

IMPROVING SERVICE PROVISION BY NON-SPECIALIST ADVISORS: THE IMPACT OF DRUGS AWARENESS TRAINING ON PERCEIVED LEVELS OF ROLE LEGITIMACY, ADEQUACY AND SATISFACTION

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Abstract

Drug use for other than medical reasons, whether of legal or illicit substances, is highly stigmatised (McPhee, Duffy, & Martin, 2009). Some drug users experience a range of health and social problems that impact on both their own lives and those of many others (Scottish Government, 2008). There is evidence to suggest that staff providing care for drug users may not possess the necessary knowledge, attitudes, or skills to enable them to work effectively with this client group (Siegfried, N., Ferguson, J., Cleary, M., Walter, G., & Rey, J.M., 1999; Royal College of Psychiatrists, 2002). Attitudes have long been considered to be predictors of behaviour (La Piere, 1934; Ajzen, 1991; Eagley & Chaiken, 1993). This study reports on the evaluation of the impact of a three-day alcohol and drug awareness training programme, which was provided for 38 personal advisors (PAs) for young vulnerable people based in a government funded criminal justice project in London. A comparison of pre- and post- programme questionnaires showed that participants significantly improved their attitudes to working with, and having confidence in the engagement of young people with drug problems. Positive changes were also observed in relation to participants' role legitimacy, role adequacy, and role support. A positive but non-significant change in participant motivation was identified

Introduction

Continued attention and concern is expressed on the nature and extent of the problems associated with the misuse of drugs by young people (NHS, 2011). Increased patterns and prevalence of drugs use among young people in the UK prompted the development of many statutory and non-statutory organisations designed to intervene with young people who may have problems due to their use and misuse of alcohol and drugs. It has been suggested that staff attitudes are important factors in determining staff responses to alcohol and drugs misuse in their clients (Duffy, Holtum, & Keegan, M., 1998; Shaw, Cartwright, Spratley, & Harwin, 1978; Skinner, Roche, Freeman, & Addy, 2005; Watson, Maclaren, & Kerr, 2007). Such studies note the importance of adequate and relevant training in developing positive attitudes towards working with people misusing alcohol and drugs. Despite the relative importance and availability of training, there is a lack of research evidence on its effectiveness (Gorman, 1993). A review of such training programmes

suggests that short educational programmes have limited impact on staff attitudes, and are more successful in increasing knowledge (Duffy, et al., 1998; Skinner et al, 2005). One major theory posited by Shaw et al. in 1978 suggested that training has a particular effect on attitudes relating to role security and role adequacy and that background characteristics of training participants, such as occupational role and support, are also important in determining the impact of training on attitude change. The aim of this study is to investigate the impact of a three-day alcohol and drugs awareness programme delivered by academic personnel from a university in the west of Scotland. Participants on the course were personal advisors working in a non-statutory organisation in London. The personal advisors were not alcohol and drug specialist counsellors, but they came across such problems with the young people they worked with on a regular basis.

In the seminal work by Shaw et al. (1978), they proposed that poor responses by non-specialists in addiction in working with alcohol users were related to their knowledge and attitudes. They proposed that knowledge and attitudes could be altered by an educational intervention such a training event. The three main themes emerging from their study suggested that staff anxieties about role adequacy, role legitimacy and support of them by other staff contributed overall to what they termed *therapeutic attitude*. Within this current study, an adapted version of Shaw et al.'s AAPPQ was used to measure staff attitudes in relation to *role adequacy*, *role legitimacy* and *role support*. A description of each of these criteria is noted below.

Role Legitimacy

Shaw et al. (1978) also identified that those workers who considered that they lack the authority to intervene in a specialist subject (in this case 'alcoholism') often express anxiety about their role legitimacy. In particular, they are often uncertain about their professional boundaries and may consider that addicted clients are a mental health or specialist medical or psychiatric issue. This uncertainty is often compounded by tasks that may be considered out of areas that they believed themselves to be competent. Such role legitimacy often results in workers being reluctant to raise the issue of addiction with their clients.

Role Adequacy

According to Shaw et al., (1978) anxieties about role adequacy are related to workers feelings about their lack of required knowledge and skills necessary to recognise and respond positively to addiction problems in an effective manner. The participants in the Shaw et al. study had little knowledge in this area and were therefore unable and often unwilling to respond to an area that was deemed 'specialist'. This resulted in referrals of people with drug related problems to specialist drug counselling agencies. This was a common theme amongst participants in this study prior to their participation in the training programme.

Role Support

The third aspect of the study by Shaw et al (1978) related to the workers' belief that they were not being supported by specialist services and that they

perceived they had little in common and consequently minimal communication with them. The workers therefore received no assistance in terms of advice, support and consultation about the most effective option of engaging with drug users who were experiencing problems in their use of illicit drugs. The workers also considered that their managers and colleagues did not/were not able to support them in their role. This led to feelings of isolation and anxiety in workers. Ford, Bammer, and Becker (2009) observed that providing staff with drug education without appropriate support has no impact on trainee therapeutic attitude.

According to Shaw et al. (1978), the above three areas are considered to interact in a complex relationship, and workers who exhibit these factors are described as having *role insecurity*. This may be linked to a lack of training and experience of engaging with what is considered a complex set of psychiatric and medical problems that are out-with the remit of non-specialists. This role insecurity in turn fosters an emotional detachment and physical disengagement with clients with alcohol or drug problems and is termed low *therapeutic commitment* (Cartwright, 1980; Shaw et al., 1978). Non-specialists can be seen to have low therapeutic commitment, and therefore role insecurity, if demonstrating the following attitudes and behaviours:

- Avoiding alcohol or drugs problems in their clients by denying its existence
- Prioritising other issues over the alcohol or drug use
- Referring clients with alcohol or drug problems to *specialists*
- Feeling hopelessness that nothing can be done with this client group
- Blaming the client for the situation due to their lack of ‘motivation’ or will- power to change
- Accepting and colluding with drink and or drugs use.

These attitudes and behaviours are due in a large part to the lack of adequate training in order to effectively intervene with problem drink and drugs users. Consequently Shaw et al. (1978) found that workers with a high therapeutic commitment had four basic characteristics that strengthened their role: (a) they had a good knowledge of drug related issues; (b) they had received training in working with problem drugs users; (c) they were experienced in working with problematic drug users; and (d) they were provided appropriate and effective support in conducting this role. Shaw et al., (1978) concluded that basic role requirements such as training, experience, confidence and support help develop *role security*, which in turn fostered and supported a high therapeutic commitment. Gorman (1993) notes the need for providers of training courses to appropriately evaluate the impact of their training provision. The following section outlines the methodology put in place to evaluate this specific training programme.

Methodology and Data Collection

This study was conducted following a five-stage approach.

Stage 1: Adaptation of AAPPQ

The Shaw and Cartwright (1978) self-assessment instrument (AAPPQ) was adapted for use in this study. Within the instrument participants are invited to respond on a 4-item likert scale where 1 = Strongly Agree, 2 = Agree, 3 = Disagree and 4 = Strongly Disagree. Each item is positively worded. However, scores were reverse coded so that a high score indicates a desirable response. The questionnaire consisted of 22 items. Within the original AAPPQ the focus of assessment related solely to alcohol. In the revised version, the focus was on drugs, with alcohol being included as a drug. One example of the questions asked is, "I feel I have a working knowledge of drugs and drug related problems."

Stage 2: Time 1 Completion of AAPPQ

All participants in this study were Personal Advisors (PAs) and team leaders affiliated to a non-statutory, non-specialist agency in London. The PAs helped young vulnerable people achieve qualifications by advising and guiding on enrolment at a school, college, or university. Some acted as career advisers, and acted as advocates, linking the young people to other helping agencies, voluntary work and leisure activities. In their role within their government funded criminal justice agency they would often come across young people with drug or alcohol related problems. Although the PAs were often office based, part of their role included accessing young people in schools, colleges, and universities and in the community on the street. Assisting young people with such problems was not their primary role; however there was interest and an identified need to deal more effectively with such client groups. Hence, their participation in this training and study programme.

Prior to commencement of the alcohol and drug awareness training programme, PAs were invited to complete the AAPPQ self-assessment instrument. This measured participants' responses to their perceived skills and attitudes to drug and alcohol use in relation to the role adequacy, role legitimacy and role support sub-scales identified by Shaw and Cartwright (1978).

Stage 3: Alcohol and Drug Awareness Training Programme

Participants attended a three-day alcohol and drug awareness programme. The three-day workshop consisted of short PowerPoint presentations, multimedia presentations, small group exercises, focused case study vignettes facilitated realistic and relevant skills demonstration, skill rehearsals and evaluation. Participants were provided with additional information packs which included journal articles, directed reading relevant to the learning outcomes, and web links for further reading in the virtual learning environment blackboard. Learning outcomes of the programme were negotiated in advance with the agency senior management team. These were:

- a) Increased knowledge of drugs and their effects including alcohol,
- b) Understand drugs use historically and currently,

- c) Understand how theories of addiction determine interventions,
- d) Understand core skills of brief interventions, including motivational interviewing, problem solving and goal setting, and
- e) To explore workers support requirements and organisational constraints in implementing brief interventions with young people.

Stage 4: Time 2 Completion of AAPPQ

Three weeks after the alcohol and drug awareness programme, participants were invited to complete the AAPPQ. The intention of this stage was to identify changes in AAPPQ scores over time.

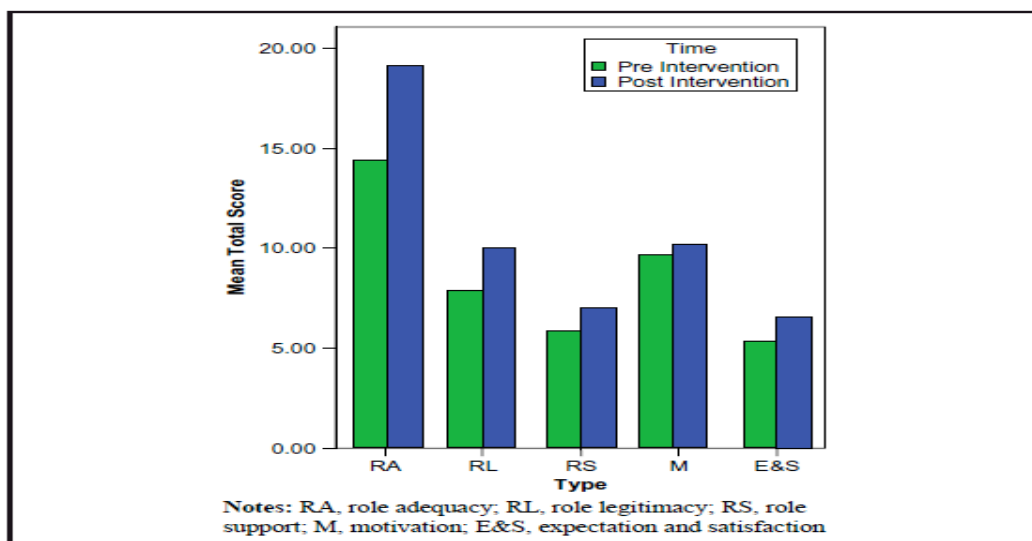
Stage 5: Data Input and Analysis.

Time 1 and Time 2 AAPPQ data for each participant were coded to enable identification of the participants. Reverse coded data from the completed questionnaires was then input into the statistical package SPSS. Data from participants who did not complete all components of the three-day programme were automatically excluded from the data analysis procedure. Data were analysed using 5-paired samples T-tests.

Results

Sixteen participants fully attended the training programme and completed the AAPPQ questionnaires both at Time 1 (at the beginning of day 1 of the training programme) and Time 2 (three weeks after the training programme).

A higher score indicates a desirable response - the higher the score, the more positive the attitudes in that category. As can be seen in Figure 1 below, all Time 2 mean total scores for the 16 participants are higher than Time 1 scores. This indicates that all scores on each of the criteria measured have improved from pre-training to three weeks after training.



RA = Role adequacy; RL = Role legitimacy; RS = Role Support; M = Motivation; E&S = Expectation and Satisfaction

Figure 1. AAPPQ Time 1 and 2 results.

The mean score was calculated for each of the five facets of Role Adequacy, Role Legitimacy, Role Support, Motivation and Expectation & Satisfaction). Pre-score is the baseline measure taken before the training intervention began. Post-score refers to the score on the follow-up questionnaire administered three weeks after the training intervention.

Data analysis was conducted using five 'paired samples' T-tests. As can be seen in Table 1 below, statistically significant improvements in AAPPQ scores were observed in relation to participant scores in Role Adequacy, Role Legitimacy, Role Support, Expectation & Satisfaction but not in Motivation.

Table 1

Overview of Pre- and Post- Training Scores on Revised AAPPQ

AAPPQ sub-scales (n = 16, df = 15)		t	p
Role Adequacy (Pre)	Role Adequacy (Post)		
Mean 14.38 (SD 2.25)	Mean 19.25 (SD 2.75)	5.73	**p< .0005
Role legitimacy (Pre)	Role Legitimacy (Post)		
Mean 7.81 (SD 1.52)	Mean 10.13 (SD 2.13)	4.90	**p< .0005
Role Support (Pre)	Role Support (Post)		
Mean 5.81 (SD 1.38)	Mean 7.00 (SD 1.67)	3.45	**p< .004
Motivation (Pre)	Motivation (Post)		
Mean 9.63 (SD 1.82)	Mean 10.37 (SD 1.82)	1.82	**p< .09
Expectation and Satisfaction (Pre)	Expectation and Satisfaction (Post)		
Mean 5.31 (SD 1.08)	Mean 6.56 (SD 1.03)	3.87	**p< .002

Discussion

It is clear from the Time 1 and Time 2 results that statistically significant changes have taken place in relation to participants' therapeutic commitment over the three-week assessment period. This indicates that these non-specialist workers perceive themselves as more able to work effectively with clients misusing alcohol and/or drugs. Such a role is normally recognised as being the realm of *addiction specialists* only.

Lightfoot and Orford (1986) suggest that educators should be aware of factors they termed *situational determinants* when providing such training. Situational determinants can include factors such as lack of priority within their

organization, little encouragement to engage with such a client group and lack of supervision. These factors may contribute to negative attitudes and educators should be aware of this when delivering interventions designed to influence therapeutic commitment. To this end, the three- day training event by the University staff concentrated on promoting and clarifying role ambiguity, enhancing the motivation of participants in engaging with what is often considered to be a difficult client group, and finally in increasing their role legitimacy. The measures used in this pilot study were assessing therapeutic commitments (Cartwright 1980), based on the research conducted by Shaw et al. (1978).

Conclusion

It is possible that the training and the effects of other variables made the participants aware of the *hill that they now had to climb* on completion of the three-day training intervention. It is possible that that they are more aware of the issues surrounding the effective engagement with young people who may have issues related to the misuse of illegal drugs.

Also, it should be noted that although changes in levels of motivation were not statistically significant between Time 1 and Time 2, this might be due to the high levels of motivation and commitment to engage with this client group in the base line measure at Time 1. That is, there was little change over the three weeks as these participants were highly motivated already.

It is also possible that further research with a larger group of participants and a longer period between Time 1 and Time 2 would enable more sophisticated statistical and correlation analysis.

The results of this study indicate that participants in this study increased their *therapeutic commitment* to drug using clients between Time 1 and Time 2. It must however be noted that this was a very small sample with only 16 participants completing the revised AAPPQ at Time 1 and Time 2. The inclusion of team leaders within the context of the study may also have facilitated support for the positive effects observed.

The significant findings in this small study indicate strongly that a training module in alcohol and drugs awareness delivered by university trainers can enhance attitudes and increase knowledge and confidence of working with drugs users who are highly stigmatised. After completion of the training event, the participants all reported more positive attitudes to drugs using clients, suggesting that such training programmes can benefit the non-specialist participants who are required in their job remit to engage with drug using clients.

The criminal justice agencies that the PA's were employed in were set up by the UK government to help reduce crime considered to be related to drug misuse. This training input has equipped the PA's with the necessary skills, knowledge and role support to identify 'at risk' young people and to design and implement relevant interventions with the aim of reducing the impact of drug related harms and offending.

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