<td>1866</td>
<td>0.942</td>
</tr>
<tr>
<td>Education</td>
<td>No &quot;0&quot; exams: 2.94, One or more exams: 2.71</td>
<td>1942</td>
<td>0.560</td>
</tr>
<tr>
<td>Prescription</td>
<td>No Prescription: 2.94, Prescription: 2.73</td>
<td>2446</td>
<td>0.547</td>
</tr>
<tr>
<td>Agency</td>
<td>Comm. Drug Team: 2.88, Advice Centre: 2.67, Residential Rehab: 3.18, Drug Dependency Unit: 2.28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Again, there was mild agreement with this statement but the score was half way between agreement and neutrality. Age was negatively
correlated. The older the drug user, the more they agreed. This reached statistical significance. Gender, educational level and whether they had a prescription or not were not significant variables towards responding to this statement. Those from residential rehabilitation programmes were more neutral and edged towards disagreeing, but no statistically significant differences were found between any two groups.

---

**TABLE 122**

*Question 28 - The objectives of my key worker are often quite different from my own.*

The mean response to this statement was 3.81.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>Description</th>
<th>Response</th>
<th>Mann-Whitney U Value</th>
<th>Level of sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Correlation of -.073</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>level of significance = .382</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Women mean response</td>
<td>3.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Men mean response</td>
<td>3.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 1856</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>No &quot;0&quot; level exams</td>
<td>3.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One or more exams</td>
<td>3.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 1876</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td>No Prescription</td>
<td>3.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prescription</td>
<td>3.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value 2482</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td>Comm. Drug Team</td>
<td>3.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advice Centre</td>
<td>4.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Rehab</td>
<td>3.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug Dependency Unit</td>
<td>3.52</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was disagreement with this statement, indicating that most drug users feel that their key workers had the same objectives as they do. None of the differences in variables (i.e. age, gender, education, receipt of a prescription or agency) came near
statistical significance. Those drug users from advice centres indicated that they had the strongest agreement with their key workers over goals, but differences between groups were not statistically significant.

-----

**TABLE 123**

Question 29 - The distribution of key workers among problem drug users is as follows:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td>25</td>
<td>17%*</td>
</tr>
<tr>
<td>Doctor</td>
<td>16</td>
<td>11%</td>
</tr>
<tr>
<td>Nurse</td>
<td>29</td>
<td>19%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>22</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>33%</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Rounded off to the nearest percent.

-----

The large number of the "other" category suggests that non-professionally qualified drugs workers were by far the largest group of key workers.

**SUMMARY**

Broadly speaking, drug users indicated a good relationship with the agencies where they went for help. Women demonstrated a somewhat better relationship with the agencies than men. They felt that they had more influence over the agencies than men, identified their own goals as closer to those of the agency and perceived the agencies as being less controlling. This was an interesting finding as drug services were sometimes accused of being male dominated. This will be explored further in the
All drug users expressed cynicism towards government policy by agreeing that government pays lip service to harm reduction and that government and authorities were more interested in controlling them then helping them.

Education was not an important variable when responding to these statements. Those with "0" level or GCSE results were more likely to disagree with the statement that this agency is too controlling compared to those with no results. This was the only statement where the differences between the two groups reach statistical significance. Being in receipt of a prescription was not an important variable either. In none of the 10 statements were those in receipt of a prescription responding in a statistically significant way.

There were not large differences in the responses of drug users when considering the agency which they attended as a variable. There were no statistically significant differences between the responses from any two agencies within any of the questions. Those from residential programmes disagreed most with the statement that the agency is too controlling. Harm reduction was seen as less important to residential agencies as they promoted abstinence while the other agencies promoted harm reduction as their first priority.
TABLE 124

QUESTION 19 - My goals are the same as the agency I work for.

The mean response to this statement was 2.50.

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation of</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.062</td>
<td>.279</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>2.54</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>2.47</td>
<td>Mann-Whitney U value 12277 Level of sig.935</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5 &quot;0&quot; levels</td>
<td>2.63</td>
<td>Mann-Whitney U value 11335 Level of sig.519</td>
</tr>
<tr>
<td>6 + &quot;0&quot; levels</td>
<td>2.32</td>
<td></td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Profession</td>
<td>2.55</td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>2.36</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>2.47</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>2.58</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comm. Drug Team</td>
<td>2.40</td>
<td></td>
</tr>
<tr>
<td>Advice Centre</td>
<td>2.51</td>
<td></td>
</tr>
<tr>
<td>Residential Rehab</td>
<td>2.24</td>
<td></td>
</tr>
<tr>
<td>Drug Dependency Unit</td>
<td>2.80</td>
<td></td>
</tr>
<tr>
<td>How long at agency</td>
<td>Correl.</td>
<td>-.065</td>
</tr>
<tr>
<td>Level of significance</td>
<td>.249</td>
<td></td>
</tr>
<tr>
<td>How long w/ dr. users</td>
<td>Correl.</td>
<td>-.153</td>
</tr>
<tr>
<td>Level of significance</td>
<td>.007</td>
<td></td>
</tr>
</tbody>
</table>

None of the above variables were related to the responses for question 19, except for how long the drug worker has been working with problem drug users. For this variable, the correlation was negative. That means that the longer the drug worker had been working with problem drug users, the stronger the agreement with
the statement that their goals were the same as the agency they worked for. Overall, drug workers mean score fell between agreement and neutrality in responding to this statement.

-----

TABLE 125

Question 20 - The government and authorities are more interested in controlling problem drug users than in helping them.

The mean response to this statement was 2.21.

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Response</th>
<th>Gender</th>
<th>Mann-Whitney U value</th>
<th>Level of sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Correlation of</td>
<td>0.107</td>
<td>Women mean response</td>
<td>2.30</td>
<td>11858</td>
</tr>
<tr>
<td>level of significance =</td>
<td>0.060</td>
<td>Men mean response</td>
<td>2.12</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Men mean response</td>
<td>2.12</td>
<td>Mann-Whitney U value</td>
<td>11858</td>
</tr>
<tr>
<td>Education</td>
<td>0 - 5 &quot;0&quot; levels</td>
<td>2.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 + &quot;0&quot; levels</td>
<td>2.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profession</td>
<td>No Profession</td>
<td>2.16</td>
<td>Mann-Whitney U value</td>
<td>11447</td>
</tr>
<tr>
<td></td>
<td>Doctor</td>
<td>2.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>2.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>2.08</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were statistically significant differences between doctors and nurses.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean Response</th>
<th>Agency</th>
<th>Mann-Whitney U value</th>
<th>Level of sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comm. Drug Team</td>
<td>2.20</td>
<td>Advice Centre</td>
<td>2.07</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Rehab</td>
<td>2.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug Dependency Unit</td>
<td>2.38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were no statistically significant differences.

<table>
<thead>
<tr>
<th>Correlation</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long at agency</td>
<td>0.129</td>
</tr>
<tr>
<td>Level of significance</td>
<td>0.021</td>
</tr>
<tr>
<td>How long w/ dr. users</td>
<td>-0.052</td>
</tr>
<tr>
<td>Level of significance</td>
<td>0.360</td>
</tr>
</tbody>
</table>

There was a positive correlation between age and disagreement with the above statement, not quite reaching statistical significance. This could have reflected a growing conservatism with age. Doctors were the least likely to agree with this
statement and this could have represented a more conservative profession than the other two. The differences between doctors and nurses reached statistical significance at a 0.05 level. The remainder of the variables were not related to the responses to this statement, except for how long the worker had been working at the agency. Similar to age, the longer they had been working at the agency, the more they disagreed with the statement. This was probably not a function of age because there was a slight negative correlation with how long they had been working with problem drug users. The response from drug workers as a group suggested agreement with the above statement. Drug workers, as a group, seemed cynical about the motives of governmental policy. This cynicism cuts across profession, agency, gender, etc. and may have represented a widespread ethos within the field.
TABLE 126

Question 21 - I feel that I have an influence over how this agency uses resources and develops policy.

The mean response to this statement was 2.61.

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation of</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
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<table>
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<table>
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<th>6 + &quot;0&quot; levels 2.34</th>
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<th>2.65</th>
<th>2.45</th>
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<tbody>
<tr>
<td></td>
<td>No Profession</td>
<td>Doctor</td>
<td>Nurse</td>
<td>Social Worker</td>
</tr>
</tbody>
</table>

There were no statistically significant differences

<table>
<thead>
<tr>
<th>Agency</th>
<th>2.39</th>
<th>2.64</th>
<th>2.62</th>
<th>2.96</th>
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<tbody>
<tr>
<td></td>
<td>Comm. Drug Team</td>
<td>Advice Centre</td>
<td>Residential Rehab</td>
<td>Drug Dependency Unit</td>
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</table>

There were statistically significant differences between DDUs and CDTS

<table>
<thead>
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<th>Correlation</th>
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<td>Level of significance</td>
<td>How long w/ dr. users</td>
</tr>
<tr>
<td></td>
<td>.000</td>
<td>.000</td>
</tr>
</tbody>
</table>

There was a slight negative correlation between age and agreement with this statement (i.e the older you were the more you agreed with the statement) but the difference was not significant. Men were more likely to feel that they have an influence over the agency than women and this could have reflected the greater
proportion of men managers and senior staff members such as doctors. Drug workers with more "O" level or GCSE results agreed with the statement more than those with fewer "O" level results or GCSEs and the difference between the two groups was statistically significant. This also could reflect the relative position in the agency between the more and less qualified staff. Doctors felt they had more influence than other professions but the differences were not significant. Those from CDTs were more likely to agree that they had an influence over policy compared to DDUs and this could have reflected the size of the agencies, i.e. CDTs are much smaller agencies compared to DDUs.

There was a negative correlation between how long the drug worker had been with the agency and the score, indicating a stronger agreement. The same was true when considering how long the drug worker had been working with problem drug users, i.e. the longer they had worked with problem drug users, the more influence they felt that they had within the agency. Both correlations were highly significant.
TABLE 127

Question 22 - Most problem drug users see this agency as too controlling.

The mean response to this statement was 3.55.

**VARIABLES**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation of</th>
<th>Level of significance</th>
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<tr>
<td>There were no statistically significant differences</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Agency**        |                |                       |
| Comm. Drug Team   | 3.47           |                       |
| Advice Centre     | 4.09           |                       |
| Residential Rehab | 3.68           |                       |
| Drug Dependency Unit | 3.14         |                       |
| There were statistically significant differences between responses from advice centres compared to those from CDTs and DDUs |

<table>
<thead>
<tr>
<th><strong>How long at agency</strong></th>
<th>Correlation</th>
<th>Level of significance</th>
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</thead>
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<table>
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<th>Level of significance</th>
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<tbody>
<tr>
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<td>.615</td>
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</table>

Age was not a factor in responding to this statement, nor was the number of "0" level or GCSE results. Gender, however, was a factor and the difference between men and women was statistically significant, with women disagreeing more strongly than men.
Doctors and those with no professional qualification disagreed with the statement more than social workers and nurses. Workers from advice centres disagreed more than those from other agencies, especially CDTs and DDUs where the differences were statistically significant, possibly reflecting the less demanding aspect of the agency compared to other agencies. There was no apparent relationship between the response to this statement and the length of time the worker has been with the agency or how long they have worked with problem drug users.
TABLE 128

Question 23 - There are no major differences in the aims and objectives of this agency and those of the Department of Health and the Home Office.

The mean response to this statement was 3.68.

VARIABLES

<table>
<thead>
<tr>
<th>Variable</th>
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<th>Mean Response Women</th>
<th>Mann-Whitney U Value</th>
<th>Level of Significance</th>
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<td>Social Worker</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>There were no statistically significant differences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
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<td></td>
<td></td>
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<td>There were statistically significant differences between advice centres compared to CDTs and between Residential rehabilitation agencies compared to CDTs and DDUs</td>
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There was a low negative correlation, not reaching statistical significance, between the scores on this statement and age. The older the respondent, the more they agreed with the statement. Women were more likely to disagree with this statement than men.
and the difference was statistically significant. Doctors were less likely to agree than other professions but the differences were not statistically significant. Workers at residential programmes were more strongly in disagreement with the statement than were workers from other agencies (statistically significant compared to CDTs and DDUs) and the differences were statistically significant when compared to the responses from CDTs. Again, the scores were not distributed evenly between the agencies. There was a negative correlation between how long the worker had been employed in the agency and also a negative correlation between how long they had been working with drug users. Both were statistically significant.

The range of differences in responses to this statement was larger than in the other statements. Groups divided upon professional, agency, gender, and experience variables. The divide was not educational, as there was no difference between those with up to 5 "O" level or GCSE qualifications and those with 6 or more. I have no explanation for these results.
Question 24 - Harm reduction is an important part of this agency's work.

The mean response to this statement was 1.70.

VARIABLES

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<th>Correlation of Education</th>
<th>Correlation of Profession</th>
<th>Correlation of Agency</th>
<th>Correlation of How long at agency</th>
<th>Correlation of How long w/ dr. users</th>
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<td>.804</td>
<td>.804</td>
<td>.804</td>
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<td>Women mean response</td>
<td>1.74</td>
<td>Women mean response</td>
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<td>Women mean response</td>
<td>1.74</td>
</tr>
<tr>
<td>Men mean</td>
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<td>Men mean response</td>
<td>1.65</td>
<td>Men mean response</td>
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<td>0 - 5 &quot;0&quot; levels</td>
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<td>0 - 5 &quot;0&quot; levels</td>
<td>1.71</td>
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<td>6 + &quot;0&quot; levels</td>
<td>1.58</td>
<td>6 + &quot;0&quot; levels</td>
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<td>6 + &quot;0&quot; levels</td>
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<tr>
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<td>Social Worker</td>
<td>1.71</td>
<td>Social Worker</td>
<td>1.71</td>
</tr>
</tbody>
</table>

There were no statistically significant differences.

There were statistically significant differences between the responses from residential agencies compared to CDTs and DDUs.

There were only two variables which reached statistical significance, the agency and how long the worker had been working at the agency. Residential rehabilitation programmes had far less commitment to a harm reduction programme than Community Drug Teams and Drug Dependency Units and these differences were
statistically significant. As stated previously, this was almost certainly because they had as their goal immediate abstinence and did not knowingly allow drug use. All of the other programmes accepted that to varying degrees, nearly all of their clients or patients will continue to use illicit drugs. The longer the worker had been at the agency, the more they disagree with the statement.

Overall, there was a great deal of agreement that harm reduction was an important part of the work of the agency. It was surprising that the previous statement suggested that many workers did not believe that their agencies policy was in line with those policies of the Department of Health and the Home Office. In 1991 and 1992, harm reduction was the official policy of the government towards drug treatment. This issue will be explored in the conclusion.
**TABLE 130**

Question 25 - *I see this agency as too controlling.*

The mean response to this statement was 3.81.

**VARIABLES**

<table>
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<tr>
<th>Variable</th>
<th>Correlation of</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
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<table>
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<th>3.67</th>
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<th>6 + &quot;0&quot; levels</th>
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</table>

There were statistically significant differences between those with no professional qualifications and nurses.

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<th>Agency</th>
<th>Comm. Drug Team</th>
<th>3.66</th>
<th>Advice Centre</th>
<th>4.31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Residential Rehab</td>
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<td>Drug Dependency Unit</td>
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</tr>
</tbody>
</table>

There were statistically significant differences between residential agencies and CDTs and DDUs, and also between advice centres and CDTs and DDUs.

<table>
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<tr>
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<table>
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<tbody>
<tr>
<td>Level of significance</td>
<td>.752</td>
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</table>

There was no significant association between this statement and age but there was a significant difference in relation to gender. Women were disagreed more with this statement than men and the difference was statistically significant. Education was not a
factor but there was a clear divide between those with professional qualifications and those with none, who disagreed more. The differences between those with no professional qualifications and nurses reached statistical significance at a 0.05 level. Drug workers from advice centres and residential programmes disagreed more with the statement than those workers from drug dependency units and community drug teams and the differences were statistically significant. There was a good deal of agreement amongst drug workers in their response. The only differences were in the degree that they disagreed.
TABLE 131

Question 26 - *Harm reduction is an important part of my work.*

The mean response to this statement was 1.76.

**VARIABLES**

<table>
<thead>
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<th>Variable</th>
<th>Correlation of</th>
<th>Level of significance</th>
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</thead>
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**Gender**

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Mann-Whitney U value 11709 Level of sig. 387

**Education**

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Mann-Whitney U value 11215 Level of sig. 406

**Profession**

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</tr>
<tr>
<td>Social Worker</td>
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</table>

There were statistically significant differences between those with no professional qualifications and nurses.

**Agency**

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</thead>
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<tr>
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There were statistically significant differences between residential agencies and the other three agencies.

**How long at agency**

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**How long w/ dr. users**

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</tbody>
</table>

There was a positive correlation between age and the response to this statement. In other words, the older the worker, the more they disagreed with this statement and the differences were statistically significant. Gender and education were not statistically significant variables but those with no
professional qualifications were less likely to agree with this statement and compared to nurses the differences were statistically significant. Residential rehabilitation programmes were significantly less in agreement, as expected because of their commitment towards abstinence. The longer the worker had been at the agency, the less they agreed but there was not a statistical difference when considering how long they have worked with problem drug users. Nearly all workers agreed with this statement, thus exhibiting a good deal of commitment to harm reduction.
Question 27 - Government policy often pays lip service to harm reduction but in reality fails to carry it through.

The mean response to this statement was 2.47.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Correlation of</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.041</td>
<td>.468</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Women mean response</th>
<th>2.44</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men mean response</td>
<td>2.51</td>
</tr>
<tr>
<td></td>
<td>Mann-Whitney U value</td>
<td>10773</td>
</tr>
</tbody>
</table>

| Education | 0 - 5 "0" levels | 2.43 |
|           | 6 + "0" levels  | 2.40 |
|           | Mann-Whitney U value | 11042 | Level of sig. 0.739 |

| Profession | No Profession mean response | 2.49 |
|           | Doctor mean response        | 2.92 |
|           | Nurse mean response         | 2.41 |
|           | Social Worker mean response | 2.08 |
|           | There were no statistically significant differences |

| Agency    | Comm. Drug Team mean response | 2.45 |
|          | Advice Centre mean response   | 2.31 |
|          | Residential Rehab mean response | 2.65 |
|          | Drug Dependency Unit mean response | 2.57 |
|          | There were no statistically significant differences |

There was no statistically significant correlation between response to this statement and age. Women were more likely to agree with this statement than were men and the difference was statistically significant. Doctors were less in agreement with this statement than other professionals but as a group fell just
short of neutrality. Social workers were more in agreement with this statement than other professionals. Like similar statements, most drug workers expressed a degree of cynicism towards government drug policy.

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**TABLE 133**

**Question 28 - The objectives of my team leader or manager are often quite different from my own.**

The mean response to this statement was 3.64.

**VARIABLES**

<table>
<thead>
<tr>
<th>Variable</th>
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<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.104</td>
<td>.068</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
<td>Women</td>
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<tr>
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<tr>
<td>Education</td>
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<tr>
<td>0 - 5 &quot;0&quot; levels</td>
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<tr>
<td>6 + &quot;0&quot; levels</td>
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<tr>
<td>Mann-Whitney U</td>
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<tr>
<td>Profession</td>
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<td>Mann-Whitney U</td>
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<td>Level of sig.311</td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td></td>
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<tr>
<td>Comm. Drug Team</td>
<td>3.46</td>
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<tr>
<td>Advice Centre</td>
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<tr>
<td>Residential Rehab</td>
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<tr>
<td>Drug Dependency Unit</td>
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<td></td>
</tr>
<tr>
<td>Mann-Whitney U</td>
<td>11041</td>
<td>Level of sig.311</td>
</tr>
<tr>
<td>How long at agency</td>
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<td>.950</td>
</tr>
<tr>
<td>How long w/ dr. users</td>
<td>.100</td>
<td>.077</td>
</tr>
</tbody>
</table>

Older drug workers were less likely to agree with this statement than younger drug workers but the difference did not quite reach statistical significance. This could simply reflect the
likelihood that older workers themselves are supervisors or managers and younger workers are less likely to be. Though there were differences between men and women and drug workers with more or less "0" level or GCSE results, those differences did not reach statistical significance. It is not surprising that doctors were more likely to disagree with this statement as most doctors have more autonomy than other professionals, but the differences were not statistically significant compared to other professions.

SUMMARY OF DRUG WORKERS

Overall, most drug workers seemed to understand and agreed with the goals of the agency where they were employed. The mean response to the statement, "My goals are the same as the agency I work for." was 2.50, midway between agree and neutral. Most also felt that they had some influence over that policy, mean score 2.61. There was even more agreement that harm reduction was a part of the work of the agency (1.68, between agree and strongly agree) and that harm reduction was a part of their own work (score of 1.8). Most drug workers disagreed (score of 3.61 - edging towards disagree from neutral) with the statement that the objectives of their team leaders or managers were different from their own.

The relationship to national policy was quite different. Most drug workers agreed (score of 2.21) that the government was more interested in controlling drug users than helping them and disagreed with the statement that there were no major differences between government policies and those of the agencies (score of 3.68). Finally, many felt that the government paid lip service to harm reduction (score of 2.47) while they and their agencies
had a strong commitment to harm reduction.
The variables in these beliefs were different for each of the statements. There were statistically significant correlations between the responses to 4 statements and how long the worker had been working at the agency. Clearly, the agency where the worker was from was an important variable in their responses.
There was also a divide when considering professions. The responses in 5 of the 10 statements were not evenly distributed amongst the 3 main professions (doctor, nurse, social worker), with a 4th category of no profession. Age, "0" level and GCSE results, how long the worker had been working with problem drug users produced few differences as a variables. In many ways, professional allegiance was an important variable. Doctors tended to be more sympathetic to the policies of government and social workers less. Despite the differences, most doctors were sceptical of government policy, simply less so than other professions.

SEMI STRUCTURED INTERVIEWS
A total of 12 semi-structured interviews (6 problem drug users and 6 drugs workers) were carried out in the course of the study. The same questions were asked of the problem drug users and the drug workers. Each was tape recorded and later transcribed. The participants came from a total of 11 different agencies (one agencies provided two interviews). The drug workers included doctors, social workers, nurses and drug counsellors. There were 3 women and 3 men drug workers who took part in the interviews and 4 men and two women who took part in the problem drug user interviews. The purpose of the semi-structured interviews was to
give another dimension to views about the origins and best
treatment for problem drug use. The questions were structured in
a way so as not to be repetitive of the questionnaire but to
allow the respondents the opportunity to express their views in
response to open ended questions.

The following questions were asked of the drug workers.

1/ Why do you think problem drug users use drugs in a way
which causes themselves and others problems?
2/ Are problem drug users different from people who do not
use drugs problematically? If so, how?
3/ What prevents problem drug users from changing their
drug using habits? From becoming abstinent?
4/ What are the best way for agencies to help problem drug
users reduce the harm from their drug use? Become
abstinent?
5/ Do the aims and objectives of the agency which you work
for correspond to your own? What are they and how are they
different?
6/ Do you see the needs of problem drug users as being in
conflict with the larger interests of society?
7/ What is more important to you as a goal, harm reduction
or abstinence? What is more important for your agency?
8/ Do most of your clients/patients share your goals? If
not, how do they differ?
9/ If you could change what your agency does, what would
you do?
10/ If you could change Health Authority, Regional or
National policy, how would you change it?
The questions for the problem drug users were the same, except for questions:

5/ Do the aims and objectives of this agency correspond to your own? What are they and how are they different?

8/ Does your key worker or the person you see most often at this agency share your personal goals? If not, how do they differ?

The first 4 statements are covered in the previous section. They had to do with the choice of models or problem drug use. The last 6 statements are reviewed below.

What problem drug users say

5/ Do the aims and objectives of this agency correspond to your own? What are they and how are they different?

Five of the six respondents interviewed suggested that the aims and objectives of the agency were similar to their own, while the sixth was simply unsure of what the aims and objectives of the agency was. They expressed this in a number of ways. One problem drug user said,

"I do feel they are the same. I've come to ............... to find out when my problems have been and why I haven't been able to cope. I feel this is the purpose of Phoenix House. It will open your eyes and make you aware of your situation, you personal situations. I feel this is the purpose of............."

Another said,

"I am happy with the treatment I am getting. It is helping me."

Even when there was disagreement, the respondent was sympathetic
to the agency,
"I agree with what this agency does. They've been good with me although I have a moan. I try to get the next day's gear a bit early now they've refused to do it again for me........they've done me no wrong. Maybe their hands are tied a bit when it comes to certain things like how much they can supply. "

6/ Do you see the needs of problem drug users as being in conflict with the larger needs of society?

There was general agreement (with one exception) that heavy drug use was inherently unsocial. Some of those interviewed indicated that the main source of that conflict was the law,
"Yes, because it is illegal everyone has to go out robbing to get the money and they always hurt somebody."

Another said,
"Definitely, yes. If you're referring to crime - yes, definitely. It does cause a lot of conflict depending on what your doing. I didn't consider how other people were after I committed a crime........"

Some respondents mentioned what they described as the selfish nature of problem drug use as the main reason for the conflict. They seemed to indicate that putting their need to obtain drugs over other peoples needs was bound to lead to conflict. In this sense, some did not think that a change in the law was necessarily going to diminish that conflict.

"I think you are looking for mostly the impossible. When you are a drug addict, it's want, want, want. You want as much as you can get and can't find a happy medium. "

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Several others thought that the main source of the conflict was the stereotype of "drug addicts" that society in general holds about the nature of drug addicts and addiction.

"We may as well be lepers, black, have AIDS. We are a minority group. You feel like people are talking about you."

Another said,

"I get so angry with society. They are so hypocritical. They are telling you as an addict to take drugs (i.e. provide a Methadone prescription) and then when you are trying to do something about it and you are being open and saying I am an ex-addict or a recovering addict, they say once an addict always an addict."

7. What is more important to you as a goal, abstinence or harm reduction? What is more important to this agency?

There was an even split between those who felt that harm reduction was their main aim and those who felt that abstinence was what they wanted. Some saw abstinence as a distant goal which they would like to strive for, but practice harm reduction along the way. Others regarded harm reduction as a goal in itself and seemed to accept that drug use, within limits was acceptable. The influence of the agency was not always evident. One problem drug user from North Western Region who was in receipt of a large Methadone prescription felt that abstinence was more important to him than harm reduction.

"I want to come off it and not on a maintenance. I want to be drug free and to be able to handle problems instead of turning to drugs."
This ex problem drug user in a therapeutic community (which was abstinence orientated) recognised the conflict in what he wanted and what he felt was acceptable to the agency.

"Reduce the harm. Me as an individual - I have my boundaries or I've laid down my boundaries and aims to keep to, where as it would be abstinence around certain drugs. I'm leaving my options open around certain other drugs, i.e. cannabis."

He was asked how the agency felt about his decision.

"I don't think they can accommodate it. I think they just leave it up to the individual to find their own boundaries and where they draw the line."

The issue of cannabis is often ignored by treatment agencies. This will be considered in the concluding chapter.

8/ Does your keyworker or the person you see most often share your personal goals? If not, how do they differ?

This question had a range of responses. Two respondents said that they have common goals with their key worker.

"She's very good." and "yes, you tell them what you want and they'll show you different ways how to inject and this and that."

Another two admitted to conflict with their key workers.

"To a certain extent, the goals - we do work in the same direction as my goals. Around the Cannabis which I've been openly honest about, he does feel that this could be unnecessarily setting myself up."

and

"I have quite a few conflicts with my keyworker about what
is right for me. I don't think we share the same sort of goals but he does agree with taking one day at a time."

Another problem drug user was open about his own part in the conflict with his key worker.

"My own keyworker has had so much shit off me it's unbelievable. We still don't know where we're heading after all this time."

The chance for conflict to arise is much greater within therapeutic communities than in community agencies. In therapeutic communities, the problem drug user was seen much more frequently and all aspects of his or her behaviour is under scrutiny all of the time. Even for those on prescription, they often only see their keyworker for 1/2 to 3/4 hour every other week.

9/ If you could change what this agency does, what would you do? The answers to this question were of a practical nature. Despite conflicts with key workers and complaints about certain aspects of the work of agencies, the comments were almost universally of a positive nature.

One of those interviewed wanted the agency to prescribe controlled drugs because he was unhappy with the agency that was prescribing for him. Another wanted the agency to be less rigid about slips.

"Someone might have a relapse now and again - it shouldn't give them the right to throw you out."

Someone else, in a therapeutic community wanted more structure rather than less,

"I am not one for a great structure and loads of groups but
I would like it for people in here to get a bit more structure within the project as in time-giving because you are very much left to do your own thing."

In a similar vein, one young problem drug user who was receiving Methadone felt that more time needs to be spent on communication and setting goals, especially at the start of the programme.

"There has got to be a better interaction between doctor, keyworker and client. A goal should be established first thing."

Others thought that the agency was about right.

"I don't think I can fault it or their approach towards people's addiction."

10/ If you could change the Health Authority policy or the Regional Health Authorities policy, or national policy about drug use, how would you change it?

Four out of the six respondents suggested changes in the availability of drugs. Two thought that some drugs (especially cannabis) should be legalised but that other drugs require controls. The favourite method of control seemed to be through a physician, but two respondents thought that General Practitioners should more involved. There were a variety of suggestions about controls though.

"If you are going to give prescriptions out, you should have some sort of counselling because you could be giving it to anybody. You've got to make sure that person is of sound mind."

Another said,

"Gradually getting back into a system where the family GP
is more into it."

Other suggestions concerned treatment policy and practice. One problem drug user did not want to go for a "detox" in a general psychiatric ward. Another wanted to be able to bring her children into hospital when she is admitted for detoxification.

"I wanted to go into a detox unit with my children. They said they couldn't fund it. That would have really helped me and the children."

Not everyone had something to say,

"I will give you a straight 'don't know'."

Drug Workers

The drug workers comprised two doctors, one nurse, one drug counsellor, one manager (of a small service) and one social worker. They came from Drug Dependency Centres, a Community Drug Team and two voluntary agencies (a residential project and an information/advice centre).

As with the drug users, the first 4 questions are covered in the previous section of the results. This section covers the last 6 questions.

5/ Do the aims and objectives of the agency which you work for correspond to your own? What are they and how are they different?

All of the drug workers interviewed agreed that the aims and objectives of the agency correspond to their own. This was expressed in many ways. One worker at a residential project said,

"I think my aims and objectives are similar to the project's. I think what we look for and what we encourage people to do is to become responsible for their own
thoughts, feelings and behaviour."

A Social Worker in a Community Drug Project said,

"They are fairly similar to mine. Probably the same in terms of trying to attract drug users into the service and reduce the harm that is associated with their drug use."

Differences which do occur are often about the availability of resources, usually an issue which is in the hands of the funding authority rather than the agency itself.

One doctor from a Drug Dependency Unit said,

"Things I would wish to change or improve are often as a result of economic limitations rather than a difference in views from my colleagues or managers."

The influence of managers was about policy and was clearly stated by the manager of a small project,

"One of the advantages of being the coordinator of an autonomous agency is that the aims and objectives do correspond with mine because I wrote them."

6/ Do you see the needs of problem drug users as being in conflict with the larger interests of society?

All save one of the drug workers thought that there is an inherent conflict between problem drug users and society. As a start it was pointed out that the very act is against the law and most problem drug users who come to agencies finance their habits through illegal activity. One drug counsellor from a residential project said,

"The use of drugs such as heroin is an illegal act. In that sense, their engagement in the use of drugs is an
illegal act."

Another said that the financing of the habit is the main source of conflict.

"Drug users do contravene the laws and I'm not an advocate of saying well they can get on with it - they can rob and steal - 'cos I understand them."

The conflict comes from other sources besides the law. Some workers pointed out that society has to pay the financial bill to employ her to help problem drug users and the money could be spent on other groups. Others pointed out the human cost to drug users lives and the impact on family, friends and the capacity to work.

7/ What is more important for you as a goal, harm reduction or abstinence? What is more important to the agency?

All workers, to a varying degree suggested that harm reduction is both important to the agency and to them personally, as a goal. The most explicit advocates of harm reduction were the doctors and managers. One manager said,

"I think harm reduction is the most important because that is the one we can achieve."

A doctor is a Drug Dependency Unit said,

"I think more important to me is harm reduction. I mean the social harm they do themselves as well as the physical harm. If abstinence is not possible, it's not really important."

Even workers from residential services which are drug free find ways of supporting harm reduction.

"The way this project runs is that people have to abstain
while they are here. I think harm reduction can be seen in a wider sense. People that come here get clean of drugs so they are reducing harm. If someone has decided they are not ready to kick what they have been using then that poses no problems for me."

In one sense, harm reduction and abstinence can be seen as inherently in conflict. By reducing the harm the user creates it can be argued you take away some of the reasons for them to become abstinent. You make it easier for them to continue to use drugs by providing them with a supply of drugs, clean injecting equipment and a friendly person to talk to. One worker from an advice centre felt you had to do both. He said,

"I think there is a tendency for some agencies to go for all abstinence or all harm reduction. I think you have to be aware that in order to meet the needs of clients, you have got to be like a little bit of both really without imposing anything on people."

8/ Do most of your client/patients share your goals? If not, how do they differ?

All of the drug workers, with varying degrees of conviction, share the opinion that most of their clients share their (the workers) goals. Several thought that at least some drug users have to pretend that they want to become abstinent in order to obtain a prescription. A manager from a Community Drug Team said,

"Yes, most do (share my goals). They say they want some of the consequences of their drug use to alter - improve health and finances. They are not saying that they want to stop. However, initially a lot of people do say they want
to stop because they believe that is what the agency wants to hear."

A doctor from a Drug Dependency Unit expressed similar sentiments as the manager above. He admitted, though, that his goals have changed since he started the job.

"If I was honest, whatever goals I may have had when I first started have been modified by the people I work with."

Several drug workers said that most of their clients share their goals but disagree how they can be achieved. A Social Worker from a Community Drug Team said,

"Most would share the goal of harm reduction and most are keen to use drugs in ways that are less problematical. Where there is a disagreement sometimes is in how you actually go about that."

9. If you could change what your agency does, what would you do?

Most of the responses either suggested no change or simply more resources to do more of what they already do. One worker pointed out that they have a 6 month waiting list to be seen. He would like to see that shortened or disappear. Another suggested that they needed to open on week-ends and evenings.

A doctor suggested that they need to become more involved in training other professionals. A worker at a Community Drug Team suggested that they need to expand their work to other drug using groups.

"I would like to be able to reach clients who weren't necessarily white, male injecting opiate users which is what the majority are. I would like to be able to offer a
service more to those who are using drugs recreationally and socially, so as to hopefully prevent some of those becoming problem drug users at a later stage."

Several suggested that they could work differently with problem drug users. A drug counsellor at a residential rehabilitation programme said,

"If I could have one thing that this agency doesn't do, I would like to have a family week with families working together. More than anything I'd like to have a detox unit and we could help a lot more people."

All of those interviewed either said that they would like no changes, be able to do more of what they already do or add a few new suggestions to their existing programmes. Only one worker, a manager of a large agency suggested more radical change. He would most like to see the staff change and see themselves more as "an agent of change" than a friend to their clients. He felt that the staff had become too heavily identified with their clients and needed to reassert their professional identity.

10/ If you could change Health Authority, Regional or National policy, how would you change it?

There were a variety of answers to this question. Two respondents said that they thought that more resources should be allocated to the drug field. A manager suggested that they require more security in funding as well as more funding. A drug counsellor from thought that he would most like to see drug users given more attention by statutory agencies.

"I'd like to see drug users given a higher priority........

There is nobody in senior management (within social
services) who seems to accept any kind of responsibility for any kind of policy..."

He went on to say that he would like to see drug misuse shift to another branch of medicine, not psychiatry.

Another two workers thought that more had to be done in prisons. A drug counsellor from a residential project said,

"If people are going into prison with a serious drug problem, there should be facilities built for that. Specifically for drug using people or people who are HIV (+) - not lock them up for 23 hours a day and allow them access to injecting equipment and not deny them access to facilities where they can deal with their drug problems..."

Another two workers (a doctor and a drug counsellor) suggested that simply increasing money for treatment agencies would not be effective unless there were much larger changes within society.

"You can make lots of different changes in terms of drug users and isolated batches of society, but unless you improve things for them overall, then I think it is a drop in the ocean......."

There was no consistent view amongst those who were interviewed. None expressed satisfaction with current social policy and several admitted to not knowing enough about it to have a view. Mainly the comments were about allocation of greater resources or giving higher priority to the problem.

DRUG USERS AND WORKERS WITHIN THE CONTEXT OF THE AGENCY WHERE THEY MEET AND THE POLICIES WHICH GOVERN THEIR RELATIONSHIP

Drug workers/users and the agencies

Both drug workers and drug users had similar relationships to the
agencies where they met. The scores drug workers and drug users in their response to the statement that their goals were the same as the agency where they go were similar. For drug workers it was a score of 2.50 and for drug users the score was 2.44 (between neutral and agree on the scale). There were also similarities in the responses of drug workers and users to the statement that drug users saw the agency as too controlling. Both groups mildly disagreed (3.69 on the scale for drug users and 3.55 for drug workers).

Not surprisingly, drug workers felt they had much more control over the policies of the agency than drug users. Many of the agencies were small and employed only half a dozen staff. Most of those staff felt that they have some control.

Drug workers/users and national policy about drug misuse

Drug workers and users were in equal agreement (2.05 for drug users and drug workers scored 2.21) that government was more interested in controlling drug users rather than helping them. Again, there was agreement between drug workers and users that the agency where they met had major differences with the aims and objectives of national policy (drug users 2.50, drug workers 2.47).

Drug workers/user and harm reduction

Perhaps the main area of disagreement was the commitment of the agency towards harm reduction. Both groups agreed that harm reduction was an important part of the work of the agency but drug workers agreed much more strongly. Drug users agreed with the statement that harm reduction was an important part of the work of the agency with a score or 2.67, for drug workers it was
1.7 - a much stronger agreement. Note that both groups agree with the statement, one simply agrees much more than the other. Given the differences between the drug users and the drug workers in their age, social class, and education, they held remarkably similar views about their relationship to the agency where they meet, the sceptical view of government policy and commitment to harm reduction.
SUMMARY AND CONCLUSION

INTRODUCTION

To repeat the earlier statement; the purpose of this study was to examine the beliefs about the origins and treatment of problem drug use of drug workers and drug users who attended helping agencies. In addition, the personal and educational characteristics of problem drug users and drug workers were explored to determine if differences in belief within each group could be associated with these variables.

The conclusions will be structured as follows:

1/ The personal characteristics of drug workers and problem drug users.
   a. are drug workers within North Western and Merseyside Health Authority representative of drug workers within the United Kingdom?
   b. are problem drug users representative of problem drug users as a whole?
   c. do the differences matter?

2/ How are the beliefs of problem drug users and drug workers different? What are the implications for those differences?

3/ How do problem drug users and drug workers relate to agency and national policy about drug misuse?

4/ What are the implications for the education and training of drug workers?

5/ What are the implications for social policy?

1/ THE PERSONAL CHARACTERISTICS OF DRUG WORKERS AND PROBLEM DRUG USERS.
a. are drug workers within North Western and Merseyside Health Authority representative of drug workers within the United Kingdom?

A total of 80% of drug workers in Merseyside and North West Region drug agencies participated in the survey which formed the basis of this thesis. This represents a large proportion of drug workers in these two Regional Health Authorities. There is no way to tell if they are representative of drug workers within the United Kingdom. There are no data on the personal characteristics of drug workers throughout the United Kingdom so it was difficult to make comparisons. There were some similarities in the educational requirements of professionals who work in the National Health Service and for Social Services.

b. are problem drug users representative of problem drug users as a whole?

The problem drug users, however, were another issue. There was no way to know how representative they were of problem drug users within these two Regional Health Authorities or problem drug users throughout the United Kingdom.

Certainly those who attended helping or treatment agencies were a minority of drug users who had problems as a result of their drug use. Hartnoll, et al. (1989), within a larger study, compared problem drug users who attended treatment agencies to those who do not. He found that they were broadly similar in age, pattern of drug use, gender, social class and educational attainment. However, those who attended agencies started using drugs at an earlier age and suffered from more
medical and legal problems associated with their drug use. Furthermore, those not attending agencies were more successful in finding strategies to control their drug use. Problem drug users not attending agencies simply felt that they did not require help with their problems. They often felt that other problems, such as accommodation were more important than their drug problems.

There was no research comparing the beliefs of problem drug users who attended agencies with those who did not. Comparing the 150 problem drug users in this study to problem drug users as a whole may not be possible but they can be compared to problem drug users who attended agencies in Merseyside and the North West Region in a number of ways.

Within Merseyside and the North Western Region there are well developed Drug Misuse Databases. The Drug Misuse Database was initiated in the North Western Regional Health Authority in 1985 at the University of Manchester Drug Research Unit. By 1989 the Department of Health requested that all Regional Health Authorities establish a regional database similar to that developed by North Western Region. Most Regional Health Authorities have now adopted the system developed in Manchester.

Unlike the Home Office Index, which collects information from physicians only, the regional databases gather information from a far wider group of agencies and professionals. The Home Office Index only accepts information from Medical Practitioners while the regional database accepts information from agencies where no physician is employed. Also, unlike the
Home Office Index, it collects information on individuals identified by initials and dates of birth rather than names and addresses. It records those who "present to services" rather than those who fulfil the diagnostic criteria of "addict" required by the Home Office Index. In this way, the regional data base is a much closer match to the population used in this survey, i.e. clients of drug agencies. Unlike this population, which were drawn from drug helping agencies only, the regional database also uses information from Accident and Emergency Departments, other Hospital Units, and General Practitioners. All of the agencies which were used in this study reported to either the North Western or Merseyside Regional Databases; however, they were not a random sample from the regional databases.

Most of the fieldwork was carried out over a period of about 18 months, over the last half of 1991 to the start of 1993. Therefore, the calendar year 1992 from both Regional Data Bases was used.

North Western Region

A total of 4590 (Donmall and Miller, 1993) drug users were reported to the database during the calendar year 1992. Within the North Western Region, 67 of the 150 problem drug users (45%) in the current study were recorded.
TABLE 134

COMPARISON OF GENDER BETWEEN CURRENT STUDY AND THE NORTH WESTERN REGIONAL DATABASE

<table>
<thead>
<tr>
<th></th>
<th>% Men</th>
<th>% Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Study</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>North Western Database</td>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Age

The age profile of the current study and the North Western Data Base was similar but not the same. A total of 41 of the 67 problem drug users from this study (61%) was less than 30 years of age (mean age 28). In the North Western Region, 76% (Donmall, & Miller, 1993a) were less than 30 years of age.

Drug Use

This table represents the category "Main Drug Used" in the North Western Regional Database and the category "Preferred Drug" in this study. Though the categories are not precisely the same, there is a rough equivalence.

TABLE 135

COMPARISON OF "MAIN DRUG" AND "PREFERRED DRUG" BETWEEN THIS STUDY AND THE NORTH WESTERN REGIONAL DATABASE

<table>
<thead>
<tr>
<th></th>
<th>Opiates</th>
<th>Stimulants</th>
<th>Other Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Study</td>
<td>68%</td>
<td>22%</td>
<td>10%</td>
</tr>
<tr>
<td>North Western Regional Database</td>
<td>74%</td>
<td>15%</td>
<td>11%</td>
</tr>
</tbody>
</table>

The regional data base did not provide information on the educational attainment of problem drug users and the information on race did not use the same categories as this study. In terms of gender and age, the problem drug users from
this study and the North Western Regional Data Base were similar.

c. Do the differences matter?
Some of the most striking results found in this research are the marked differences in age, sex, education and belief in models between problem drug users and those who are paid to help them. Do these differences actually matter? The purpose of this section is to explore those differences in the light of other research and evidence found in the literature.

One of the main differences in demographic features between problem drug users and drug workers was their gender. A total of 76% of problem drug users were male while only 46% of the population of drug workers were male. Furthermore, women drug workers were less likely to be managers and therefore more likely to be spending most of their time seeing clients or patients. Therefore, many of the treatment sessions were conducted by older women drug workers (mean age 37) with younger (mean age 28) problem drug using men. Both drug workers and problem drug users were overwhelmingly white so the differences between them due to ethnicity could not be explored. However, many black groups claim that a major reason for black under-representation in the treatment populations of agencies is because those agencies are defined as "white" institutions to the extent that they exclude other races. The influence of these variables on therapeutic relationships is unclear. There are so many variables such as: types of clients, styles of counselling and psychotherapies, class, race, etc. that it is difficult to isolate just one, such as
gender.
Possibly the greatest difference between drug workers and problem drug users was in their respective levels of education. As a group, most drug workers were well educated and many professionally qualified. Problem drug users, as a group, had a much lower level of educational attainment, few were professionally qualified and a large proportion had no educational qualifications. While there seems to be little or no literature which addresses outcomes and the issue of differences between therapist and client in educational attainment, there is when considering social class.

Middle class therapists and working class problem drug users

Sociologists (Cole in Worsley, 1972) have noted a strong relationship between education, occupation and social class. Using a traditional classification of five levels of social class within British society, Cole suggests that physicians would occupy Social Class I and nurses Social Class II. Most other drug workers (Social Workers, Probation Officers, and non-professional drug councillors - most of whom have educational qualifications) would probably occupy Social Class II. As the majority of problem drug users are unemployed and have few educational qualifications or occupations, they would probably be allocated to Social Class 5.

The consequences of this difference have been examined by others in relation to psychotherapeutic outcome. Parloff, Waskow and Wolfe (in Garfield and Bergin, 1978) state that
most studies show that lower-class individuals are less likely than middle or upper class individuals to be accepted for psychotherapy or counselling and are more likely to drop-out of therapy once it begins. They cite research which suggests that middle-class therapists are more likely to choose middle-class patients. Therapists from social class III and V origins were more likely than therapists from social class I or II to choose patients from lower social classes.

All of the above was confirmed by Lambert and Asay (in Hersen et al., 1984). They went on to say that therapists' like or dislike for their client may be important in some types of therapies, such as psychodynamic psychotherapy but less important in others, such as behavioural therapy. Outcomes for lower class clients seem to be no different than for those from middle or upper class backgrounds, taking into account that there seems to be a higher drop-out rate.

Women drug workers and men problem drug users - Does it matter?

In recent years much of the debate has been generated from the women's movement, questioning the ability of men to help women clients. If men are the main source of oppression in women's lives, than how can they, as a group, expect to act as a therapeutic agent - regardless of their individual beliefs? In this case, the question is about women therapists' (mainly Community Psychiatric Nurses and drug counsellors) ability to help younger men.
Most studies have concentrated on process (i.e. how long the client stays in therapy, drop-out rates) rather than outcomes. Parloff, Waskow and Wolfe (in Garfield and Bergin, 1978) reviewed the literature on the influence of gender, class and race on therapeutic outcome measures. They attempted to find common outcomes or at least common themes but were unable to. They concluded that,

"Our survey of the literature relevant to the issue of matching patient to therapist according to race, social class and sex permits us to draw no firm conclusions about the influence of such matching on the outcome of psychotherapy." (pp. 264)

Curtis, Barrett and Wright (in Hersen, et al, 1984) also found it difficult to extract the variable of gender from other variables such as age, therapeutic style and theory. Many of the gender differences between therapists were expressed in assessment, i.e. women therapists were more likely than men therapists to diagnose patients of either sex to have greater problems in sexual adjustment. Other differences between men and women therapists were the greater capacity of women therapists to form "therapeutic alliances" with both men and women patients and greater treatment optimism regardless of the gender of the patient. They implied that the gender of the therapist may be a key variable in successful outcomes regardless of the gender of the patient.

White drug workers and black clients - does it matter?
Within the drug user population of this study, there were so few non-white problem drug users that it was impossible to draw many conclusions about non-white problem drug users as a group. Looking at the broader issue of race, Curtis, Barrett and Wright (in Hersen, et al, 1984) could find only two empirical studies which addressed the issue of racial differences between therapist and client or patient. They concluded,

"However, there is still no strong evidence that the race of the therapist would be a major predictor of therapy process or outcome." (pp. 369)

Parloff, Waskow and Wolfe (in Garfield and Bergin, 1978) reviewed a number of studies which looked at the influence of racial differences between therapist and client. Many of them concerned single interview studies and it is difficult to relate single interview studies to the long term work of most drug agencies. Their conclusions are similar to Curtis, Barrett and Wright. They said,

"This review of the research on race of the therapist does not provide much definitive information about the effects of race per se or of intra and interracial matching on the outcome of therapy." (pp. 258)

It may be that variables such as those discussed above are less important for counselling problem drug users in drug agencies than in more generic settings. Drug workers usually go into this work have a good idea of the gender, age, social class, etc. of their clients. Those with personal difficulties with clients from this somewhat stereotyped picture would
probably not enter this profession. The very fact that they have chosen to work with this group may suggest that they are more favourably disposed to them than those practising counselling with other groups.

Does previous experience of drug use matter?

The differences between problem drug users and the drug workers who were employed by the agencies which provided services are many. The most obvious differences was that only 10% of the drug workers ever admitted to having had problems with alcohol or drugs, while by definition (i.e. they all attended drug agencies) all of those who attended the agencies were problem drug users. Does this matter?

Some treatment approaches, such as those advocated by Alcoholics and Narcotics Anonymous, are run entirely by ex-users. They claim that only ex-users are able to provide the understanding and empathy ("walking the walk, talking the talk" in A/A terminology) which is crucial to helping users change their behaviour. They say that the inevitable deceit which is part and parcel of drug addiction can only be confronted by those who recognise it through their own experience.

Furthermore, they say that ex-users are able to provide role models for abstinence that professionals are not able to furnish. A/A and N/A (Narcotics Anonymous) were not included in this research because they did not fulfil the basic requirements of being a treatment agency. They were a self
help group, there were no staff and they received no funding from government, charities or received fees for services. The only income was provided by members contributing towards the cost of room rental and refreshments.

Some aspects of the philosophy of Alcoholics and Narcotics Anonymous were found within Residential Rehabilitation agencies. The traditions of drug Residential Rehabilitation agencies were drawn partially from British sources (especially within the Mental Health field) but mainly from American models such as Synanon and Daytop Village. These communities arose from a splinter group within Alcoholics Anonymous and much of the philosophy remained though these similarities are growing smaller. Still, most residential rehabilitation agencies employed a large proportion of ex-users, use group work techniques and emphasis the importance of individual responsibility. The question arises, did the beliefs of drug workers in residential services more closely resemble those beliefs of problem drug users? The results of this research suggested that drug workers with a previous history of alcohol or drug problems do not hold beliefs that were more similar to problem drug users than any other drug worker.

The reasons for this may be that they had discarded their previous identity as a problem drug user and had taken on the values of the profession which they have trained for or the values of the agency which they now work for. It is also possible that as problem drug users they did not have the same beliefs as other users and hence their beliefs have not altered because they were different in the first place.
2/ HOW ARE THE BELIEFS OF PROBLEM DRUG USERS AND DRUG WORKERS DIFFERENT? WHAT ARE THE IMPLICATIONS FOR THOSE DIFFERENCES?

The question arises, why do beliefs matter?

i/ Beliefs are the foundations of attitudes and attitudes are important in the decision whether to offer help to problem drug users or not. As clearly demonstrated in the literature review, many professionals have negative attitudes towards those with drug problems and this is bound to affect their judgment and ability to offer help.

ii/ Those involved in the treatment of problem drug users are influential in the formulation of social policy. Their opinions are often sought by those who make public policy on illicit drugs.

iii/ Some beliefs may stand in the way of the formation of a therapeutic alliance, even if they do not lead to negative attitudes. Schaler (1997) in a recent article suggested that therapists with a previous experience of alcohol problems who have been through a 12-step programme (a medical/biological model which the author labels a "disease" model) may be biased toward the form of treatment that helped them. He suggests that there are therapeutic disadvantages in believing in this model. These includes a sense of powerlessness and acceptance of the view that addiction is an involuntary process.

Others (Bergmark and Oscarsson, 1991) ask the question, does belief in any one model of problem drug use hold an advantage over any other model? There seem to be three schools of thought. One school suggests that therapeutic effectiveness is related to the skill of the therapist. In a study of the
treatment of depression in Nottingham (Kingdon et al., 1996), therapists with greater skill in cognitive therapy achieved better outcomes, both immediate and over two years, than those with less skill.

Another school of thought suggests that the key variable is the commitment of the therapist to their client and confidence in their skill as a therapist (and hence, confident in their belief of the therapy used). Research supporting this view can be found in the field of treatment for problem alcohol use (Cartwright, et al., 1996). The authors claim that the commitment of the therapist is a key variable in client engagement to the service. They go further and suggest that it is a major predictor of outcome and engagement, which can be measured in drop-out rates. It might not matter what the treatment is (and by implication, the belief it is based upon), so long as the therapist believes in it.

Finally, Keene and Raynor, (Keene & Raynor, 1993) propose that clients with drug problems in treatment in a "disease model" treatment programme have a much better outcome if their model of problem drug use is similar to that of their therapists. This study fails to address whether the problem drug user came into the treatment programme with the belief or learned it on the programme. Whether or not they learned their belief on the programme or had it before they began, the study shows how important a matching of beliefs for therapist and client is in terms of outcome.

Perhaps these three trends in thought are not mutually exclusive. The important variable in the Nottingham study may...
not be skill of the therapist but commitment to a therapeutic system. The most skilled (having taken the time, trouble and expense to learn that skill) may simply be more committed to that form of therapy than less skilled practitioners but more effective because of their commitment rather than their proficiency in using a therapeutic technique based on a belief about the nature of the problem.

Does it make any appreciable difference that problem drug users hold, as a group, different beliefs than drug workers? The answer is at least partially determined by the therapeutic goals of the drug user and the agency. For those agencies which have as their goals the immediate achievement of abstinence, such as the residential rehabilitation, differences in beliefs are inevitable at the start of the programme, where, they would claim most problem drug users hold on to beliefs which they use to justify their drug use. The function of the first phase of the programme (often the most intense) is to challenge those beliefs and begin to move them to match the beliefs held by the drug workers and enshrined by the institution.

Beliefs are thought to be enduring, stable and central cognitive processes which form the basis of attitudes. They work together in an organised system which, for most people, form the basis of how the world is perceived (Oskamp, 1977). Beliefs are the product of personality, past experience, education, relationships, economic and social position, etc.

How can structures, which are so central to our personality be changed? Such questions are beyond the scope of this research,
but it is clear that beliefs do not change quickly and substantial effort is required. Therapeutic programmes which seek to change beliefs face a daunting prospect. Residential rehabilitation programmes have advantages over other types of programmes in changing beliefs. Programmes begin early in the morning and carry on into the evening, often seven days a week. This is compared to "community" programmes where the problem drug user may only be seen once every two weeks, or even less, for 1/2 to one hour. The nature of residential programmes requires a far greater commitment than do other programmes. The problem drug user must reside on the premises. His or her behaviour is scrutinised continually, visits from friends is restricted or prohibited, and in the early stages, mail and telephone communication with the outside world is restricted. The programmes require a rejection of previous life styles and friends, not just abstinence.

There are many similarities between the residential programmes and the 12-step programme of Alcoholics (and Narcotics) Anonymous. Abstinence is believed to be the only legitimate goal of the programme. "Confession" of unacceptable past behavioural difficulties is essential and many (though not all as in A/A or N/A) of the drug workers are former problem drug users who have been through the programme. In their study of a residential rehabilitation programme which uses the methods and philosophy of Alcoholics Anonymous, Keene and Raynor (1993) found that the acceptance of an A/A belief system was the essential determining factor in deciding who would remain
in the programme and who dropped out. Residents who were able to take on the belief systems of the programme (and therefore of the workers) stayed and achieved abstinence. Those who were unable to do so left early and most (though not all) returned to problem drinking. While there was obviously a high correlation between accepting the A/A belief system and length of stay in the programme, this does not necessarily mean cause and effect - i.e that changing the residents belief system caused them to stay longer within the programme. The opposite could also be true, that residents stayed for a variety of reasons and those that stayed the longest changed their belief system as a result of staying longer.

The importance of beliefs is not only central to abstinence orientated residential programmes but is also a key feature of cognitive therapy which has become more influential in the last several years in treating drug problems. The altering of belief systems is at the heart of the therapy. Cognitive therapy recognises the fundamental nature of beliefs and their stability and powers of endurance.

"Addictive beliefs develop over an extended period of time. As a result they become overlearned and extremely resistant to change... Given the resistant nature of addictive beliefs, the process of modifying them is quite a challenge." (Beck et al., 1993, pp. 176)

The role of the cognitive therapist is to offer problem drug users techniques to change their beliefs in such a way as to modify their drug-taking behaviour.

"The role of the cognitive therapist is to assess,
examine, and test those beliefs with the patient, in order to ultimately replace them with control beliefs." (Beck et al., 1993, pp. 186)

How different were the beliefs of problem drug users and drug workers?

The differences in beliefs between problem drug users and drug workers was substantial, yet there were also similarities. The differences were apparent. For problem drug users, the Psychological model was by far the preferred model with the Social/Economic model and Medical/Biological model having near equal scores. For drug workers, the Social/Economic model was preferred but only by a small margin over the Psychological model with the Medical/biological model running a poor third.

BELIEFS HELD BY DRUG WORKERS AND PROBLEM DRUG USERS

The following tables are repeated from the chapter on results.

### TABLE 136
**BELIEFS OF DRUG USERS**

<table>
<thead>
<tr>
<th>Name of the theory</th>
<th>Mean score origin</th>
<th>Mean score treatment score</th>
<th>Combined mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Economic Theory</td>
<td>3.19</td>
<td>2.74</td>
<td>2.97</td>
</tr>
<tr>
<td>Medical/Biological Theory</td>
<td>3.23</td>
<td>2.75</td>
<td>2.99</td>
</tr>
<tr>
<td>Psychological Theory</td>
<td>3.19</td>
<td>2.25</td>
<td>2.72</td>
</tr>
</tbody>
</table>

### TABLE 137
**Beliefs of Drug Workers**

<table>
<thead>
<tr>
<th>Name of the theory</th>
<th>Mean score origin</th>
<th>Mean score treatment score</th>
<th>Combined mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Economic Theory</td>
<td>3.27</td>
<td>2.87</td>
<td>3.07</td>
</tr>
<tr>
<td>Medical/Biological Theory</td>
<td>4.10</td>
<td>3.46</td>
<td>3.78</td>
</tr>
<tr>
<td>Psychological Theory</td>
<td>3.50</td>
<td>2.72</td>
<td>3.11</td>
</tr>
</tbody>
</table>
While the differences have already been mentioned, the similarities were also important. Perhaps the most important was the preference for Psychological treatment by both problem drug users and drug workers. It was this similarity which may be the most important because it may have informed the transaction between the drug worker and the problem drug worker.

Former problem alcohol or drug using drug workers did not hold models which were closer to drug users than those without problems. The following table is repeated from the chapter on Results.

**TABLE 138**

THE BELIEFS OF DRUG WORKERS WITH A PAST HISTORY OF SUBSTANCE MISUSE COMPARED TO THOSE WITH NO HISTORY OF SUBSTANCE MISUSE

<table>
<thead>
<tr>
<th></th>
<th>Econ/Social Theory Total scores</th>
<th>Med/Biological Theory Total scores</th>
<th>Psychological Theory Total scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug workers with previous substance problem</td>
<td>2.96</td>
<td>3.95</td>
<td>3.14</td>
</tr>
<tr>
<td>Drug workers with no previous substance problem</td>
<td>3.13</td>
<td>3.76</td>
<td>3.10</td>
</tr>
<tr>
<td>Problem drug users</td>
<td>2.97</td>
<td>2.99</td>
<td>2.72</td>
</tr>
</tbody>
</table>

These results suggested that drug workers with previous alcohol and drug problems did not hold beliefs which were closer to problem drug users compared to drug workers who did not have alcohol or drug problems. There may be several reasons for this. Former drug users may have rejected their former identity and belief system and with it their similar
beliefs with other drug users. They may have undertaken formal education or professional training and that may have influenced their beliefs. Their rehabilitation may have included attendance at a therapeutic community which may have had a large influence on their beliefs. Finally, their beliefs may have not changed in any meaningful way since they were a problem alcohol or drug user. Drug users had a wide range of beliefs and if anything their beliefs were more heterogeneous than drug workers. This question does not address the issue of drug workers being more effective, able to empathise more convincingly, etc. It merely addresses the issue of their beliefs.

No one type of agency had beliefs in a model which were closer to that of problem drug users. When considering the chosen model by problem drug users for treatment, i.e. no one agency had the strength of conviction in psychological treatments as problem drug users (2.25) but most were not far off.

<table>
<thead>
<tr>
<th>Psychological Theory</th>
<th>Mean score origin</th>
<th>Mean score treatment score</th>
<th>Combined mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Drug Team</td>
<td>3.45</td>
<td>2.83</td>
<td>3.14</td>
</tr>
<tr>
<td>Advise/Info Agency</td>
<td>3.66</td>
<td>2.80</td>
<td>3.23</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3.21</td>
<td>2.59</td>
<td>2.90</td>
</tr>
<tr>
<td>Drug Dependency Unit</td>
<td>3.58</td>
<td>2.50</td>
<td>3.04</td>
</tr>
</tbody>
</table>

In many ways, the beliefs of drug workers were remarkably consistent. While agencies and professional boundaries account for some variation in the beliefs of drug workers, the range
of scores on beliefs is relatively small. Within most agencies, the range of beliefs is even smaller. No doubt this has something to do with need for agency staff to work together. Often they felt under siege from both the demands of their clients or patients and from their Health Authority or Social Services purchasers and central government. It is no wonder that they should seek support from each other and merge their beliefs in order to work together more effectively.

Recently, in the field of treatment for alcohol problems, a large study (Project Match Research Group, 1997) tried to match client variables to successful treatment outcomes using one of three treatment programmes (12 Step Facilitation Therapy, Cognitive Behavioural Coping Skills Therapy and Motivational Interviewing). The 12 Step programme relied on a "Medical/Biological" model while the other two programmes were based on a "Psychological" model. The results showed that only one of ten variables (severity of psychiatric condition) was associated (negatively) with the treatment outcome in only one of the three treatment programmes (12 Step Programme). None of the variables were specifically concerning beliefs about the origins or treatment of problem alcohol use. However, it did demonstrate the difficulty in matching client characteristics with a specific treatment in order to improve success rates. The study could not easily be related to the field of drug treatment because alcohol is a legal drug and the client profiles of those who come for treatment may be quite different to those who come for drug treatment. Indeed, those excluded from the study (i.e. the homeless, poor educational
attainment, diagnosed Sociopathy) would make up a large proportion of the clients of most drug treatment agencies.

3/ HOW DO PROBLEM DRUG USERS AND DRUG WORKERS RELATE TO AGENCY AND NATIONAL POLICY ABOUT DRUG MISUSE?

While there may have been considerable differences between problem drug users and drug workers in their beliefs about models of problem drug use, there was much more agreement regarding attitudes to agencies and government policy. Problem drug users and drug workers scored very similarly when considering whether they had the same goals as their agency (scoring 2.44 and 2.50 respectively). Their different status within the agency was recognised by both. Drug workers felt that they had more influence over how the agency used its resources compared to drug users. Drug workers with fewer educational achievements, like problem drug users, felt they had less influence. This result is not surprising because those drug workers with the best educational attainment were more likely to move into management positions.

Again, there was some agreement between problem drug users and drug workers in the views on how "controlling" the agency was. In response to the statement "Most problem drug users see this agency as too controlling", women drug workers scored 3.72 (i.e. between 3 - neutral and 4 - disagree) while problem drug users scored 3.69. Men drug workers were significantly (compared to women) more neutral, scoring 3.35.

They both had an equally cynical view of authorities and government policy. For instance drug workers had a mean score of 2.2 on the statement, "The government and authorities are
more interested in controlling problem drug users than in helping them." Problem drug users were in slightly more agreement with this statement, scoring 2.05. Perhaps agencies provide a safe environment for drug workers and users to express anti-establishment views. A degree of shared ideological beliefs could be an important link between younger, usually male, problem drug users and older, often women drug workers.

The largest differences in the views of problem drug users views of agencies compared to those of drug workers is in the realm of harm reduction. Drug workers were much more in agreement with the statement, "Harm reduction is an important part of this agency's work.", than were problem drug users, scoring 1.7 on the scale compared to 2.67. The second question regarding harm reduction, "I regard harm reduction an important part of my work.", had a similar response. Drug workers might have been more interested in harm reduction than their clients. On the other hand, they may have not regarded methadone as a harm reduction measure.

4/ WHAT ARE THE IMPLICATIONS FOR THE EDUCATION AND TRAINING OF DRUG WORKERS?

The influence of training and education on beliefs is essential in the formation of both attitudes and beliefs (Etzioni, 1969, Greenwood, 1992). Many of those who worked in treatment agencies for problem drug users had professional qualifications. The most common were in the field of nursing, social work or medicine. Attitudes towards problem drug use were probably already partially formed even before
professional training began. Professional training, however, was a crucial time in the development of attitudes and beliefs about drugs and drug users. The amount of time devoted by professional training courses to problem drug use is minimal.

Professional Training for Social Workers and Probation Officers

Over the previous 10 years, a number of reports from Government bodies (Department of Health and Social Security, 1982; Home Office, 1984; Home Office, 1990; House of Commons Social Services Committee, 1985) have urged those responsible for Social Work training to include substance misuse in the curriculum. Before 1991, with the introduction of the new Diploma in Social Work, there was no mandatory requirement for the inclusion of substance misuse in social work training courses by the Central Council for Education and Training in Social Work. Since then it has been a national requirement. However, despite the new requirements, the amount of time devoted to substance misuse training has been minimal. Harrison (1992) sent a postal questionnaire to 80 universities, polytechniques and colleges offering the Certificate of Qualification in Social Work, within the United Kingdom, to determine if training on substance misuse was included in the curriculum. He had a response rate of 74%. A large majority (89%) did provide some training. Most of those included it in the "Core Curriculum" which has mandatory attendance. However, the medium number of hours devoted to
substance misuse was only 11.25 hours. Some of those courses only included alcohol.

Professional Training for Nurses

In the United States, Schlesinger and Barg (1986) surveyed Schools of Nursing, psychiatric residency programmes, and schools of social work to determine how much of the curriculum was devoted to substance misuse. Responses were received by 950 (68% of those sent surveys) nursing programmes, 103 (48%) of psychiatry residencies and 61 (71%) of schools of social work. Information was asked about didactic teaching and patient/client contact with substance misusers. The percentage of didactic training hours which were devoted to substance misuse was 4% for nurses, 6% for psychiatrists and 8% for social workers. Patient contact time was higher, 12% for nurses, 16% for psychiatrists and 21% for social workers. The main focus of the training was about treatment and the authors concluded that abstinence (by a rate of 4:1 in the case of nursing and psychiatry and 2:1 in the case of social work) was by far the most favoured treatment goal, rather than moderation of alcohol or drug habits. While the authors were surprised at the relatively low proportion of time devoted to substance misuse on these professional training programmes, they are generous compared to British practice. The results must be viewed cautiously because of the relatively low response rate, especially from Psychiatric Residencies where the response rate was less than
Another large survey of Nursing Schools within the United States was conducted by Hoffman and Heinemann (1987). Out of 1035 postal questionnaires, 336 were returned. Like the previous survey, the number of hours dedicated to the subject of substance misuse was minimal. Most of the programmes (53%) combined the teaching of alcohol and drug problems into a substance misuse module. The remainder divided the curriculum into separate alcohol and drug modules. A total of 94% of drug modules had 10 hours or less dedicated hours and a 82% of substance abuse modules had 10 hours or less dedicated hours. Only 57 of the 336 programmes had elective courses on drug abuse or substance abuse.

While both of these studies suffer from a low response rate, their results were consistent. The amount of time dedicated to substance misuse in Schools of Nursing was minimal.

Professional Training for Doctors

The training offered in Medical School for undergraduates in the United Kingdom was surveyed by Glass (Glass, 1989). She was able to secure a 70% response rate from each of 13 departments in all 28 Medical Schools within the United Kingdom. Of those that responded, 54% provided formal teaching (lectures, seminars, and symposia). The average number of teaching hours was 14 over the 5 year course. While 43% of the major clinical specialities provided some teaching on substance misuse, only 21% of the clinical and non-clinical
departments ensured that students were examined on the issue. Less time was spent on the drugs field that on the alcohol field (5 hours compared to 6). Not surprisingly, psychiatry offered a consistently large number of hours devoted to substance misuse. General Practice, however, was near the average in the number of hours devoted to substance misuse. Only 14 of the 253 departments surveyed regularly examined students on these issues. There was no written component in 70% of the departments.

Often the exposure of medical students to clinical work with drug abusers altered their attitudes. Gertler and Ferneau (1974) found that first-year psychiatric residency physicians altered their attitudes towards drug addiction as a result of 10 months working at an out-patient unit for drug addicts. Using a drug abuse questionnaire which was derived from altering a standardized questionnaire for professionals about alcoholism, the authors tested the first year residents at the start of their year and retested at the end of their year. There were mixed results which were difficult to interpret. On the one hand doctors gave more credence to social factors in their understanding of addiction after a year of working with drug addicts. On the other hand, they more firmly advocated a medical model which emphasises that addicts are unable to control their addiction and that regulated use is not possible since it is only a stage towards inevitable chronic use. The authors felt that some of the results were consistent with the young physicians expressing a more negative attitude towards drug addicts than they had before they began their work with
addicts.
With few exceptions, studies have demonstrated that professional training for physicians, social workers and nurses was rarely systematic or of sufficient duration to cover the field well. None of the studies provided sufficient information to gauge the quality of teaching or what the models were which underpinned the training. The only exception to this was the recent training advice from the Central Council for Training of Social Workers for Social Workers and Probation Officers. This fact alone must influence the relative importance of training and education in the formation of professional attitudes.

5/ WHAT ARE THE IMPLICATIONS FOR SOCIAL POLICY?
From the mid 1980s until 1994, drug policy, within the United Kingdom has been driven by health issues - especially the fear of HIV/AIDS. Coinciding with the development of HIV/AIDS as the driving force behind drug policy, the estimated numbers of problem drug users has increased at a rapid rate. Prior to the mid 80s, there was an over-reliance on the Home Office Index as the single best indicator of the prevalence of problem drug use. Most problem drug users would not qualify as Home Office Registered "addicts" because of the type of drugs they would normally use and narrow definitions of addiction. Many commentators (Pearson (1986), M. Plant (1993),) and several empirical research studies (Drugs Indicator Project, 1989, etc.) suggest that only a minority of problem drug users come for help even when they feel they need it. There may be a variety of reasons for this such as:
many drug users do not necessarily see their drug use as a problem which can be helped by a professional agency

fear that the service is not confidential

fear that their children may be scrutinised by Social Services

perception that the service is exclusively for opiate users

fear of authority in general, the agency representing that authority

Pearson (1986) pointed out that another reason is to be found in how some drug users who have not had contact with a drug agency perceive the drug workers within the agency, i.e. they feel they may be judgemental. Perhaps this is the case, especially for younger drug users who are new to the agency.

The influence of HIV/AIDS

The discovery of the relationship between HIV/AIDS and drug use was to prove a milestone in both social policy and the attitudes and beliefs held by professionals about problem drug use. Before HIV/AIDS, problem drug use was a public issue because of the connection between crime and drugs. However, in the mid 1980s problem drug use was still rare and mainly a problem of large urban conurbations. It was just one of a series of big city problems.

HIV/AIDS changed the perception of drugs and drug users. The disease was spreading quickly in the United States amongst gay men and injecting drug users. The risk of becoming infected by
HIV/AIDS was seen to be high for injecting drug users and there were thought to be risks that injecting drug users could spread the virus to the public at large through sexual intercourse. The spread of HIV/AIDS to the larger population was possible through several routes, one of which were drug using prostitutes who were doubly at risk from both their occupation and their drug using habits (Plant, 1993).

In May 1987, the Advisory Council on the Misuse of Drugs discussed the problem of the spread of the HIV virus among injecting drug misusers. They decided to establish a Working Group and gave them the following terms of reference;

"To examine the implications of AIDS for drug misuse services and report urgently on measures which can be taken by services to help combat the spread of HIV infection" (Advisory Council on the Misuse of Drugs, 1988, pp.82)

Unlike the previous working party on "Treatment and Rehabilitation" which took 7 years to report, the "Aids" Working Group issued their first report by 1988 and their second report the following year. The report left no doubt as to their point of view;

"The spread of HIV is a greater danger to the individual and public health than drug misuse. Accordingly, we believe that services which aim to minimise HIV risk behaviour by all available means would take precedence in development plans" (Advisory Council on the Misuse of Drugs, 1988, pp.75)
The implications for social policy, treatment and prevention and attitudes towards drug users was enormous. Prevention programmes such as the "Heroin Screws You Up" campaigns which was the British version of the American campaign, "Just Say No" were quietly scrapped. Harm minimisation became the watchword. Needle and syringe exchange programmes, previously rejected as a response to Hepatitis B contagion, were quickly implemented even before the first hint of their evaluation was published. Advice to professionals changed overnight. Previously General Practitioners were warned about the problems of treating problem drug users and urged to send them to treatment agencies. Now GPs were told that they must join the fight instead of just sending them on to other agencies;

"The advent of HIV makes it essential that all GPs should provide care and advice for drug misusing patients to help move them away from behaviour which may result in them acquiring and spreading the virus" (Advisory Council on the Misuse of Drugs, 1988, pp. 76)

The report went on to say that all agencies and every professional group must ensure that they adopt attitudes towards drug users which maximise the chances that they will make themselves known in order to get help. Previous advice from the "Treatment and Rehabilitation" (1982) report which questioned long term prescribing of controlled drugs was discarded. Prescribing was now a means of enticing drug users into contact with helping agencies rather than as a means of achieving abstinence. Abstinence was now the fourth goal in a
hierarchy of goals which began with "cessation of sharing equipment" (Advisory Council on the Misuse of Drugs, 1988, pp.49). It was clear that the most important feature of the problem drug users was his or her capacity to spread HIV/AIDS.

Beliefs about problem drug users in the 1980s

The ideology which underpinned the drug policy of the 1980s suggested particular attitudes and a set of beliefs about problem drug users. Problem drug users were no longer in the grip of a disease (addiction) from which they had no control. The fundamental principle was that of enlightened self interest. Problem drug users could be gently persuaded to present themselves for help if encouraged by non-judgemental agencies giving them what they say they wanted, i.e. clean injecting equipment and prescribed drugs. Education and counselling were the keys to helping them change. The goals of those changes could be negotiated. The time span in which they occurred could be negotiated, as could the drugs they were prescribed. They were no longer so deviant and psychopathic that only Consultant Psychiatrists could offer them help. General Practitioners were encouraged to treat them and even prescribe them drugs.

It may have been social control but at least it was social control with a velvet glove. Beliefs about problem drug users similarly altered. Within treatment agencies, the "normality" of problem drug users was stressed. Problem drug users were seen to be making rational choices, not responding to their
addictive personalities. Therapies, such as cognitive therapy and rational emotive therapy, which emphasized the ability of problem drug users to exercise control became fashionable. Problem drug users were encouraged to take an active part in the running of the agency. Their opinions about the service were solicited. By the early 1990s, many Health Authority Purchasers made user surveys mandatory. All of the above could only be possible if beliefs about the nature of problem drug use and problem drug users were consistent with a view which allowed them to be rational players. If they were simply slaves to their addiction, suffering from personality disorders which, by definition, made them irresponsible, then appeals to their "enlightened self interest" were bound to fail. Gentle persuasion, education, encouraging "responsible" choice became the hallmarks of most treatment agencies. Perhaps the most important aspect of this change was the acceptance that treatment goals had to be negotiated and not offered as a take it or leave it option. A range of goals allowed for problem drug users to choose less risky drug use as a goal rather than abstinence. Clearly, abstinence was not an immediate goal for many of the problem drug users who attended treatment agencies. The policy of acceptance of a hierarchy of goals no doubt opened the door to many problem drug users who would have otherwise felt excluded.
The end of HIV/AIDS as the driving force in drug policy

The worst fears of HIV/AIDS, within the United Kingdom did not transpire. Early projections suggested the possibility of rapid transmission of the disease from high risk groups such as problem drug users. The spread of HIV/AIDS from intravenous drug users to the larger population could have come through transmission from HIV infected sex workers, many of whom were known to be intravenous drug users (Plant et al, 1989). Though this was a reasonable fear in the late 1980s, the situation in the mid 1990s is more hopeful.

For reasons which are still debated, the spread of HIV/AIDS was much slower than expected. Many believed that the quick expansion of treatment agencies coupled with a policy of free and easy access to clean injecting equipment were the key factors. Furthermore, the life span of those infected was lengthened by the careful use of powerful drugs to control infection once AIDS developed. By the early 1990s, HIV/AIDS was no longer the driving force in drug policy.

The evidence to support the hypothesis that public health measures in the United Kingdom avoided the worst case scenarios in relation to the HIV/AIDS epidemic of the mid 1980s is put forward in the editorial section of the influential journal, *Addiction*. The author of the editorial, Professor Stimsom, (Stimsom, 1996) suggests that the public health measure such as needle and syringe exchanges, more access to treatment programmes with more liberal prescribing policies and greater user choice in determining treatment
goals, while HIV prevalence was low, was the key to success. He pointed out that outside London (which has a steady prevalence of 7%), the rest of the England has a prevalence rate of about 1%. Elsewhere, throughout the world, most urban areas saw the increase in prevalence grow to between 40% and 80%. The total number of cumulative cases of AIDS, to March 1995, attributed to drug injecting with the United Kingdom is just 614 cases (Stimson, 1996, pp. 1085). All of this occurred within the framework of greatly increasing numbers of problem drug users. The format for such editorials is to then present several opposite opinions from known "experts" in the field. In this case, the other opinions all agreed with his hypothesis. The only debate was about the weight of the evidence and most of the other opinions were of the belief that Professor Stimson understated his case.

The re-invention of the criminal/deviant addict

By the early 1990s there were already signs that the social policies (and the shift in the paradigm in the beliefs about the nature of problem drug use and users required to sustain that shift) were leading to successful outcomes in relation to HIV/AIDS. Simultaneously, the political climate with regard to law and order was also shifting, but in the opposite direction.

The rise in reported crime (Bean, 1993) and the increase in the estimated numbers of drug users sparked a competition between both major political parties in trying to portray
themselves as "tough on crime". The Labour Party went one better and declared themselves to be "tough on and crime and the causes of crime". No doubt, drug use was seen as a cause of crime. The shift in drug policy quickly followed.

In October 1994, a Green Paper (Tackling Drugs Together) was published for consultation. Within a short time, and little protest besides a few worried drug workers, the new policy was adopted, with few changes from the Green Paper. Whereas, the previous policy was, in the main, left to the Advisory Council on the Misuse of Drugs, the new policy stayed in the hands of senior Conservative politicians. The authors, lead by Tony Newton, Leader of the House of Commons, were the Secretaries of State for Health, Education, the Paymaster General and the Home Secretary. The introduction was signed by the Prime Minister. With such notable political backing there was no doubt about the intent and determination behind the new policy.

The new policy changed the focus of social policy on drugs. From the mid 1980s the prevention of HIV/AIDS was the key to government strategy. From the date of the publication of the, now, White Paper (Tackling Drugs Together) in May 1995 the policy had shifted. Now the objectives were quite different. They were to be found in the first page of the report:

"The strategy is driven by the following Statement of Purpose:

To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:
* increase the safety of communities from drug-related crime;
* reduce the acceptability and availability of drugs to young people; and
* reduce the health risks and other damage related to drug misuse." (The House of Parliament, 1995)

The unreserved commitment to tackle HIV/AIDS was not even mentioned. First on the agenda was to make communities feel safer followed by preventing young people from even trying drugs. After these two, the reduction of health risk and other damage came a poor third. The shift from public health issues to law and order issues was explicit. Behind the change in policy was the fear of drug use as the source of what was perceived to be increasing crime. No evidence was put forward to suggest that the effect of illicit drugs on behaviour was the source of crime. Ironically, it is alcohol which lowers inhibitions, which may well have the most harmful effect on behaviour. The relationship was seen to be the need to finance excessive drug habits through property crime. The loss of volition by the "addict" could only be supported by a medical/biological model, the least acceptable of all the models.

Along with the new strategy came new institutions. In order to ensure that the new strategy was implemented, Drug Action Teams were organised to give local expression to the new policy. Since the late 1960s, the Health Authority was the key agency. Under the new Drug Action Teams, law enforcement (with three representatives from the Police, Probation and Prison
Service) looks to play the dominant role. New moneys are already being channelled through the Drug Action Teams in areas traditionally claimed by Health Authorities, such as the treatment of young people with drug problems. In many ways this is a shift in paradigm, back to the biological/medical model which stressed the "personality disorder" of drug users. The consensus of the 1980s about the nature of problem drug use and the policy which flowed from (or at least with) that consensus was shattered by Tackling Drugs Together. The policy, however, was not without favour from other parties. The Labour Party broadly supported the new policy. Recently the then Shadow Home Secretary, Jack Straw, announced at the 1996 Labour Party Conference plans to give courts the power to order mandatory drug testing and treatment in cases involving drugs offences (Guardian, October 4, 1996). It will be up to the Probation Service to determine the role of drug taking in the offence. They will have new powers to insist upon drug tests. The willingness of the Probation Service to go along with this new scheme may be no better than their willingness to comply with the new "Treatment Orders" within the Criminal Justice Act.

Many treatment agencies have refused to accept Probation Orders with a condition of treatment. That is not to say that they have refused treatment to problem drug users but they have not accepted responsibility for reporting to the courts about non-compliance with treatment, illicit drug use, etc. In order for courts to sentence an offender to a Probation Order with a condition on treatment, they must have confirmation
that the treatment agency will report to the court, with or without the consent of their clients. Many treatment agencies, such as the Leicestershire Alcohol and Drug Team, have decided in principle not to accept such conditions. The refusal is based on two arguments. Firstly, it would interfere with current policies on confidentiality. This is a key issue if problem drug users are to be encouraged to come for help. Secondly, it makes the formation of a "therapeutic alliance" more difficult.

If the proposed policy of using treatment agencies as instruments of the court is enacted, the nature of treatment could be altered. Problem drug users who are not offending and part of the criminal justice system could find that they need to wait for treatment. In the United States, the frustration of courts of their inability to control voluntary drug treatment agencies led the courts to develop their own treatment agencies with the Judge as director of the agency. It is beyond the scope of this section of the thesis to consider whether coercive treatment leads to different outcomes from voluntary treatment. What is noteworthy is that this issue was not regarded as being of sufficient interest to investigate before court treatment orders were made part of a new drug policy.

Models of the future

There were three striking features of the response of drug workers to the questionnaire. The first was the uniformity of belief about the origins of problem drug use. The model which drew the most support overall was the economic/social theory.
followed closely by the psychological theory. However, the theory which drew the most support in terms of the treatment section of the theory was the psychological theory. This combination (overall preference of the social/economic theory and a preference for the treatment section of the psychological theory) was particularly robust. It is a model that fits the policy of harm reduction well.

A harm reduction model makes assumptions about the nature of problem drug use that includes aspects of the Psychological model and the Social/economic model. Problem drug users are believed to be capable of persuasion, i.e. education and learning, and rational and able to change their behaviour in the own self interest. A Medical/biological model suggests an involuntary response to drug use which does not alter through treatment. Control through sanctions is seen as the best option.

The recent change to "Tackling Drugs Together" suggest another model which may not fit as well into the beliefs of problem drug users or drug workers. The beliefs of those who are the target of that policy and those who have to carry out that policy is a crucial element in implementing policy. Despite the new policy, which has been operational for nearly 3 years, there seems to be little change in how agencies perform their duties. The one exception is that some agencies have entered the field of drug counselling in prisons but only when they were able to secure extra funding to do it. They have not given up any of their traditional methods of working in order to comply with new policy. The previous policy of harm
reduction in order to prevent the spread of HIV had enormous support from drug workers, hence their commitment to harm reduction on the questionnaire. Changing to a social control model may be more difficult than it at first seems.

Since the 1920s, the so called "British System" has developed a less than systematic yet pragmatic policy towards problem drug use. The main feature of that policy has been a balancing of legal and health objectives which may have created a degree of tension between the Home Office and the Department of Health but also a consensus amongst most practitioners. A swing towards the use of the criminal justice system to the detriment of health orientated treatment programmes could fracture that consensus.

Finally, the issue of beliefs is essential in the implementation of social policy. Without a consensus, the ability of government to carry out policy is undermined. Individuals who work in drug agencies, ever distrustful of government intentions, will undermine social policy if their beliefs are not accounted for by that policy. Problem drug users, even more distrustful of government agencies than drug workers, could be further alienated.


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Appendix

Drug Workers

Correlation between questions within the Social Economic Model

Q4  .2159  Spearman Correlation  
N( 304)  Number  
Sig .000  Level of Significance  

Q6  .2000  .3621  
N( 268) N( 270)  
Sig .000 Sig .000  

Q10  .1091  .2039  .2594  
N( 302) N( 307) N( 269)  
Sig .029 Sig .000 Sig .000  

Q12  .2012  .3298  .2728  .2708  
N( 301) N( 303) N( 268) N( 301)  
Sig .000 Sig .000 Sig .000 Sig .000  

Q14  .1846  .4068  .3107  .2518  .3671  
N( 293) N( 296) N( 259) N( 293) N( 293)  
Sig .001 Sig .000 Sig .000 Sig .000 Sig .000  

Correlation between questions within the Medical/Biological Model

Q5  .5570  Spearman Correlation  
N( 285)  Number  
Sig .000  Level of Significance  

Q7  .3346  .3941  
N( 292) N( 291)  
Sig .000 Sig .000  

Q8  .2923  .2803  .3136  
N( 290) N( 289) N( 298)  
Sig .000 Sig .000 Sig .000  

Q11  .1102  .1600  .2623  .3973  
N( 294) N( 293) N( 303) N( 301)  
Sig .030 Sig .003 Sig .000 Sig .000  

Q2  Q5  Q7  Q8
Drug Workers

Correlation between questions within the Psychological Model

Q9  .2878 Spearman Correlation
    N( 290) Number
    Sig .000 Level of Significance

Q13 .2198 .2827
     N( 280) N( 286)
     Sig .000 Sig .000

Q15 .3590 .1826 .0848
     N( 284) N( 284) N( 275)
     Sig .000 Sig .001 Sig .080

Q17 .0832 .1610 .1829 .0974
     N( 298) N( 300) N( 287) N( 289)
     Sig .076 Sig .003 Sig .001 Sig .049

Problem Drug Users

Correlation between questions within the Social Economic Model

Q4  .0172 Spearman Correlation
    N( 127) Number
    Sig .424 Level of Significance

Q6  .0523 .1759
    N( 106) N( 115)
    Sig .297 Sig .030

Q10 .1227 .2213 .2761
     N( 125) N( 137) N( 111)
     Sig .086 Sig .005 Sig .002

Q12 -.0034 .2756 .1345 .2163
     N( 121) N( 133) N( 111) N( 131)
     Sig .485 Sig .001 Sig .080 Sig .007

Q14 -.0783 .2856 .1784 .2703 .3187
     N( 116) N( 128) N( 105) N( 128) N( 125)
     Sig .202 Sig .001 Sig .034 Sig .001 Sig .000

Q1 Q4 Q6 Q10 Q12
Problem Drug Users

Correlation between questions within the Medical/Biological Model

Q5  .2484  Spearman Correlation
    N( 105)  Number
    Sig .005  Level of Significance

Q7  .2095  .1579
    N( 113)  N( 108)
    Sig .013  Sig .051

Q8  .0863  .1345  .2162
    N( 114)  N( 110)  N( 123)
    Sig .181  Sig .081  Sig .008

Q11  -.0037  .0650  .1102  .0741
    N( 111)  N( 109)  N( 116)  N( 119)
    Sig .485  Sig .251  Sig .119  Sig .212

Q2  Q5  Q7  Q8

Correlation between questions within the Psychological Model

Q9  .0898  Spearman Correlation
    N( 124)  Number
    Sig .161  Level of Significance

Q13  .0712  .1505
    N( 127)  N( 122)
    Sig .213  Sig .049

Q15  .4141  .0733  .1404
    N( 126)  N( 122)  N( 125)
    Sig .000  Sig .211  Sig .059

Q17  .0421  .1217  .2507  .1354
    N( 127)  N( 124)  N( 126)  N( 125)
    Sig .319  Sig .089  Sig .002  Sig .066

Q18  .4803  .1228  .2338  .3391  .2281
    N( 131)  N( 127)  N( 128)  N( 128)  N( 130)
    Sig .000  Sig .084  Sig .004  Sig .000  Sig .005

Q3  Q9  Q13  Q15  Q17
Dear Drug Worker,

My name is Ira Unell. I work full time for the Nottingham Alcohol and Drug Team and I'm also doing research at Loughborough University. I am interested in finding out what people who work in agencies for problem drug users and problem drug users themselves believe about drug use. I am asking for your help in completing the following questionnaire.

* All questionnaires will be totally confidential. Those agencies which help me will get a report on the combined total results but will not see individual questionnaires. DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE.

* If you do not wish to answer the question, please LEAVE THE ANSWER BLANK. If you do not know the answer, tick the box 'Don't Know'.

If you have any questions, please feel free to ask me. If I am not around, please ask your line manager.

THANK YOU FOR HELPING ME
Firstly, please could you tell us a little about yourself:

<table>
<thead>
<tr>
<th>Your job title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of agency</td>
</tr>
<tr>
<td>How long have you worked at this agency? Years Months</td>
</tr>
<tr>
<td>Full time of Part Time? (F or P)</td>
</tr>
<tr>
<td>How long have you been working with problem drug users Years Months</td>
</tr>
<tr>
<td>Have you ever been a problem drug user yourself? (Y/N)</td>
</tr>
<tr>
<td>If YES was your problem with: drugs ... (tick) and/or alcohol .....</td>
</tr>
<tr>
<td>Gender ('M' or 'F')</td>
</tr>
<tr>
<td>Age last birthday</td>
</tr>
<tr>
<td>Ethnicity (CRE categories)</td>
</tr>
<tr>
<td>A = Afro/Caribbean. C = Caucasian.</td>
</tr>
<tr>
<td>I = India/Pakistan. O = Oriental.</td>
</tr>
<tr>
<td>X = Other/Mixed race</td>
</tr>
<tr>
<td>R = Refuse to categorise</td>
</tr>
</tbody>
</table>

Education/Qualifications.

<p>| How many 'O' levels, CSE grade I, and/or GCSEs do you have?                    |
| Please TICK ANY of the following certificates or qualifications that you have: |
| 'A' Levels                                                                     |
| F.E. Certificate (eg. HNC, HND)                                                |
| Degree                                                                         |
| Post graduate degree (eg. Masters/PhD/Diploma)                                 |</p>
<table>
<thead>
<tr>
<th>Profession</th>
<th>Tick</th>
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<tbody>
<tr>
<td>Doctor</td>
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<td>Social Worker</td>
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<tr>
<td>Clinical Psychologist</td>
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<tr>
<td>Occupational Therapist</td>
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</table>

What professional qualifications do you have:
1. A more caring and equal society would do more to help problem drug users than any treatment programme.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

2. Genetic influence is an important factor in becoming a problem drug user.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

3. Problem drug users have difficulties expressing their emotions because their parents did not allow them to do so.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

4. Economically deprived people are more likely to become problem drug users than other more advantaged people because of poor housing, lack of opportunity, and unemployment.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

5. There are biological differences between problem drug users and those who are not problem drug users.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

6. Racism and sexism are major contributing factors in problem drug use among black people and women.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

7. Problem drug use is a disease like schizophrenia or other forms of mental illness.

   Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □
8. Once someone becomes a problem drug user, if abstinence is achieved, even one injection of a psychoactive drug will probably lead to problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

9. Only when problem drug users begin to make new, non-exploitative relationships can their drug use change.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

10. If poverty and inequality would disappear, so would problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

11. Abstinence is the only realistic goal for problem drug users, attempts at control are bound to fail.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

12. The hopelessness which most problem drug users experience is caused more by poverty than by their problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

13. Problem drug users particularly benefit from group work because it helps them work on their relationship problems.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

14. If there is a rise in unemployment, there will almost certainly be a rise in problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

15. Most problem drug users come from broken homes.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □
16. Prescribing Methadone is important because it helps reduce cravings, control withdrawals and makes drug use less enjoyable.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

17. One must help problem drug users with their psychological problems if they are to become abstinent or reduce the harm of their drug use.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

18. Problem drug users have difficulties forming relationships because of unresolved problems in their childhood.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

19. My goals are the same as the agency I work for.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

20. The government and authorities are more interested in controlling problem drug users than in helping them.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

21. I feel that I have an influence over how this agency uses resources and develops policy.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

22. Most problem drug users see this agency as too controlling.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

23. There are no major differences in the aims and objectives of this agency and those of the Department of Health and the Home Office.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

Attitudes and Beliefs Questionnaire

Please turn over ... Page 5.

410
24. Harm reduction is an important part of this agency's work.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

25. I see this agency as too controlling.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

26. Harm reduction is an important part of my work.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

27. Government policy often pays lip service to harm reduction but in reality fails to carry it through.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

28. The objectives of my team leader or manager are often quite different from mine.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □

PLEASE TURN PAGE
29. When you see your clients/patients face to face, how often do you talk about the following issues: (Please TICK ONE in each case)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Often</th>
<th>Some Times</th>
<th>Never</th>
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<tbody>
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<td>Relationships</td>
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<tr>
<td>Other problems (Specify below)</td>
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</tbody>
</table>

30. When you see your clients/patients face to face, which issues do you feel they need the most help with? (Please TICK ONE in each case)

<table>
<thead>
<tr>
<th>Issue</th>
<th>No Help</th>
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<th>Most Help</th>
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Dear Drug Service User,

My name is Ira Unell. I work full time for the Nottingham Alcohol and Drug Team and I'm also doing research at Loughborough University. I am interested in finding out what people who work in agencies for problem drug users and problem drug users themselves believe about drug use. I am asking for your help in completing the following questionnaire.

* All questionnaires will be totally confidential. Those agencies which help me will get a report on the combined total results but will not see individual questionnaires. DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE.

* If you do not wish to answer the question, please leave the answer blank. If you do not know the answer, tick the box 'Don't Know'.

If you have any questions, please feel free to ask me. If I am not around, please ask your key worker.

THANK YOU FOR HELPING ME!
Firstly, please could you tell us a little about yourself:

Gender ( M or F )

Age last birthday

Ethnicity
- A = Afro/Caribbean.
- C = Caucasian.
- I = India/Pakistan.
- O = Oriental.
- X = Other/Mixed race
- R = Refuse to categorise.

Which drugs have you regularly used in the past or use now:

* Opiates (eg. Heroin, Methadone)
* Stimulants (eg. Amphetamine, Cocaine, Crack, Ecstasy)
* Barbiturates (eg. Tuinal, Seconal)
* Hallucinogenics (eg. LSD, Magic Mushrooms)
* Inhalants (eg. glue, lighter fluid, butane gas)
* Cyclizine (eg. Valoid, Marzine)
* Others (Specify)

The one drug I prefer is (Specify)

I am currently receiving a prescription for (Specify)

From this agency
From another agency or GP

Education/Qualifications:

How many 'O' levels, CSE grade I, and/or GCSEs do you have?

Please TICK ANY of the following certificates or qualifications that you have:

'A' Levels
F.E. Certificate (eg. HNC, HND)
Degree
Post graduate degree (eg. Masters/PhD/Diploma)
1. A more caring and equal society would do more to help problem drug users than any treatment programme.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

2. Genetic influence is an important factor in becoming a problem drug user.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

3. Problem drug users have difficulties expressing their emotions because their parents did not allow them to do so.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

4. Economically deprived people are more likely to become problem drug users than other more advantaged people because of poor housing, lack of opportunity, and unemployment.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

5. There are biological differences between problem drug users and those who are not problem drug users.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

6. Racism and sexism are major contributing factors in problem drug use among black people and women.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

7. Problem drug use is a disease like schizophrenia or other forms of mental illness.

   - Strongly agree □
   - Agree □
   - Neutral □
   - Disagree □
   - Strongly disagree □
   - Don't know □

Attitudes and Beliefs Questionnaire
8. Once someone becomes a problem drug user, if abstinence is achieved, even one injection of a psychoactive drug will probably lead to problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

9. Only when problem drug users begin to make new, non-exploitative relationships can their drug use change.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

10. If poverty and inequality would disappear, so would problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

11. Abstinence is the only realistic goal for problem drug users, attempts at control are bound to fail.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

12. The hopelessness which most problem drug users experience is caused more by poverty than by their problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

13. Problem drug users particularly benefit from group work because it helps them work on their relationship problems.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

14. If there is a rise in unemployment, there will almost certainly be a rise in problem drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

15. Most problem drug users come from broken homes.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

Please turn over ...

Page 2.
16. Prescribing Methadone is important because it helps reduce cravings, control withdrawals and makes drug use less enjoyable.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

17. One must help problem drug users with their psychological problems if they are to become abstinent or reduce the harm of their drug use.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

18. Problem drug users have difficulties forming relationships because of unresolved problems in their childhood.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

19. My goals are the same as the agency I come to for help.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

20. The government and authorities are more interested in controlling problem drug users than in helping them.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

21. I feel that I have an influence over how this agency uses resources and develops policy.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

22. Most problem drug users see this agency as too controlling.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

23. There are no major differences in the aims and objectives of this agency and those of the Department of Health and the Home Office.

Strongly agree □ Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

Attitudes and Beliefs Questionnaire

Please turn over ...
Page 3.
24. Harm reduction is an important part of this agency's work.

Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

25. I see this agency as too controlling.

Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

26. Harm reduction is an important part of what I hope to achieve.

Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

27. Government policy often pays lip service to harm reduction but in reality fails to carry it through.

Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

28. The objectives of my key worker are often quite different from mine.

Agree □ Neutral □ Disagree □ Strongly disagree □ Don't know □

29. My key worker is a:

Social Worker □ Doctor □ Nurse □ Don't know □ Other □

Specify ____________________

Attitudes and Beliefs Questionnaire

Please turn over ... Page 4.
30. When you see your key worker, at this agency, how often do you talk about the following issues:

(Please TICK ONE in each case)

<table>
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31. What issues do you feel you need the most help with?

(Please TICK ONE in each case)

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Attitudes and Beliefs Questionnaire

Page 5.