

Effective Interventions Unit

Measuring staff attitudes to people with drug problems: The development of a tool

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SUMMARY

The aims of this study were:

- to evaluate the psychometric properties of a new instrument, the Drug and Drug Problems Perceptions Questionnaire (DDPPQ), which was designed to measure mental health professionals' attitudes to working with drug users
- to pilot a variation of the DDPPQ designed to assess the attitudes of practitioners to individuals who have co-existing mental health and substance misuse problems. This second instrument was the Comorbidity Problems Perceptions Questionnaire (CMPPQ).

The study was conducted in two stages. In the first stage, an existing instrument, called the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPQ) was modified to form the DDPPQ. Analysis was then undertaken to determine the reliability and validity of the DDPPQ. In the second stage, the CMPPQ was developed and piloted to assess its content validity.

Further details of the development and validation of both tools are given in the full report of the study, which is available from the Effective Interventions Unit upon request.

INTRODUCTION

This study was undertaken to evaluate the psychometric properties of a new instrument, the Drug and Drug Problems Perceptions Questionnaire (DDPPQ), which was designed to measure mental health professionals' attitudes to working with drug users. A further aim of the study was to pilot a variation of the DDPPQ to assess the attitudes of practitioners to individuals who have co-existing mental health and substance misuse problems. It was funded as part of the EIU research competition in November 2001 from the Scottish Executive's Drug Misuse Research Programme.

BACKGROUND TO THE STUDY

Drug use for other than medical reasons, whether of legal or illicit substances, carries considerable risk, and many drug users experience a range of health and social problems which impact on both their own lives and those of many others. There is evidence that problematic drug use is increasing. Figures, published in a report of drug use in the UK, indicated that there were 2,207 new referrals to drug services in Scotland over a 6 month period in 1993. Over the corresponding period in 2000 this number was found to have risen to 4,789 (Drugscope 2003). ISD statistics also highlight the frequency with which drug users attend general acute hospitals, GPs, maternity hospitals, and psychiatric services (ISD 2003). Staff who work within such environments, therefore, are increasingly required to provide care for people with problems associated with their substance use.

Co-existing substance misuse and mental health problems also represent an increasing and complex challenge to the mental health, social and fiscal services (Crome 1999, Scottish Executive Health Department 2000). There is evidence to suggest that staff who provide care for drug users, and those who have co-existing problems, may not possess the necessary knowledge, attitudes, or skills

to enable them to work effectively with this client group (Siegfried et al 1999, Royal College of Psychiatrists 2002).

Attitudes have long been known to be predictors of behaviour (La Piere 1934, Ajzen 1991, Eagley and Chaiken 1993). The attitudes, which members of the health professions hold towards the individuals for whom they care, have been found to impact on the quality of care delivered (Moodley-Kunnie, 1988). Since attitudes can also impact on the extent to which knowledge is accepted and used in practice, staff attitudes towards individuals with substance misuse problems play an important part in the management of this client group. This view is recognised by the Scottish Executive which has highlighted attitudes of staff as *'the cornerstone of therapeutic activity'* (Scottish Executive Health Department 2002, page 9).

Valid tools currently do exist for the measurement of attitudes to problem drinkers and to those with mental health problems, namely the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ, Appendix 1) and the Mental Health Problems Perceptions Questionnaire (MHPPQ, Appendix 2).

The original questionnaire, the AAPPQ, was developed by Shaw *et al* (1978), who maintained that therapeutic attitudes and commitment are influenced by practitioners' concepts of Role Adequacy, Role Legitimacy, and Role Support. Role Adequacy refers to the fact that practitioners who feel adequately prepared for the role view themselves as having appropriate knowledge. The term Role Legitimacy was used by Shaw *et al* to describe the extent to which people regard particular aspects of their work as being their responsibility. Role Support relates to the support which practitioners acknowledge receiving from colleagues to help them to perform their role effectively. Shaw *et al* suggest that the presence of these factors enhances motivation to work with problem drinkers, expectations of satisfaction, and professional self-esteem when engaging with them in therapeutic activity.

Given the acknowledged importance of attitudes, it is essential that reliable and valid means are available to assess attitudes of people who work with substance users, and those with co-existing mental health problems. Such tools could provide a useful aid in reaching decisions about the recruitment of staff who demonstrate therapeutic commitment and are attitudinally suited to work with drug users. In addition, they could be used to determine individuals' continuing professional development needs, and to evaluate the effectiveness of educational programmes.

In the study presented in this report, the AAPPQ was revised to form the DDPPQ (Appendix 3) as a tool to measure the attitudes of mental health professionals to drug users. This summary report provides some information on how the reliability and validity of the DDPPQ were evaluated. Further details are given in the full report which is available from the Effective Interventions Unit.

In addition, the AAPPQ was further revised to form a tool with which to measure attitudes to working with people with comorbidity problems, namely the Comorbidity Problems Perceptions Questionnaire (CMPPQ, Appendix 4).

PSYCHOMETRIC EVALUATION

The psychometric properties of an instrument reflect its quality, particularly in terms of its validity and reliability (Polit and Hungler 1997).

Validity

The validity of an instrument is the degree to which it measures the attribute that it claims to be measuring. In this study, both the content and construct validity of the DDPPQ were assessed. Content validity concerns the extent to which an instrument addresses all of the attributes of the concept under examination, in other words, its comprehensiveness. It also relates to whether the instrument contains items which are irrelevant to the concepts and are therefore redundant.

Construct validity, on the other hand, is the degree to which the instrument reflects the concepts and specific theoretical assumptions about which it is concerned. *Content* validity, then, in this study, is to do with whether the DDPPQ was sufficiently comprehensive to address all of its components and contains no irrelevant items. *Construct* validity, on the other hand, concerns the extent to which it relates to the concepts of Role Adequacy, Role Legitimacy, and Role Support, Motivation, Satisfaction, and Professional Self-esteem as described by Shaw *et al* (1978), who developed the theory of therapeutic commitment.

Reliability

The reliability of an instrument is the degree of consistency with which it measures an attribute. The less variation it produces when used on repeated occasions, the greater its reliability. Another aspect of reliability is the extent to which an instrument measures only the attribute under investigation and nothing else. This aspect of reliability is known as internal consistency.

STUDY DESIGN

The study was conducted in two distinct stages.

The aim of Stage One of the study was to determine the reliability and validity of the initial version of the DDPPQ. The objectives were to assess the following properties:

- test-retest reliability
- internal consistency
- construct validity
- content validity

Stage Two aimed to develop and pilot the CMPPQ as an instrument to measure attitudes to individuals with co-existing drug or alcohol and mental health problems to establish its content validity.

STAGE ONE: THE DDPPQ

The initial version of the DDPPQ (Appendix 3) was developed in this project as an adaptation of the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ). Although the focus of the AAPPQ relates to attitudes to a different client group, namely problem drinkers, only minor amendments to the original

form of words were required prior to testing its psychometric properties in relation to drug users.

It was estimated that 336 completed questionnaires would provide sufficient data for the purposes of the statistical analysis to show true, rather than chance, effects. However, postal questionnaires are known to yield low response rates, so twice as many questionnaires were distributed as were required in an attempt to overcome the anticipated problems. The questionnaire was distributed to a sample of 672 members of staff of the multidisciplinary mental health care team within the Greater Glasgow Primary Care NHS Trust. Three hundred and seventy-seven completed questionnaires were returned, giving a response rate of 56%.

Construct validity of the initial version of the DDPPQ

A factor analysis was conducted to assess the construct validity of the DDPPQ. This statistical procedure produced six distinct groups of items, or factors (see Appendix 5 for the factor structure of the validated DDPPQ).

The factors clearly comprised items which, at face value, relate to each other. For example, the items of the first factor (Role Adequacy) share a common focus of whether the participants felt they had the knowledge and skills they thought necessary to work effectively with drug users. These were shown by statistical analysis to be grouped together within one factor. The last item listed in this factor, which refers to a sense of satisfaction with role performance does not belong to the corresponding factor on the AAPPQ (see Appendix 6). However, there is an intuitive logic that this item is relevant to the others in this factor since satisfaction with one's performance may result from a sense of Role Adequacy. A further example of the link between the results of the statistical analysis and a more qualitative judgement is the fact that Items 12, 13, and 14, all of which relate to support for the role, were grouped within a separate factor.

Several items which exist on the AAPPQ and are shown in Appendix 6 have no corresponding items on the validated DDPPQ (Appendix 7). These items were shown to be unreliable and were deleted as a result of the process which is described in the next two paragraphs.

Test-retest reliability of the initial version of the DDPPQ

The questionnaire was distributed on a second occasion to the participants who had responded on the first occasion in order to examine its test-retest reliability. This time 258 participants returned questionnaires, giving a response rate of 68% of those who returned completed questionnaires on the first occasion. The proportions of staff from each professional grouping who returned completed questionnaires on both occasions appear to be relatively representative of the population from which the sample was derived. As indicated above, a low response rate had been anticipated as this is not uncommon in studies which use a postal survey method. Although the final number of returned questionnaires on the second occasion was lower than had been planned, the loss of statistical power was modest.

The instrument as a whole demonstrated satisfactory test-retest performance. However, when the test-retest reliability of each individual item was analysed, nine items were found to be of questionable reliability. These nine items (8, 9, 15, 19, 21, 23, 24, 26, and 30) were subjected to further examination.

Internal consistency of the initial version of the DDPPQ

The reliability of the instrument in terms of its internal consistency was also assessed by examining the structure of the factors which had been produced by the factor analysis mentioned above. Firstly, the internal consistency of the instrument as a whole was assessed using the value of coefficient alpha. (Coefficient alpha is a statistic which is used to determine the internal consistency of an instrument.) This was found to be satisfactory. Then each factor was examined in turn. The internal consistency of each factor was also found to be satisfactory, with the exception of the last factor. This factor comprised two items only, one of which was shown to be of questionable test-retest reliability (Items 18 and 19).

The next step was to see if removal of any of the items which had been shown to be of dubious test-retest reliability would have an adverse effect on the internal consistency of the factors to which the suspect items belonged. Where a factor contained an item whose reliability had been shown to be suspect, that item was provisionally discarded prior to evaluating the internal consistency of the factor without it. This was done by calculating the value of coefficient alpha for the remaining items. If the value of alpha for the factor remained above the cut-off point of 0.7, at which point internal consistency is deemed to be satisfactory, the decision to discard the item was confirmed since the item was not contributing to the internal consistency of the factor. However, when the value of alpha for the factor fell below this cut-off point, the item was retained. This was because, despite the fact that the test-retest reliability of the item had been found to be questionable, it did appear to contribute to the internal consistency of the factor.

When the factor analysis was undertaken, two items (Items 17 and 20) were found to have a low factor loading (i.e., a low correlation with the other items of the factor with which each was associated). This suggested that they may also be unreliable and be detracting from the internal consistency of the subset of items which made up their factors. The contribution of these items to the internal consistency of the DDPPQ was therefore also further examined.

Using this strategy for each of the unreliable items, two were retained because the impact of discarding them resulted in a fall in the value of alpha to below 0.7. As a consequence of applying this process to each factor, eight items were discarded and 22 of the original 30 items were retained. The items which were discarded from the initial, unrefined version of the DDPPQ were Items 8, 15, 17, 19, 20, 21, 26, and 30.

Content validity of the DDPPQ

Two hundred and seventy-six respondents commented on the content validity of the tool. In most respects the content validity of the DDPPQ was found to be satisfactory. Comments were made by a minority of respondents that some of the items were ambiguous and/or value-laden. Of the nine items which were shown by the statistical analysis of the test-retest data to be of dubious reliability, six were identified by the participants to be ambiguous, repetitive or undesirable. These were Items 9, 21, 23, 24, 26, and 30.

The content analysis provided participants with the opportunity to suggest issues which were not addressed in the questionnaire. Although not appropriate for inclusion in the DDPPQ, the issues raised were matters which the participants themselves highlighted as concerns.

The validated version of the DDPPQ

The analysis described within this report showed that the majority of items of the initial unrefined version of the DDPPQ were reliable. However, the effect of discarding the items whose reliability was found to be questionable enhanced its overall reliability. The validated DDPPQ (Appendix 7), comprising 22 items, is therefore a shorter questionnaire, having retained only the most reliable items from the original instrument. The items of the validated questionnaire were numbered consecutively from 1-22, the result being that some numbers of some of the retained items are different from those in the initial version (Appendix 3).

Using the DDPPQ

The validated DDPPQ is a self-complete 'paper and pencil' questionnaire. Respondents are asked to rate their level of agreement on a series of 22 statements about working with people who use licit or illicit drugs in a non-therapeutic way. There are seven possible responses to each item on a scale of 'Strongly agree' to 'Strongly disagree'. Low scores denote positive attitudes, whereas high scores are associated with negative views. Several of the items are worded negatively. These are Items 15, 16, 17 and 18. The scores for these items should be reversed before tallying a total score for the entire questionnaire. The minimum possible score is 22 and the maximum is 154.

STAGE TWO: THE CMPPQ

In the second stage of the study, the 30-item unvalidated version of the DDPPQ was further amended to form the Comorbidity Problems Perceptions Questionnaire (CMPPQ) as an instrument to measure attitudes of the mental health care team to working with people who have co-existing substance misuse and mental health problems.

A different random sample of 200 individuals from the same population (i.e., members of the multidisciplinary mental health care team from the Greater Glasgow Primary Care NHS Trust) was invited to assess the tool's content validity. Two additional tools of a similar design and format were also distributed. These were the Alcohol and Alcohol Problems Perceptions Questionnaire and the Mental Health Problems Perceptions Questionnaire, both of which have previously been validated for the purposes of measuring attitudes of health care professionals to problem drinkers and attitudes to those with mental health problems respectively.

A total of 127 sets of questionnaires were returned, giving a response rate of 64%. The content validity of the CMPPQ was confirmed, with a minority of participants expressing similar reservations to the equivalent items as had been highlighted as problematic in the DDPPQ. The issue which was mentioned most frequently concerned training and education of staff to manage clients with co-existing mental health and substance misuse problems.

CONCLUSIONS

The psychometric analysis of the initial DDPPQ has produced a valid and reliable tool (the validated DDPPQ, Appendix 7). One of its possible uses is to help ascertain the training requirements of staff who work with drug users. It may also be used to evaluate the impact of education programmes on staff's attitudes. Since drug users utilise primary and secondary care in both medical and mental health services, the outcomes of this research are pertinent to health care providers. In addition, the DDPPQ provides researchers with a valid tool for further study in a field which is likely to be of growing concern as the rise in drug use does not appear to be diminishing. It is also likely to be of value to the local authority social services, the voluntary sector, and the prison services.

Several of the staff who participated highlighted the need for training in issues surrounding the management of clients who are drug users and also those with co-existing mental health and substance misuse problems.

The AAPPQ and MHPPQ currently exist within the public domain as instruments to measure attitudes and therapeutic commitment to people with alcohol and mental health problems respectively. The new instruments, whose development has been described in this report, uses the same format and can therefore readily be used in conjunction with these other instruments to measure related attitudes.

The objective of Stage Two of the study was to pilot the CMPPQ as an instrument to measure attitudes to individuals with co-existing drug or alcohol and mental health problems to establish its content validity. The content validity of the tool was broadly confirmed, with a small minority of participants expressing reservations regarding the subjective nature of some of the questions.

It is recommended that the psychometric properties of the CMPPQ be tested as a means of identifying whether its performance can be enhanced.

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ALCOHOL AND ALCOHOL PROBLEMS PERCEPTIONS QUESTIONNAIRE

Please indicate how much you agree or disagree with each of the following statements about working with *problem drinkers*.

Please circle one number for each question.		Strongly agree					Strongly disagree				
1	I feel I have a working knowledge of alcohol and alcohol-related problems.	1	2	3	4	5	6	7			
2	I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	1	2	3	4	5	6	7			
3	I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	1	2	3	4	5	6	7			
4	I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	1	2	3	4	5	6	7			
5	I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with drinkers.	1	2	3	4	5	6	7			
6	I feel I know how to counsel drinkers over the long term.	1	2	3	4	5	6	7			
7	I feel I can appropriately advise my patients about drinking and its effects.	1	2	3	4	5	6	7			
8	I feel I have a clear idea of my responsibilities in helping drinkers.	1	2	3	4	5	6	7			
9	I feel I have the right to ask patients questions about their drinking when necessary.	1	2	3	4	5	6	7			
10	I feel that my patients believe I have the right to ask them questions about drinking when necessary.	1	2	3	4	5	6	7			
11	I feel I have the right to ask a patient for any information that is relevant to their drinking problems.	1	2	3	4	5	6	7			
12	If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	1	2	3	4	5	6	7			
13	If I felt the need when working with drinkers I could easily find someone who would help me clarify my professional responsibilities.	1	2	3	4	5	6	7			
14	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker.	1	2	3	4	5	6	7			
15	I am interested in the nature of alcohol related problems and the responses that can be made to them.	1	2	3	4	5	6	7			
16	I want to work with drinkers.	1	2	3	4	5	6	7			
17	I feel that the best I can personally offer drinkers is referral to somebody else.	1	2	3	4	5	6	7			
18	I feel that there is little I can do to help drinkers.	1	2	3	4	5	6	7			

Please circle one number for each question.		Strongly agree					Strongly disagree				
19	Pessimism is the most realistic attitude to take toward drinkers.	1	2	3	4	5	6	7			
20	I feel I am able to work with drinkers as well as others.	1	2	3	4	5	6	7			
21	All in all I am inclined to feel I am a failure with drinkers.	1	2	3	4	5	6	7			
22	I wish I could have more respect for the way I work with drinkers.	1	2	3	4	5	6	7			
23	I feel I do not have much to be proud of when working with drinkers.	1	2	3	4	5	6	7			
24	At times I feel I am no good at all with drinkers.	1	2	3	4	5	6	7			
25	On the whole, I am satisfied with the way I work with drinkers.	1	2	3	4	5	6	7			
26	I often feel uncomfortable when working with drinkers.	1	2	3	4	5	6	7			
27	In general, one can get satisfaction from working with drinkers.	1	2	3	4	5	6	7			
28	In general, it is rewarding to work with drinkers.	1	2	3	4	5	6	7			
29	In general, I feel I can understand drinkers.	1	2	3	4	5	6	7			
30	In general, I like drinkers.	1	2	3	4	5	6	7			

MENTAL HEALTH PROBLEMS PERCEPTIONS QUESTIONNAIRE

To which professional group do you belong?

☐ Doctor

☐ Clinical Psychologist

☐ Occupational therapist

☐ Community-based Nurse

☐ Other (please specify)

☐ Hospital-based Nurse

Please indicate your current grade. What is your clinical specialty? How long have you held this post?

Please indicate how much you agree or disagree with each of the following statements about working with people with *mental health problems*.

Please circle one number for each question.		Strongly agree							Strongly disagree
1.	I feel that I know enough about the factors that put people at risk of mental health problems to carry out my role when working with this client group	1	2	3	4	5	6	7	
2.	I feel I know how to treat people with long term mental health problems	1	2	3	4	5	6	7	
3.	I feel that I can appropriately advise my patients about mental health problems	1	2	3	4	5	6	7	
4.	I feel that I have a clear idea of my responsibilities in helping patients with mental health problems	1	2	3	4	5	6	7	
5.	I feel that I have the right to ask patients about their mental health status when necessary	1	2	3	4	5	6	7	
6.	I feel that my patients believe I have the right to ask them questions about mental health problems when necessary	1	2	3	4	5	6	7	
7.	I feel that I have the right to ask a patient for any information that is relevant to their mental health problem	1	2	3	4	5	6	7	
8.	If I felt the need when working with patients with mental health problems, I could easily find someone with whom I could discuss any personal difficulties I might encounter	1	2	3	4	5	6	7	
9.	If I felt the need when working with someone with mental health problems, I could easily find somebody who would help me clarify my professional difficulties	1	2	3	4	5	6	7	
10	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a patient with mental health problems	1	2	3	4	5	6	7	

Please circle one number for each question.		Strongly agree							Strongly disagree
11. I am interested in the nature of mental health problems and the treatment of them		1	2	3	4	5	6	7	
12. I feel that I am able to work with patients with mental health problem as effectively as with other patients who do not have mental health problems		1	2	3	4	5	6	7	
13. I want to work with patients with mental health problems		1	2	3	4	5	6	7	
14. I have the skills to work with patients with mental health problems		1	2	3	4	5	6	7	
15. I feel that I can assess and identify the medical/psychiatric/psychological/occupational therapy/nursing (as appropriate to your professional group) problems of patients with mental health problems		1	2	3	4	5	6	7	
16. I feel that there is nothing I can do to help patients with mental health problems		1	2	3	4	5	6	7	
17. I feel that I have something to offer patients with mental health problems		1	2	3	4	5	6	7	
18. I feel that I have much to be proud of when working with patients with mental health problems		1	2	3	4	5	6	7	
19. I feel that I have a number of good qualities for work with patients with mental health problems		1	2	3	4	5	6	7	
20. Caring for people with mental health problems is an important part of a district nurses role		1	2	3	4	5	6	7	
21. In general, one can get satisfaction from working with patients with mental health problems		1	2	3	4	5	6	7	
22. In general, it is rewarding to work with patients with mental health problems		1	2	3	4	5	6	7	
23. I often feel uncomfortable when working with patients with mental health problems		1	2	3	4	5	6	7	
24. In general, I feel that I can understand patients with mental health problems		1	2	3	4	5	6	7	
25. On the whole, I am satisfied with the way I work with patients with mental health problems		1	2	3	4	5	6	7	
26. When working with patients with mental health problems I receive adequate supervision from a more experienced person		1	2	3	4	5	6	7	
27. When working with patients with mental health problems I receive adequate on-going support from colleagues		1	2	3	4	5	6	7	

DRUGS AND DRUG USERS' PROBLEMS PERCEPTIONS QUESTIONNAIRE

(INITIAL UNVALIDATED VERSION)

To which professional group do you belong?

Doctor ☐ Clinical Psychologist ☐ Occupational therapist ☐ Community-based Nurse ☐ Other (please specify) ☐
 Hospital-based Nurse ☐

Please indicate your current grade. _____ **What is your clinical specialty?** _____ **How long have you held this post?** _____

Please indicate how much you agree or disagree with each of the following statements about working with people who use licit or illicit drugs in a non-therapeutic way.

Please circle one number for each question.		Strongly agree					Strongly disagree				
1.	I feel I have a working knowledge of drugs and drug related problems.	1	2	3	4	5	6	7			
2.	I feel I know enough about the causes of drug problems to carry out my role when working with drug users.	1	2	3	4	5	6	7			
3.	I feel I know enough about the physical effects of drug use to carry out my role when working with drug users.	1	2	3	4	5	6	7			
4.	I feel I know enough about the psychological effects of drugs to carry out my role when working with drug users	1	2	3	4	5	6	7			
5.	I feel I know enough about the factors which put people at risk of developing drug problems to carry out my role when working with drug users.	1	2	3	4	5	6	7			
6.	I feel I know how to counsel drug users over the long term.	1	2	3	4	5	6	7			
7.	I feel I can appropriately advise my patients/clients about drugs and their effects.	1	2	3	4	5	6	7			
8.	I feel I have a clear idea of my responsibilities in helping drug users.	1	2	3	4	5	6	7			
9.	I feel I have the right to ask patients/clients questions about their drug use when necessary.	1	2	3	4	5	6	7			
10.	I feel that my patients/clients believe I have the right to ask them questions about drug use when necessary.	1	2	3	4	5	6	7			
11.	I feel I have the right to ask a patient for any information that is relevant to their drug problems.	1	2	3	4	5	6	7			
12.	If I felt the need when working with drug users I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	1	2	3	4	5	6	7			

Please circle one number for each question.		Strongly agree					Strongly disagree				
13. If I felt the need when working with drug users I could easily find someone who would help me clarify my professional responsibilities.		1	2	3	4	5	6	7			
14. If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drug user.		1	2	3	4	5	6	7			
15. I am interested in the nature of drug-related problems and the responses that can be made to them.		1	2	3	4	5	6	7			
16. I want to work with drug users.		1	2	3	4	5	6	7			
17. I feel that the best I can personally offer drug users is referral to somebody else.		1	2	3	4	5	6	7			
18. I feel that there is little I can do to help drug users.		1	2	3	4	5	6	7			
19. Pessimism is the most realistic attitude to take toward drug users.		1	2	3	4	5	6	7			
20. I feel I am able to work with drug users as well as other client groups.		1	2	3	4	5	6	7			
21. All in all I am inclined to feel I am a failure with drug users.		1	2	3	4	5	6	7			
22. In general, I have less respect for drug users than for most other patients/clients I work with.		1	2	3	4	5	6	7			
23. I feel I do not have much to be proud of when working with drug users.		1	2	3	4	5	6	7			
24. At times I feel I am no good at all with drug users.		1	2	3	4	5	6	7			
25. On the whole, I am satisfied with the way I work with drug users.		1	2	3	4	5	6	7			
26. I often feel uncomfortable when working with drug users.		1	2	3	4	5	6	7			
27. In general, one can get satisfaction from working with drug users.		1	2	3	4	5	6	7			
28. In general, it is rewarding to work with drug users.		1	2	3	4	5	6	7			
29. In general, I feel I can understand drug users.		1	2	3	4	5	6	7			
30. In general, I like drug users.		1	2	3	4	5	6	7			

Thank you for your help

CO-MORBIDITY AND CO-MORBIDITY CLIENTS' PROBLEMS PERCEPTIONS QUESTIONNAIRE

To which professional group do you belong?

☐ Doctor

☐ Clinical Psychologist

☐ Occupational therapist

☐ Community-based Nurse

☐ Hospital-based Nurse

☐ Other (please specify)

Please indicate your current grade.

What is your clinical specialty?

How long have you held this post?

Please indicate how much you agree or disagree with each of the following statements about working with people with co-morbidity problems, i.e. a *co-existing substance use and mental health problem*.

Please circle one number for each question.		Strongly agree							Strongly disagree
1.	I feel I have a working knowledge of co-morbidity problems.	1	2	3	4	5	6	7	
2.	I feel I know enough about the causes of co-morbidity to carry out my role when working with co-morbidity clients.	1	2	3	4	5	6	7	
3.	I feel I know enough about the <i>physical</i> effects of <i>alcohol</i> use to carry out my role when working with co-morbidity clients.	1	2	3	4	5	6	7	
4.	I feel I know enough about the <i>psychological</i> effects of <i>alcohol</i> use to carry out my role when working with co-morbidity clients	1	2	3	4	5	6	7	
5.	I feel I know enough about the factors which put people at risk of developing alcohol problems to carry out my role when working with co-morbidity clients.	1	2	3	4	5	6	7	
6.	I feel I know enough about the <i>physical</i> effects of <i>drug</i> use to carry out my role when working co-morbidity clients.	1	2	3	4	5	6	7	
7.	I feel I know enough about the <i>psychological</i> effects of <i>drug</i> use to carry out my role when working with co-morbidity clients	1	2	3	4	5	6	7	
8.	I feel I know enough about the factors which put people at risk of developing drug problems to carry out my role when working with co-morbidity clients.	1	2	3	4	5	6	7	

Please circle one number for each question.		Strongly agree					Strongly disagree				
9.	I feel I can advise co-morbidity patients/clients appropriately about alcohol and its effects.	1	2	3	4	5	6	7			
10.	I feel I can advise co-morbidity patients/clients appropriately about drugs and their effects.	1	2	3	4	5	6	7			
11.	I feel I know how to counsel co-morbidity patients/clients over the long term.	1	2	3	4	5	6	7			
12.	I feel I have a clear idea of my responsibilities in helping co-morbidity clients.	1	2	3	4	5	6	7			
13.	I feel that my patients/clients believe I have the right to ask them questions about their drug use when necessary.	1	2	3	4	5	6	7			
14.	I feel I have the right to ask a patient for any information that is relevant to their drug or alcohol problems.	1	2	3	4	5	6	7			
15.	If I felt the need when working with co-morbidity clients I could easily find someone with whom I could discuss any <i>personal</i> difficulties that I might encounter.	1	2	3	4	5	6	7			
16.	If I felt the need when working with co-morbidity clients I could easily find someone who would help me clarify my <i>professional</i> responsibilities.	1	2	3	4	5	6	7			
17.	If I felt the need I could easily find someone who would be able to help me formulate a care plan for a co-morbidity client.	1	2	3	4	5	6	7			
18.	I am interested in the nature of co-morbidity problems and the responses that can be made to them.	1	2	3	4	5	6	7			
19.	I want to work with co-morbidity clients.	1	2	3	4	5	6	7			
20.	I feel that the best I can personally offer co-morbidity clients is referral to somebody else.	1	2	3	4	5	6	7			
21.	I feel that there is little I can do to help co-morbidity clients.	1	2	3	4	5	6	7			
22.	Pessimism is the most realistic attitude to take toward co-morbidity clients.	1	2	3	4	5	6	7			
23.	I feel I am able to work as well with co-morbidity clients as with other client groups.	1	2	3	4	5	6	7			
24.	All in all I am inclined to feel I am a failure with co-morbidity clients.	1	2	3	4	5	6	7			
25.	In general, I have less respect for co-morbidity clients than for most other patients/clients I work with.	1	2	3	4	5	6	7			
26.	I feel I do not have much to be proud of when working with co-morbidity clients.	1	2	3	4	5	6	7			

Please circle one number for each question.		Strongly agree					Strongly disagree				
27.	At times I feel I am no good at all with co-morbidity clients.	1	2	3	4	5	6	7			
28.	On the whole, I am satisfied with the way I work with co-morbidity clients.	1	2	3	4	5	6	7			
29.	I often feel uncomfortable when working with co-morbidity clients.	1	2	3	4	5	6	7			
30.	In general, one can get satisfaction from working with co-morbidity clients.	1	2	3	4	5	6	7			
31.	In general, it is rewarding to work with co-morbidity clients.	1	2	3	4	5	6	7			
32.	In general, I feel I can understand co-morbidity clients.	1	2	3	4	5	6	7			
33.	In general, I like co-morbidity clients.	1	2	3	4	5	6	7			

Thank you for your time and help which are much appreciated.

FACTOR STRUCTURE OF THE VALIDATED DRUG AND DRUG PROBLEMS PERCEPTIONS QUESTIONNAIRE

Item	Role adequacy	Item	Role legitimacy	Item	Role support
1	I feel I have a working knowledge of drugs and drug related problems	8	I feel I have the right to ask patients questions about their drug when necessary.	11	If I felt the need when working with drug users I could easily find someone with whom I could discuss any personal difficulties that I might encounter.
2	I feel I know enough about the causes of drug problems to carry out my role when working with drug users	9	I feel that my patients believe I have the right to ask them questions about drug when necessary.	12	I feel the need when working with drug users I could easily find someone who would help me clarify my professional responsibilities.
3	I feel I know enough about the physical effects of drug use to carry out my role when working with drug users	10	I feel I have the right to ask a patient for any information that is relevant to their drug problems.	13	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drug user.
4	I feel I know enough about the psychological effects of drugs to carry out my role when working with drug users				
5	I feel I know enough about the factors which put people at risk of developing drug problems to carry out my role when working with drug users				
6	I feel I know how to counsel drug users over the long term.				
7	I feel I can appropriately advise my patients/clients about drugs and their effects.				
19	On the whole, I am satisfied with the way I work with drug users.				
	Motivation		Task specific self-esteem		Work Satisfaction
15	I feel that there is little I can do to help drug users.	16	In general, I have less respect for drug users than for most other patients/clients I work with.	14	I want to work with drug users.
		17	I feel I do not have much to be proud of when working with drug users.	21	In general, it is rewarding to work with drug users.
		18	At times I feel I am no good at all with drug users.	20	In general, one can get satisfaction from working with drug users.
				22	In general, I feel I can understand drug users.

SUB-SCALES OF THE ALCOHOL AND ALCOHOL PROBLEMS PERCEPTIONS QUESTIONNAIRE

Item	Role adequacy	Item	Role legitimacy	Item	Role support
1	I feel I have a working knowledge of alcohol and alcohol related problems.	8	I feel I have a clear idea of my responsibilities in helping drinkers.	12	If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties that I might encounter.
2	I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	9	I feel I have the right to ask patients questions about their drinking when necessary.	13	I feel the need when working with drinkers I could easily find someone who would help me clarify my professional responsibilities.
3	I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	10	I feel that my patients believe I have the right to ask them questions about drinking when necessary.	14	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker.
4	I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	11	I feel I have the right to ask a patient for any information that is relevant to their drinking problems.		
5	I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with drinkers.				
6	I feel I know how to counsel drinkers over the long term.				
7	I feel I can appropriately advise my patients about drinking and its effects.				
	Motivation		Task specific self-esteem		Work Satisfaction
15	I am interested in the nature of alcohol related problems and the responses that can be made to them.	20	I feel I am able to work with drinkers as well as others.	26	I often feel uncomfortable when working with drinkers.
16	I want to work with drinkers.	21	All in all I am inclined to feel I am a failure with drinkers.	27	In general, one can get satisfaction from working with drinkers.
17	I feel that the best I can personally offer drinkers is referral to somebody else.	22	I wish I could have more respect for the way I work with drinkers.	28	In general, it is rewarding to work with drinkers.
18	I feel that there is little I can do to help drinkers.	23	I feel I do not have much to be proud of when working with drinkers.	29	In general, I feel I can understand drinkers.
19	Pessimism is the most realistic attitude to take toward drinkers.	24	At times I feel I am no good at all with drinkers.	30	In general, I like drinkers.
		25	On the whole, I am satisfied with the way I work with drinkers.		

DRUGS AND DRUG USERS' PROBLEMS PERCEPTIONS QUESTIONNAIRE
(VALIDATED VERSION)

To which professional group do you belong?

☐ Doctor

☐ Clinical Psychologist

☐ Occupational therapist

☐ Community-based Nurse

☐ Hospital-based Nurse

☐ Other (please specify)

Please indicate your current grade. What is your clinical specialty? How long have you held this post? _____

Please indicate how much you agree or disagree with each of the following statements about working with people who use licit or illicit drugs in a non-therapeutic way.

Please circle one number for each question.		Strongly agree					Strongly disagree				
1.	I feel I have a working knowledge of drugs and drug related problems.	1	2	3	4	5	6	7			
2.	I feel I know enough about the causes of drug problems to carry out my role when working with drug users.	1	2	3	4	5	6	7			
3.	I feel I know enough about the physical effects of drug use to carry out my role when working with drug users.	1	2	3	4	5	6	7			
4.	I feel I know enough about the psychological effects of drugs to carry out my role when working with drug users	1	2	3	4	5	6	7			
5.	I feel I know enough about the factors which put people at risk of developing drug problems to carry out my role when working with drug users.	1	2	3	4	5	6	7			
6.	I feel I know how to counsel drug users over the long term.	1	2	3	4	5	6	7			
7.	I feel I can appropriately advise my patients/clients about drugs and their effects.	1	2	3	4	5	6	7			

Please circle one number for each question.		Strongly agree					Strongly disagree				
8.	I feel I have the right to ask patients/clients questions about their drug use when necessary.	1	2	3	4	5	6	7			
9.	I feel that my patients/clients believe I have the right to ask them questions about drug use when necessary.	1	2	3	4	5	6	7			
10.	I feel I have the right to ask a patient for any information that is relevant to their drug problems.	1	2	3	4	5	6	7			
11.	If I felt the need when working with drug users I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	1	2	3	4	5	6	7			
12.	If I felt the need when working with drug users I could easily find someone who would help me clarify my professional responsibilities.	1	2	3	4	5	6	7			
13.	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drug user.	1	2	3	4	5	6	7			
14.	I want to work with drug users.	1	2	3	4	5	6	7			
15.	I feel that there is little I can do to help drug users.	1	2	3	4	5	6	7			
16.	In general, I have less respect for drug users than for most other patients/clients I work with.	1	2	3	4	5	6	7			
17.	I feel I do not have much to be proud of when working with drug users.	1	2	3	4	5	6	7			
18.	At times I feel I am no good at all with drug users.	1	2	3	4	5	6	7			
19.	On the whole, I am satisfied with the way I work with drug users.	1	2	3	4	5	6	7			
20.	In general, one can get satisfaction from working with drug users.	1	2	3	4	5	6	7			
21.	In general, it is rewarding to work with drug users.	1	2	3	4	5	6	7			
22.	In general, I feel I can understand drug users.	1	2	3	4	5	6	7			