A SURVEY OF COMMUNITY HEALTH PROFESSIONALS: THEIR KNOWLEDGE AND ATTITUDES REGARDING CHEMICALLY DEPENDENT WOMEN

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A SURVEY OF COMMUNITY HEALTH PROFESSIONALS: THEIR KNOWLEDGE AND ATTITUDES REGARDING CHEMICALLY DEPENDENT WOMEN

BY

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ABSTRACT

This practicum report presents a descriptive analysis of a mail survey of community health professionals' knowledge and attitudes pertaining to chemically dependent women. The individuals surveyed were community health professionals located in the Winnipeg region. A goal of the practicum was to identify the knowledge and attitudes that may be prerequisites to community health professionals referring chemically dependent women to treatment. The findings indicated that most respondents had a similar level of knowledge about chemical dependency and treatment. In contrast, findings regarding attitudes indicated respondents had varying attitudes regarding chemical dependency and treatment. Recommendations were made that would promote positive attitudes toward women with chemical dependencies and treatment. One recommendation was to increase the availability of treatment programs that are based on different theories regarding chemical dependency. Another recommendation was to provide treatment in the community health programs where chemically dependent women identify their problems.

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INTRODUCTION

A PERSPECTIVE ON CHEMICAL DEPENDENCY

People drinking alcoholic beverages in excessive quantities resulting in harm to themselves and/or others is a very old problem. People drinking and/or taking other drugs in excessive quantities and doing harm to themselves and/or others as a result, is not such a very old phenomenon. Very few activities of a research nature have been undertaken in order to determine factors which might lead to alleviation of this latter problem. For this very reason, this study has focused on chemical dependency and not just alcoholism per se.

Although this research strives to address chemically dependent women, most of the research available addresses alcohol abuse in women. The author was faced with a dilemma - to continue to expound research on women and alcohol abuse or to make a concerted effort to focus on chemical dependency and women. The author chose to focus on chemical dependency and women. Only for brevity, the author utilized the phrase "chemically dependent women" rather than "women with chemical dependency".

The problems faced by those in the helping professions who deal with alcoholism and other chemical dependencies are basically the same. There is a lack of common definition and a lack of consistent data on the causes of the problem. Many different factors have been suggested as the cause of chemical dependency including heredity, physiological attributes, psychological attributes, and sociological factors. None of these has as yet been shown to be the single cause in producing chemical dependency. On the other hand, none of them have been rejected as possible causes or

contributing factors. An obvious implication to be drawn is that there is much yet to be learned about the roles of different factors and the extent of their inter-relatedness in the etiology of chemical dependency.

Alcoholism has been viewed as many different things i.e., a moral problem, a health problem, a mental disorder, and a combination of these. A popular concept has been that alcoholism is an illness. The Alcoholism Foundation Of Manitoba (A.F.M.) concurs with the illness model and has expanded it to include other chemicals in addition to alcohol.

The Alcoholism Foundation Of Manitoba defines chemical dependency as the following :

> Chemical dependency is an illness where dependence upon mood-altering substances has attained such a degree as to disrupt academic or work performance, interfere with family and inter-personal relationships, disrupt smooth social and economic functioning, and impair the state of physical and/or mental health (AFM 1985, pages 29-30).

According to the AFM the concept of chemical dependency as an illness implies the following:

1. The illness can be described.
2. The course of the illness is predictable and progressive.
3. The illness is **PRIMARY**. It is not just a symptom of some other underlying disorder.
4. It is permanent.
5. If left untreated, it invariably results in premature death.
6. Early diagnosis, intervention, and treatment can lead to permanent remission (AFM 1985, pages 29-30).

Inherent in the illness perspective is the concept that using drugs interferes with the person's functioning. Consequently, the illness perspective has been important in challenging the myth that persons with chemical dependency are morally inadequate people who have wilfully brought problems on themselves through their weakness or sinfulness. However, the illness concept has falsely conveyed the impression that all chemical dependent individuals are the same or manifest the same characteristics. The problem is really much more complex. Chemical dependency and its effects manifest a great many shades of grey between extremes.

Another pitfall to defining chemical dependency is that different categories of people in different social situations differ systematically in their assessments of what counts as chemical dependency. According to Robinson, "...people do employ the words alcoholism and alcoholic with respect to what are to them at that time clearly delineated classes of states and person. Similarly, their action is informed by these definitions and by their assumptions concerning the definitions of significant others." (Robinson 1973, page 92).

PROBLEM TO BE STUDIED

The relative success of different types of chemical dependency treatment has long been debated. Nonetheless, there is some evidence that treatment programs, regardless of their orientation, produce more positive and lasting outcomes than no treatment programs (Beckman and Amaro, 1984). Estimates of the prevalence of drug abuse problems in women and their rates of use of drug treatment services suggest that many women in need

of services never reach treatment. Of course many men with alcohol/drug problems also never gain access to treatment, but women are less likely than men to receive help for their drug problems (Beckman and Amaro, 1984). In the state of California, a study revealed that men entered treatment two and one-half times more frequently than women (Beckman and Amaro, 1984). Canadian data indicates that of all clients utilizing specialized treatment programs, 78.2% were males and 21.8% were females (Working Group On Alcohol Statistics, 1984). In 1985-86, of the individuals who took part in the Alcoholism Foundation Of Manitoba and Funded Agency treatment services, 29% were women and 71% were men (A.F.M. Annual Report, 1987).

This research studied the process involved in seeking treatment by chemically dependent women. The intent was to comprehend why women are less likely to receive treatment for their drug problems. It was assumed that to enter the road to recovery the chemically dependent individual must generally find help from individuals familiar with drug treatment. Community health professionals were considered to be in key positions to identify and refer. However are they familiar with drug treatment services? Can community health professionals identify the signs and symptoms of women's problem chemical usage? Are their attitudes regarding the efficaciousness of treatment conducive to referring women? The purpose of this study is to examine the knowledge and attitudes of community health professionals that may be related to the referral of chemically dependent women to treatment services in Winnipeg.

This practicum report is organized in the following manner. Chapter I contains a review of the literature on alcoholism and other chemical dependencies. Chapter II describes the design of the practicum. In chapter III the survey findings are presented. The first part focuses on the descriptive findings. The second part gives a comparative account of the survey findings between three sample groups. Chapter IV identifies the major findings and their implications. Chapter V contains the author's conclusions and recommendations.

CHAPTER I

LITERATURE REVIEW

> "Chemically dependent women are among the most wounded and needy members of our society, yet their special problems have long gone under-recognized and under-treated" (Mondanaro, 1989 page 1).

There are many factors that contribute to the unmet needs of chemically dependent women. One of the most obvious reasons is the paucity of research regarding women and addiction. Although women's use of alcohol goes back to the dawn of recorded history, research regarding women and alcohol is a recent development. Schuckit (1972) found between 1929-1970 there were only 29 studies of women's alcohol abuse published in the English language. In the 47,000 people examined in 271 studies between 1952 and 1971, only 6.2% were women. Only 7.1% of 64,000 subjects were women in 259 studies published between 1972 and 1980 (Vannicelli 1984). Exploring the reasons for the lack of research uncovers more explanations for the lack of recognition for female addiction. According to Avallone (1983) the male population bias occurred for two reasons. First, men did drink more than women. Second, women's abuse was, and continues to be, concealed or unrecognized by authorities, family members, and friends. Heinemann's (1986) explanation for gender bias in studies is that male researchers are less likely to include females in their study samples than female researchers. Whatever the reasons for gender bias in

the research, one can conclude that there has not been a significant commitment to the study of women and chemical dependencies.

Today addicted women are still victims of this lack of recognition. Contradictory data regarding prevalence of women's drug abuse is one such indication. Edith Gomberg in 1982 found that in mental health facilities the male-female ratio with alcoholic diagnosis is about 5:1 and that Alcoholics Anonymous claims a 2:1 ratio. The cirrhosis death rate, which remains the closest thing available to hard evidence, shows a 1:1 ratio (Smith 1986). Smith contends that women constitute 50% of all alcoholics rather than the conservative estimate of 20%.

This lack of consistency in prevalence of women's drug abuse may be the outcome of previous research that was conducted on a predominately male population and then generalized to a female population. The generalizations created misconceptions about etiology, physiological and psychological responses, symptomology, and prognosis of illness for women. (Avallone, 1983). It may also be the result of differences in social roles and cultural expectations for men and women.

A study by Russo and Sobel (1981) revealed that diagnosis can be affected by role expectations. They found that for mental health disorders that are congruent with sex-role expectations such as depressions, women show higher rates of use of services than men. In contrast, for problems such as alcoholism that are incongruent with idealized sex-role stereotypes, women show much lower utilization rates than men. In 1982, Braiker analyzed 60 common symptoms of alcoholism and found no differences between men and women among late stage alcoholics.

She concluded that what differs is the effect frequent intoxication has on the lives of men and women because of differences in social roles and cultural expectations.

Heinemann (1986) attributes the sex bias of researchers to be a reflection of the societal bias assigned to women with alcohol problems. Heinemann views this bias as a stigma. Goffman quoted by Heinemann defines stigma as the following:

> "Stigma is an attribute that is deeply discrediting. It places the individual in a position of being disqualified from full social acceptance. By definition, we believe the person with a stigma to be not quite human. On this assumption we exercise varieties of discrimination through which we effectively, if not unthinkingly, reduce his (sic) life chances. We construct an ideology to explain inferiority and account for the danger he (sic) represents, sometimes rationalizing an animosity based on other differences, such as those of social class" (Heinemann, 1985, p. 156).

The stigma experienced by women with chemical dependency problems is also a reflection of the value-or lack of it- assigned to women as a group. According to Watts as quoted by Heinemann:

> "Nowhere is the sexist character of American society more blatant than in the area of human resources and services. One has only to examine the quantity or quality of services across a broad spectrum of needs to see the failure of this society to address the needs of women" (Heinemann, 1986, p. 158).

Whether it is a social role, cultural expectation, or research bias at play, chemically dependent women remain hidden. They are seriously under-represented in treatment. Blume (1988) quotes: "Although our best estimate of the ratio of males to females suffering from alcoholism in the United States today is about 2:1, our best current national statistics reveal a male to female ratio in alcoholism treatment closer to 4:1". This reality is exacerbated by the following. The most effective early intervention and treatment programs such as impaired driver and employee assistance have one characteristic in common. They reach a far greater proportion of male problem drinkers than females (Mondanaro, 1989). Another variable focuses on the partners of chemically dependent men and women. While chemically dependent men typically have non-drug user partners, chemically dependent women are likely to be alone or to have partners who are themselves chemically dependent (Mondanaro, 1989). It is believed that a chemically dependent partner will not be helpful in identifying the woman's drug problem or in motivating her to enter and complete treatment. In contrast, most men become aware of and seek help for their chemical dependency problems through encouragement by their spouse. Without early intervention by the spouse and programs such as impaired driver's and employee assistance, there is little in the typical woman's environment to confront her with the fact that she is experiencing difficulty with alcohol/drugs.

The problems that do motivate women to treatment are most likely to be health and family problems (Mondanaro, 1989). Primary case finders for the female are physicians, other health professionals, social and family

service agencies, and attorneys. Nevertheless, the woman with chemical dependency problems has a difficult task in gaining the assistance she needs to help her recover. Reed (1985) acknowledges there is a less sensitive referral network for women and considers this to be a barrier to treatment entry. This practicum studied community health professionals to discover if there is a less sensitive referral network for women which affects treatment entry.

This study used a knowledge/attitudes/behaviour approach to examine referral practices. Research indicated that individuals generally experience the acquisition of knowledge and development of attitudes in the course of behaviour change (Ajzen and Fishbein 1978; Best and Flay 1978; Hochheimer 1979; McGuire 1978). Although it is often assumed that knowledge must precede attitudes formation, which in turn must precede the adoption of a behaviour, this is not valid. It has been demonstrated that such a progression is neither necessary nor sufficient for all types of behaviour change (Hochheimer 1979; Ray 1973; Wallack 1981). For instance, adoption of a behaviour may precede the development of complementary knowledge and attitudes. Rather than viewing knowledge to attitudes to behaviour, it would appear that various sequences may have a potentially useful and effective place in the behaviour change process. The author chose to gather information about present knowledge and attitudes of community health professionals in order to gain a better understanding of referral behaviour for chemically dependent women.

COMMUNITY HEALTH PROFESSIONALS' ATTITUDES TO THE CHEMICALLY DEPENDENT

Attitudes have to do with the way we respond to people, things and events based on our beliefs (Craig 1986). Attitudes include positive or negative evaluations, emotional feelings and the intensity of our responses. We can have a favourable, unfavourable or neutral attitude toward a person, thing or event. The strength with which we hold attitudes refers to how much we like or dislike someone or something. The importance of the attitude to us means that we place more significance on specific people, things, or events than others and our responses and behaviours will reflect this. All of our beliefs and attitudes are learned. We learn from the people we live with and from associations of things and events we experience (Craig, 1986). Because these attitudes are learned, they can be unlearned, changed, or altered. Nevertheless, these changes will often be resisted.

Gomberg (1979) identifies attitude change as a key factor in the recognition and reduction of drug abuse among both males and females. Vannicelli (1984) and Heinemann (1986) both agree that beliefs of the treatment personnel can be passed to the clients and that these beliefs can affect the results of the treatment goals. A study by Leake and King (1977) regarding the effect counsellor expectations have on the client's recovery, found when therapists expressed positive expectations for a client, the client performed significantly better than the control subjects. It is conceivable that a referral agent's expectations of a client's recovery can influence the likelihood of a client utilizing

treatment. In other words, the expectations of a referral agent may be a determining factor in the chemically dependent person's own potential for attaining his or her goal.

Two negative attitudes held by health professionals towards women with drug problems is that chemically dependent women are either more or less sick than their male cohorts. Women have been described as more deviant or abnormal than men (Gomberg 1979). Beckman (1975) found evidence that women and men have similar levels of psychopathology and that in contrast to the general attitude, women may not have as severe behavioral impairment. McCranie, Horowitiz, and Martin (1978) discover physicians are less likely to believe that a woman's symptoms indicate underlying physical problems than a man's. A review of women's vulnerability to biomedical consequences of alcohol abuse by Harris (19875) concluded death from all alcohol - related causes is as high for female alcoholics as male alcoholics. Furthermore some research indicates the development of some conditions, particularly liver disease may be accelerated in women (Harris, 1985).

These attitudes combined with a doctor being unable or unwilling to diagnose a woman as chemically dependent, results in the doctor giving her condition another label. "All too often a physician notes the distraught state of the alcoholic female client, makes a preliminary diagnosis of 'depression' or 'anxiety' and proceeds to prescribe a pill to alter her mood, most commonly a tranquillizer, sedative or antidepressant" (Sandmaier, 1980, p.210). Prescribing a chemically dependent woman tranquillizers or antidepressants can have several negative effects. It

not only provides her with another chemical escape valve, but, as a respectable "woman's drug", it can be taken openly without guilt. The prescription of a psychoactive drug may serve as a welcome reinforcement of the woman's denial and the professional's denial of her alcohol problem. Consequently, her drinking will almost certainly continue unabated, complicated now by the addiction of a second drug (Sandmaier, *1980).

Prescribing mind-altering drugs to an alcoholic can result in dependency on both substances. This is defined as cross or dual addiction. Anyone who habitually uses psychoactive drugs may become addicted to them, but the alcoholic is at particularly high risk as she has already established an addictive drug use pattern with alcohol. Cross addiction keeps a woman drinking for a longer period of time. She may be able to switch to Valium or another pill temporarily when the effects of alcohol become too staggering for her body to bear. Since physicians prescribe psychoactive drugs to women in the general population at almost twice the rate for men, it is perhaps not surprising that alcoholic women are far more likely to be cross addicted than men (Sandmaier, 1980). A woman addicted to both alcohol and pills is likely to face more difficulties in treatment. She must withdraw and recover from the effects of two or more powerful drugs instead of alcohol alone.

Psychoactive drug use is not risk free for anyone, but it is especially dangerous for problem drinkers for several reasons. Perhaps the most obvious danger is that of mixing a mood altering drug with alcohol. The combination of alcohol and certain psychoactive drugs

produces an interactive effect that is substantially more powerful than the effects of any of the drugs taken alone. Consequently, there is an increased possibility of accidental death by overdose. As well, access to both alcohol and psychoactive drugs makes suicide attempts a relatively easy matter.

In summation, negative attitudes by health professionals intensify the tragedy and pain experienced by the chemically dependent woman. They contribute to the lack of identification and referral for treatment by community health professionals. Furthermore, negative attitudes strengthen the invisibility of chemically dependent women and increase the incidence of chemical dependency in women.

COMMUNITY HEALTH PROFESSIONALS' KNOWLEDGE OF CHEMICAL DEPENDENCY IN WOMEN

As noted earlier, physicians appear highly unlikely to diagnose addiction in their female patients even though they are expected to recognize the symptoms of chemical dependency (Sandmaier 1980). The primary reason for many doctor's failure to confront addiction problems in their patients is, perhaps surprisingly, a lack of knowledge. Chemical dependency is one of the most neglected areas of study in medical schools. Sandmaier (1980) found the curriculum in medical schools for alcohol abuse ranged from a single lecture to one course on the subject. In 1984, Beckman found only 29% of private physicians and persons working in female organizations had received any type of alcohol related training.

This gap in education is largely due to alcoholism's heritage as a moral problem rather than a medical one, despite its obvious physical and emotional consequences. The complexity of alcoholism also stymies many doctors. In short, alcoholism is viewed by the medical profession as a notoriously unpopular illness to treat. These factors in combination are likely to inhibit many physicians from confronting any patient - male or female - with an alcoholic problem. Shaw et al (1978) reveal that the professionals believe they lack the knowledge and skill to deal effectively with alcohol-related problems. Consequently, they tend to doubt the legitimacy of their role in diagnosing alcoholism.

Like negative attitudes, knowledge gaps in the understanding of women's chemical dependency contribute to the lack of recognition and treatment. The prescribing of psychoactive drugs by physicians who lack knowledge of alcoholism reinforces the woman's denial of her drug use and complicates treatment as she now must experience withdrawal from two or more addictive substances. Such prescribing also complicates diagnosing of chemical dependency. In diagnosing alcoholism in a woman, the volume of alcohol consumption is an important consideration. It is well established that alcoholic women on the average drink less than men but experience the same degree of impairment. It is particularly important to recognize that use of other sedatives may contribute to the woman's alcoholic impairment. Instead of a morning drink, she may have a morning Valium; her night cap may contain less alcohol and more sedative drugs. Thus chemical dependency should not be diagnosed as a function of the quantity of intake alone. Drinking and other drug use patterns, and

changes in personality and functioning, are the primary considerations (Blume 1988).

Although lack of knowledge confounds the recognition and treatment of women's chemical dependency, it may be argued that differing knowledge bases produce a great many pernicious consequences. Attitudes and knowledge of community health professionals are influenced by educational background and experience and the place of learning. They subscribe, through indoctrination, to a particular knowledge about people, events, and things, and how they work. Professionals acquire a specific view of themselves in the world. They acquire a sophisticated set of interpersonal and technical skills which makes possible the practice of their professional roles. They embrace a code of ethics which guides their professional behaviour. Consequently, all are trained to view people from a broad range of perspectives. Each uses a different knowledge base to understand human behaviour. The result is different solutions and different problem-solving behaviours. If one believed drug dependency is a disease, one would believe in treatment of the individual by medical procedures, chemical/social education, and rehabilitation. If others believed drug dependency was a moral issue whereby the person's soul is threatened, their concern would be to change the behaviour so as to assure the person's soul is saved. Others may believe chemical dependency results from tensions arising from unmet needs, faulty learning, social inequalities and coercive social pressures. They would try to manage resources, provide support and work towards addressing inequalities.

Diverse attitudes and knowledge can act as enlightenment and enrichment of understanding or can act as barriers depending on the openness to each other and the desire to reach consensus on behalf of those in need. This study strives to understand the specific concepts to which different professionals subscribe, their attitudinal orientation, and the perspectives each have regarding chemical dependency.

In summation, negative attitudes and knowledge gaps regarding chemically dependent women do exist. These attitudes and lack of knowledge result in the lack of identification and treatment of women. Negatives attitudes and lack of knowledge perpetuate, confound, and increase drug problems in women. Attention to attitudes and knowledge is necessary in the design and implementation of effective interventions. Without such awareness, chemically dependent women will continue to be "the most wounded and needy members of our society" (Mondanaro 1989).

Chapter II

DESIGN OF THE PRACTICUM

OVERVIEW

As previously stated, the purpose of this practicum was to examine the attitudes and knowledge of community health professionals. The success of the research required the support and cooperation of the Alcoholism Foundation Of Manitoba. In order to obtain this, a number of preliminary meetings were held with relevant people to discuss the practicum and to enlist their support. The research proposal was then forwarded to the External Research Review Committee of the Planning and Research Directorate. This committee accepted the proposal after certain changes were made. This was completed in May, 1988.

A copy of the practicum report will be given to the regional administrator, the research and data systems coordinator, and A.F.M. library. A formal presentation was given by the author at the Alcoholism Foundation of Manitoba's Conference entitled "Women And Substance Abuse: Strategies For The Nineties" on March 12, 1990. All of these endeavours are an attempt to effect change. The respondents who showed an interest in these findings will receive a summation of this practicum.

RESEARCH DESIGN

The research design is a cross sectional survey utilizing a mail out questionnaire. The survey is a one time only observation with the intention to make assertions about the population being studied.

A mail-out survey design was chosen because of the following assets. This design was economical; posting and printing were the only costs incurred. A mail-out allowed a greater geographic outreach; specific groups could be reached through their professional organizations. With mail-out surveys, respondents are more accurate. Respondents are less likely to over report socially desirable behaviour and more likely to admit undesirable behaviour. (Dillman, 1978). Similarly, responses to attitude questions are thought to be more accurate with a mail-out survey (Dillman, 1978).

The liabilities of this research design are a low response rate, administrative difficulties, and sampling bias. Administratively, a mail-out survey requires simplicity, few questions, and closed versus open-ended questions. A lack of clarity and a high level of comprehension can cause sampling bias. Rather than consulting with the writer, respondents may have consulted with others or their records. Such behaviours vary performance ratings and create sampling bias.

The approach used in developing this mail survey was the "total design method" (TDM). This term reflects the premise on which it is based. Namely, to maximize both the quality and the quantity of responses, attention must be given to every detail that might affect response behaviour. The TDM was developed by Don Dillman in 1978. It relies on a theoretically based view of why people do and do not respond to questionnaires and a well-confirmed belief that attention to administrative details is essential to conducting successful surveys. Consequently, attention was given to how each aspect of the questionnaire,

from the most obvious to the least obvious, may affect the recipient's decision to respond. The goal, in short, was to present an attractive, well-organized questionnaire that was easy to complete.

A covering letter was utilized to emphasize how important it is for community health professionals' opinions to be taken into account in reviewing treatment for chemical dependency (refer to Appendix 1). An additional sense of importance was further communicated by the cover of the questionnaire, which carried an interest-stimulating title, "Chemical Dependency: A Health Concern For All". No questions were permitted on the front or back cover pages. These spaces, the ones most likely to be seen first by the respondents, were reserved for material that had the specific purpose of stimulating interest in the questionnaire.

The questionnaire booklet was reproduced on white paper and printed to ensure quality very close to the original typed copy. The questionnaire was also designed to fit the recommended size for mail-out and return envelopes. Large questionnaires require envelopes that impose a negative image. Since manilla envelopes were considered too bulky and impersonal, standard eight and one-half by eleven and one-half inch envelopes were utilized.

The initial ordering of questions was based on the belief that if respondents are able to answer early questions quickly, fears that the questionnaire contains difficult and time-consuming questions are overcome. This led to demographic questions being on the first page. The second page had questions that pertained to the respondents' perception of his/her own experience and knowledge about chemical

dependency. Again this ordering of questions was based on the earlier stated premise. The ensuing questions were harder to answer. They were questions related to attitudes, beliefs, and opinions.

Page three of the questionnaire focused on women's and men's chemical dependency. The following questions logically tied in with this focus. This was done to take advantage of the cognitive ties that respondents were likely to make among groups of questions.

The use of subtitles such as "Experience/Knowledge Of Chemical Dependency" and "Defining Who Is Chemically Dependent" were used to enhance the cognitive ties respondents would make. These subtitles are called transitions. They are the connective material that provides a sense of flow and continuity to the questionnaire. They also guide respondents from one part of the questionnaire to another, giving warning that a change is imminent. The subtitles also reduced the potential for monotony associated with a long series of questions on a single topic. They were added to give a conversational tone to what might otherwise sound like an inventory list of questionnaire items.

Questions within content areas that required respondents to indicate their extent of agreement and agreement were placed together. Two purposes were served by this plan. The first was to ease the mental effort required for constant switching from one question to another. The second purpose was to encourage well thought out answers. An example of this is on page seven of the questionnaire.

The majority of the questions in the questionnaire were closed-ended. Occasionally, open-ended questions were utilized to obtain more

information. The choice of questions was somewhat determined by prior research. Specific wording of the questions regarding attitudes was determined by the author by consulting numerous books on attitude surveys. Their order, as detailed earlier, was considered to be an integral part of the success of the questionnaire. Several colleagues, with addiction expertise, previewed the questionnaire and gave their recommendations. Professor Raymond Curry, a sociologist from the University of Manitoba, offered many valuable suggestions that enhanced the reliability of the study.

Community health professionals from the city of Winnipeg comprised the survey population. The primary sampling units of this population were community health and employee assistance workers. Employee assistance workers were considered health-oriented professionals because they provide assistance in areas of health, relationship, or mental health problems. The focus on medically-orientated programs excluded some community programs that offer services specifically for minority groups such as women, natives and immigrants.

These sampling units were chosen because they were health oriented line personnel who could have been or were potential referral agents for chemically dependent women. As mentioned earlier, women were thought to be more health conscious than men and therefore, more likely to seek help from health-oriented professionals.

> "Thus while she is less likely to avoid the fact that a problem (chemical dependency) exists than a man would be, she is very likely to seek assistance from persons or systems that she perceives to have expertise in health, relationship, or mental health problems" (Reed, 1985, p. 36).

The following list identifies the community health programs that comprise the sample.

Youville Clinic Outreach
Youville Clinic Inc.
Nor' West Co-operative
Women's Health Clinic Inc.
Hope Centre
Health Action Centre
Mount Carmel Clinic
Klinic
Victorian Order Of Nurses
City Of Winnipeg - Public Health Nurses
Community Health Services - West, South, North Divisions
Employee Assistance Program Association

Of the above mentioned community health programs, Klinic was the only agency that was unable to participate in this survey. Also the researcher excluded managerial, maternity leave and Alcoholism Foundation Of Manitoba personnel from the membership lists from each participating community health program. These exclusions were made so the sampling units would be "potential" referral agents.

Two modes of sampling that were utilized were inclusion of all possible respondents and random sampling. Both of these modes and the large size of the sample ensured the representation of the population of interest. From the membership lists of Community Health Services Division and City Of Winnipeg Public Health Nurses, there were a total of 42 sampling units each. Writer then chose 42 sampling units from the Victorian Order Of Nurses by random selection. From the updated membership list of the Employee Assistance Personnel, the writer chose to survey the total population which was 61 sampling units. From the Manual

of Social Services (1987-88), the writer determined the community health programs. The sample size of community health workers in the community, excluding Klinic, was 30. As the researcher wanted a total sample size of approximately 200, all of the possible community health workers were surveyed.

The Total Design Method was also utilized in the implementation of the mail survey. This method recommended that the initial mailing occur on Tuesday, rather than Monday or Friday. After the survey was mailed on Tuesday, October 18, 1988, two follow-up mailings were done. The first follow-up mailing (mailed Wednesday, October 26, 1988), was in the form of a reminder post card that arrived one week after the initial mailout. The second follow-up was sent three weeks after the first mailing (Tuesday, November 8, 1988). With this letter, another questionnaire was enclosed. Please refer to the Appendix for follow-up letters and post card reminder.

CHAPTER III

1) SURVEY FINDINGS

Descriptive:

The first part of this chapter presents a descriptive analysis of the survey beginning with of the response rate. In the latter part of this chapter a more specific account is given. This latter account highlights the similarities and differences between the three sample groups within the survey populations. Both the descriptive and the comparative findings are divided into three main areas. They are demographics, attitudes regarding origin of chemical dependency and treatment for chemical dependency and knowledge. These areas are discussed in the above order.

The total sample size was 217. One hundred and sixty-six completed surveys were returned to the researcher. This is an overall response of 77%. A breakdown of the response rate is as follows:

Nurses:

Community Health Services	-	83% of 42
Victorian Order of Nurses	-	79% of 42
City of Winnipeg, Public Health	-	74% of 42
Combined response rate	-	85% of 126
Community Health Workers	-	70% of 30
Employee Assistance Personnel	-	62% of 61

A. Demographics:

Of the one hundred and sixty-six respondents, eighty five per cent were female. This percentage is consistent with the over representation of women in the helping professions. The majority of the sample had attained a Baccalaureate degree. One half classified their occupations as nurses and one quarter classified their occupation as counsellor. Fifty percent of the respondents had worked 4 year or less. In summation, the majority of this female dominated sample Baccalaureate degrees and four years of less work experience.

The respondents were asked to identify how they had gained their knowledge regarding chemical dependency. The following list reveals the ways in descending order.

Publications	95%
Personal Experience	75%
Training Workshops	72%
Full Courses	41%

It appears knowledge about chemical dependency is learned most often on an individual basis versus a group basis and at an informal level versus a formal level.

The place of employment was mentioned most often as the place where training and/or courses occurred (62%). Forty-four percent indicated the Alcoholism Foundation of Manitoba was where they learned about chemical dependency. University studies was mentioned next (43%). It appears that

an understanding of chemical dependency is influenced the most by the place of employment. Ironically, the opportunity to teach such an understanding was not utilized in universities where most of this sample had attended for at least three years.

B. Attitudes:

1. Opinions re Origin of Chemical Dependency

The sample was presented with seven statements regarding the contributing factors to chemical dependency. They were asked to indicate whether they strongly agree, agree, neither agree or disagree, disagree strongly, disagree, or don't know. Responses to the statement - Chemical dependency is a result of a moral weakness revealed 41% strongly disagreed and 37% disagreed. Combining these two categories, over 75% of all the respondents disagreed with the statement. In contrast, 7% of the respondents agreed that chemical dependency is a moral weakness. 12% neither agreed or disagreed. It is evident that 20% of the sample could not disagree with the moral aspect.

The statement - Chemical dependency is a result of a personality flaw, revealed that almost two thirds of the sample disagreed with this statement (30% disagreed and 31% strongly disagreed). Fifteen percent of the total respondents agreed that chemical dependency has a character flaw. Eighteen percent neither agreed or disagreed with the statement. It appears that one third of the sample could accept to some degree that chemical dependency is a result of a personality flaw.

The following chart illustrates the percentages for the other five statements that measured opinions re the origin of chemical dependency.

The are listed in descending order for the combined value.

Table III-1 PERCENTAGE OF AGREEMENT TO STATEMENTS REGARDING ORIGIN OF CHEMICAL DEPENDENCY

		Most frequent value	Combined Strongly Agree and Agree
1.	A reaction to stress can lead to chemical dependency	Agree 58%	92%
2.	Chemical dependency is affected by the availability of drugs	Agree 51%	73%
3.	Chemical dependency is a learned behaviour	Agree 49%	69%
4.	Chemical dependency is a result of a reaction to losses	Agree 48%	58%
5.	Chemical dependency is hereditary	Agree 37%	41%

The first three statements concur with the strategies of the Alcoholism Foundation of Manitoba's prevention policy. They are, in order, competency development, control, and influence (AFM, 1986). Competence development strategy entails activities that are intended to improve individual's skills in order to enhance their ability to deal with every day life situations. The control strategy includes actions which affect legislation or regulations in order to modify a drug, its availability, or the demand for that drug. Influence strategy attempts to modify individual's attitudes through education and information. It

would seem that the respondents are very favourable of the basic tenets underlying the prevention policy of chemical dependency.

The statement - Chemical dependency is hereditary - had a fairly even grouping of scores between agree, neither agree or disagree and disagree. Combining agree and strongly agree the percentage was 41%. Combining disagree and strongly disagree, the percentage was 34%. This suggests that there is no significant agreement or disagreement that chemical dependency is hereditary.

In conclusion, it appears the respondents hold varying attitudes regarding the origin of chemical dependency. This is demonstrated by the range of combined agreement. The range of responses was from 92% to 41%. This implies there are some attitudes that are more predominant than others. Which of these attitudes are negative? As mentioned earlier, negative attitudes in part result in the lack of identification and treatment of chemical dependents.

2. Beliefs about treatment

Respondents were asked to reveal their beliefs regarding chemical dependency treatment for both men and women. It was hypothesized that there would be some varying beliefs. The respondents were asked three questions in which the response categories were strongly agree, agree, neither agree or disagree, disagree and strongly disagree.

The first question was, "In your opinion, which gender is more reluctant to seek treatment for chemical dependency?" Less than half of the total respondents believed women over men were more reluctant to seek treatment (44% to 27%). Twenty nine percent chose no difference.

Research indicates there are more negative social consequences and barriers for women than for men who enter treatment. Beckman and Amaro (1984) found that women encounter more opposition to treatment from their friends and families. They also found that women perceive more negative consequences associated with entering a treatment facility than do men, in terms of disruption in family relations, feelings of loneliness and discomfort, loss of job, being avoided by co-workers,and loss of friends. The respondents who believed women over men were more reluctant to seek treatment may have been knowledgeable about these barriers to treatment for women. However some of them may have lacked this knowledge. They may have believed that women are just harder to treat. Vanicelli (1986) discovered there is a myth that women are harder to treat. She found this myth in professionals who work directly or indirectly with chemically dependent women. The survey question does not clarify why respondents find women more reluctant to seek treatment. To the extent that chemically dependent women lack treatment services, the reasons why respondents believe women are more reluctant to seek treatment need to be more fully explored.

The next two questions pertained to beliefs regarding recovery. Respondents were asked, "<u>If both men and women received treatment for chemical dependency, which gender do you believe is more likely to recover</u>?" Half of the respondents indicated that they believed there was no particular gender that was more likely to recover after treatment. Of the remaining respondents (33%) chose women over men (16%) to more likely to recover. These findings suggest that the majority of the sample

believe that men and women are equally likely to recover from addiction.

The second question regarding recovery is similar to the previous question. The question was "What percentage of people do you believe recover from drug-related problems after seeking treatment?" The findings reveal that women are favoured to recover from drug-related problems after seeking treatment. One third of the sample favoured 30% or less for men and 37% or less for women. Similarity, two thirds of the sample favoured 50% or less for men and 60% or less for women to recover.

Although questions 33 and 34 regarding recovery are similar, the findings are somewhat different but not incompatible. An explanation for the somewhat varied findings is there exists an unconscious attitude that women rather than men are more likely to recover. This is based on the belief that women have a greater potential for change because they are more emotionally competent than men. This attitude can have two opposing effects on the treatment and recovery of chemically dependent women. It could motivate women to recover or relapse. An overgeneralized attitute regarding recovery could result in some chemically dependent women being overly critical of their recovery and themselves. Such a behaviour usually results in relapse. This explanation for different findings between two similar questions is evidence that research on attitudes is necessary in order to understand the affects attitudes can have on recovery.

In summation a majority respondents believed women are more reluctant to seek treatment and are more likely to recover after seeking treatment. If potential referral agents believe women are more reluctant

to seek treatment, they may not engage in referral discussion. Consequently, this belief could have negative effects regarding treatment for women with chemical dependency. In contrast, the belief that women are more likely to recover is a positive attitude that may positively influence recovery.

c. Knowledge

Since some knowledge about chemical dependency is dependent on who is considered an expert, the author chose to utilize the Alcoholism Foundation of Manitoba's knowledge base in order to compare responses. In particular the author wanted to research respondent's knowledge of chemical dependency as a progressive illness that is not due to a lack of will power.

Questions 27, 39 and 41 of this questionnaire covered these three dimensions of the Alcoholism Foundation of Manitoba's definition of chemical dependency. The statement - Chemical dependency is an illness or disease addresses the disease concept. Nearly all of the respondents (89%) agreed with this statement. The response to the statement - If a chemical dependent person does not get help, their chemical dependency is likely to get worse and worse was overwhelming agreement (93%). Similarly, nearly all the respondents (94%) responded in support that addiction is not due to lack of willpower - Chemical dependent individuals could easily pull themselves together and stop using drugs if they wanted to. In sum, it appears that the sample as a whole, strongly concur with the Alcoholism Foundation of Manitoba's definition of chemical dependency.

Since the respondents appear to agree with the Alcoholism Foundation of Manitoba's understanding of chemical dependency, it would logically follow that they would acknowledge the need for treatment for a chemical dependent individual. They would not blame the individual. In contrast, they, as caregivers, would feel responsible to refer an ill person to treatment.

The respondents were also asked to list three residential programs for each gender. This question identified respondents knowledge level of treatment programs. If respondents lacked knowledge regarding residential programs, it was unlikely that they would refer chemical dependent individuals. The mean score for respondents knowing about men's residential program was 1.5 and women's residential program was 1.3. In other words, the respondents could identify one out of three residential treatment programs for either gender. This can be considered minimal awareness. Chemically dependent individuals' needs are met in different ways and in different treatment programs. Limited awareness of residential programs can be equated with limited treatment opportunities for chemically dependent individuals.

Respondents were asked to list five indicators that lead them to suspect a client is chemically dependent. On the average, four out of five symptoms were listed for men and women. This is evidence the total number of respondents can recognize chemical dependency and should be able to identify it in their clients.

2) COMPARISON OF FINDINGS BETWEEN THREE GROUPS:

The following is a comparative analysis of the survey findings. This is accomplished by dividing the sample into three subsamples. The author chose to divide the health orientated sample by employment criterion. The subsample titled Nurses are employed by Manitoba Health, Victoria Order of Nurses or City of Winnipeg. These three agencies have a similar mandate - the providing of health care to the community mainly by homecare services. The subsample of group called Community Health Workers are composed of professionals employed in community health care centres wherein clients seek health care. Employee Assistance Personnel could not be divided into a common place of employment because of the realities of their role. They are representatives of various organizations. Consequently individuals who represent the subsample titled Employee Assistance Personnel (EAP) were chosen by their identification as employee assistance workers. Although the sample could have been divided by professions, the author chose not to do so. She believed that there were more opportunities in a division based on employment settings. The author was aware that the AFM analyze referral agents based on their place of employment and not their profession. Furthermore, the author was aware of the recent increase in research of employee assistance workers. She desired to gain some data on employee assistance workers in order to compare at some later date with other research that had a similar focus.

A. Demographics:

The following table (Table III-2) shows the various professionals within the three subsamples. The percentages of each type of professional are included.

Table III-1 LIST OF PROFESSIONALS WITHIN EACH GROUP

Community Health Workers	Employee Assistance Personnel	Nurses
Nurse 29%	Counsellor 68%	Nurse 84%
Counsellor 24%	Educator 8%	Home Care Worker 9%
Physician 14%	Consulting psychologist 8%	Home Economist 4%
Gerontology Worker 14%	Office Manager (Clerk) 8%	Counsellor 1%
Educator 5%	Nurse 3%	Gerontology Worker 1%
Home Economist 5%	Payroll Supervisor 3%	Community liaison support worker 1%
Home Care Worker 5%	Police sergeant 3%	
Community liaison support worker 5%		
n = 21	n = 38	n = 107

The three sample groups were mainly comprised of women respondents. Employee Assistance Personnel was the only group that was close to being equally divided between females (53%) and males (47%). The Community Health Workers had 67% females and 33% males while the Nurses was 100%

female. With reference to education, the majority of the Nurses sample had the highest educational background (84% had Baccalaureate degrees). The second highest grouping were the Community Health Workers with 38% having Baccalaureate degrees. In contrast, the majority of Employee Assistance Personnel had attained university diplomas (30%) rather than Baccalaureate degrees (21%). The majority of respondents of both Community Health Workers and Nurses were employed four years or less. The majority of respondents of the Employee Assistance Personnel were employed 8 years or less.

Table III-2 demonstrates the ways in which respondents gained knowledge about chemical dependency.

Table III-3: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES

Responses	Community Health Nurses	Employee Assistance Workers	
Publications	100%	100%	93%
Training Workshops	83%	97%	59%
Personal Experience	64%	75%	77%
Full Courses	36%	78%	26%
	n = 21	n = 38	n = 107

It appears all three groups rated publications as the most common way of gaining knowledge regarding chemical dependency. The second most common way was training workshops for both Employee Assistance Personnel and Community Health Workers. Nurses rated personal experience as the second most common way of knowing. The third way of gaining knowledge

varied between all three groups. Community Health Workers rated personal experience. Employee Assistance Personnel rated full courses. Nurses rated training workshops. The fourth most common way was full courses for both Community Health Workers and Nurses. Employee Assistance Personnel rated personal experience fourth. It is evident that the different groups varied in their ways of gaining knowledge about chemical dependency. It logically follows that the groups may also vary in their knowledge of chemical dependency.

The three sample groups were questioned where the training workshops and/or courses occurred. Employee Assistance Personnel rated first the Alcoholism Foundation of Manitoba and secondly, place of employment. Community Health Workers rated place of employment first then Alcoholism Foundation of Manitoba. Nurses rated place of employment first then university second. It appears the Alcoholism Foundation of Manitoba have more educational involvement with Community Health Workers and Employee Assistance Personnel than with Nurses. The Nurses' rating of university as the second most common place of learning is misleading. When Nurses rated their ways of learning about chemical dependency, they rated full courses fourth (26%) which was the lowest rating for all the groups. Since Nurses rated university the second most common place of learning, the author expected that full courses would be rated higher as full courses occur at university. However this was not the case. The author then realized that education regarding chemical dependency for nurses is limited to a part of a course rather than a full course.

Of the three groups, only Employee Assistance Personnel indicated that the Alcoholism Foundation of Manitoba was the most common place of training or courses. The other groups rated employment as the place where training or courses occurred. The questionnaire did not clarify whether AFM staff conducted workshops at different places of employment. If AFM staff did not conduct workshops at different places of employment, it is possible that these training workshops result in a different knowledge of chemical dependency.

B. Attitudes Regarding Chemical Dependency

Respondents were presented with seven statements regarding origin of chemical dependency. Response categories were strongly agreed, agree, neither agree nor disagree, disagree, strongly disagree, or don't know with each of the statements. Their responses are shown in the seven tables that follow the seven statements regarding chemical dependency.

With the statement - Chemical dependency is a result of a personality flaw - both Community Health Workers and Nurses most frequently responded to strongly disagree (35% and 30% respectively). Employee Assistance Personnel rated disagree most frequently (45%). Combining strongly disagree and disagree, 55% of Community Health Workers, 76% of Employee Assistance Personnel, and 57% of Nurses disagreed (Refer to Table III-4). The difference between percentages is largest between Community Health Workers and Employee Assistance Personnel. This indicates there is a noteworthy difference in intensity between these two groups. If professionals view chemical dependency as a personality flaw,

they attach responsibility for addiction on the individual. They blame the individual for his/her addiction. Community Health Workers seem to attach more responsibility of addiction on the individual then EAP. Thirty percent of Community Health Workers agreed with the statement while only 5% of EAP agreed.

Table III-4: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 25: CHEMICAL DEPENDENCY IS A RESULT OF A PERSONALITY FLAW.

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree (1)	5.0%	--	1.9%
Agree (2)	25.0%	5.3%	13.3%
Neither Agree nor Disagree (3)	15.0%	15.8%	20.0%
Disagree (4)	20.0%	44.7%	26.7%
Strongly Disagree (5)	35.0%	31.6%	30.5%
Don't Know	--	2.6%	7.6%
	N = 21 M = 3.5	N = 38 M = 4	N = 107 M = 3.8

M = mean.

With reference to the statement - Chemical dependency is a result of a moral weakness - Community Health Workers mostly disagreed (45%), Employee Assistance Personnel equally disagreed and strongly disagreed (45%) and nurses mostly strongly disagreed (41)%. Combining strongly disagree and disagree, the findings were 80% for Community Health Workers, 89% for Employee Assistance Personnel, and 74% for Nurses. These findings as shown in Table III-5 reveal there is differing levels of acceptance

regarding chemical dependency being a moral weakness. Between Employee Assistance Personnel and Nurses, there is a 15% difference when strongly disagree and disagree are combined. Although alcoholism has been recognised as a disease by the medical profession since 1956, alcoholics and other chemical dependents may be still viewed by many as weak or immoral. This view reflects an emotionally - charged judgemental attitude toward the chemical dependent rather than a view of chemical dependency as a health and/or social problem.

Table III-5: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 24: CHEMICAL DEPENDENCY IS A RESULT OF A MORAL WEAKNESS

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	--	--	0.9%
Agree	--	7.9%	6.5%
Neither Agree nor Disagree	20.0%	2.6%	14.0%
Disagree	45.0%	44.7%	32.7%
Strongly Disagree	35.0%	44.7%	41.1%
Don't Know	--	--	4.7%
	N = 21	N = 38	N = 107

The statement - Chemical dependency is a result of a reaction to losses revealed a great variation in responses as shown in Table III-6. Combining strongly agree and agree, Community Health Workers agreed 50%, Employee Assistance Personnel agreed 27%, and Nurses agreed 68%. Employee Assistance Personnel most frequently responded to neither agree nor

disagree. Their next most frequent response was disagree 24%. Utilizing the t-test, it was found that the Employee Assistance Personnel's mean was statistically different from the Nurses mean (P>.001). This statement refers to the belief that chemical dependency is the outcome of unhealthy coping behaviour. This belief has its roots in social learning theory. Opponents of this theory are those who see chemical dependency as the primary problem rather than as a result of other problems. The responses indicate that Nurses are strong supporters of the learning theory while the EAP are opponents.

According to Mondanaro chemically dependent women "see their chemical dependency as a result of other problems rather than as the primary problem and report the use of alcohol and drugs as a coping mechanism more often than men" (Mondanaro, 1989, p.5). Since chemically dependent women identify problems related to their families, relationship with their partners, emotional difficulties (such as anxiety or depression), and medical well-being, they are likely to seek assistance from persons or systems that she perceives to have expertise in health, relationship or mental health areas (Mondanaro, 1989, Reed, 1985). If professionals in these areas believe the problem is other than addiction, their behaviour will encourage the chemically dependent women to continue to avoid the fact that a chemically dependency problem exists.

Table III-6: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 30: CHEMICAL DEPENDENCY IS A RESULT OF A REACTION TO LOSSES

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	5.0%	5.4%	12.1%
Agree	45.0%	21.6%	56.1%
Neither Agree nor Disagree	30.0%	43.2%	20.6%
Disagree	5.0%	24.3%	9.3%
Strongly Disagree	10.0%	2.7%	0.9%
Don't Know	5.0%	2.7%	0.9%
	N = 21	N = 38	N = 107

Combining disagree and strongly disagree (Table III-6), Employee Assistance Personnel disagree 27%, Community Health Workers disagree 15%, and Nurses disagree 10% with the statement - Chemical dependency is a result of a reaction to losses. This order of disagreement indicates the subsamples varying focus on chemical dependency versus other problems. If professionals focus on chemical dependency, they will identify it more readily. In turn, this would facilitate the chemically dependent women accurately identifying her problems. Rather than seeing her chemical dependency as a result of other problems, she would identify chemical dependency as the primary problem. The clarity would enable her to seek assistance from persons or systems that she perceives having expertise in chemical dependency rather than health, relationship, or mental health areas.

The findings shown Table III-7 indicate that the three sample groups responded similarly to the statement - A reaction to stress can lead to chemical dependency. The most frequent response was agree. Combining strongly agree and agree, over 75% of the respondents agree with the statement. This question is somewhat similar to Question 30 - Chemical dependency is a result of a reaction to losses. They both address the interplay of stress and chemical dependency. However, question 30 promotes a stronger relationship between stress and the origin of chemical dependency. Because the findings in Table III-6 reveal strong agreement, it can be stated that all three groups believe there exists a relationship between stress and chemical dependency. However, the findings regarding Question 30 reveal that there is not such a strong belief regarding stress and the origin of chemical dependency. It is noteworthy that Employee Assistance Personnel did not as strongly agree as the other two groups for both questions. Utilizing the t-test,it was found that the Employee Assistance Personnel's mean significantly varied from Nurses' ($P>.003$) and Community Health Workers ($P>.03$).

Table III-7: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 26: A REACTION TO STRESS CAN LEAD TO CHEMICAL DEPENDENCY

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	40.0%	15.8%	40.2%
Agree	55.0%	68.4%	54.2%
Neither Agree nor Disagree	5.0%	13.2%	3.7%
Disagree	--	--	1.9%
Strongly Disagree	--	2.6%	--
Don't Know	--	--	--
	N = 21	N = 38	N = 107

With regard to the statement - Chemical dependency is affected by the availability of drugs, the majority of each group agreed with this statement as shown in Table III-8. Combining strongly agree and agree, 60% of Community Health Workers agreed, 74% of Employee Assistance Personnel agreed, and 73% of Nurses agreed. As mentioned earlier, a primary prevention strategy for chemical dependency is decreasing the availability of drugs. Those who disagree with this strategy may negatively effect the prevalence of drug abuse. In the earlier chapter, reference was made to the prescribing of other drugs to alcoholic women. This behaviour was seen supporting the denial of the chemically dependent woman and increasing her chances of being dually addicted.

Table III-8: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 28: CHEMICAL DEPENDENCY IS AFFECTED BY THE AVAILABILITY OF DRUGS

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	15.0%	23.7%	1.7%
Agree	45.0%	50.0%	50.9%
Neither Agree nor Disagree	20.0%	13.2%	10.4%
Disagree	10.0%	13.2%	9.4%
Strongly Disagree	10.0%	--	3.8%
Don't Know	--	--	3.8%
	N = 21	N = 38	N = 107

With the statement - Chemical dependency is a learned behaviour, 50% of both Employee Assistance Personnel and Nurses responded with agree. In contrast only 20% of the Community Health Workers agreed and 35% strongly agreed. When strongly agree and agree are combined the contrast is smaller. As shown in Table III-9 Community Health Workers agreed 55%, Nurses agreed 69%, and Employee Assistance Personnel agreed 58%. An implication of this finding is a majority of the respondents support unlearning and relearning in the recovery process of chemical dependency. Another implication is over half of all the respondents in all the groups acknowledge chemical dependency may be passed from one family member to another through learning. This, in turn, implicates the need for chemically dependency treatment to include family members.

Table III-9: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 31: CHEMICAL DEPENDENCY IS A LEARNED BEHAVIOUR.

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	35.0%	7.9%	18.7%
Agree	20.0%	50.0%	50.5%
Neither Agree nor Disagree	20.0%	15.8%	14.0%
Disagree	15.0%	21.1%	9.3%
Strongly Disagree	5.0%	2.6%	0.9%
Don't Know	5.0%	2.6%	6.5%
	N = 21 M = 2.3	N = 38 M = 2.6	N = 107 M = 2.2

Responses to the statement - Chemical dependency is hereditary were mainly agreed, neither agree and disagree (Table III-10). This suggests a weak agreement. Employee Assistance Personnel and Nurses responded most frequently with agree - 39% and 35% respectively. Community Health Workers responded most frequently with neither agree nor disagree 30%. Combining strongly agree and agree, 25% of Community Health Workers agreed, 45% of Employee Assistance Personnel agreed, and 38% of Nurses agreed. Combining strongly disagree and disagree, 40% of Community Health Workers disagreed, 24% Employee Assistance Personnel disagreed, and 32% of Nurses disagreed. These findings reveal there is substantial variation in agreement and disagreement with the hereditary factor of chemical dependency.

Table III-10: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 29: CHEMICAL DEPENDENCY IS HEREDITARY

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	--	5.3%	3.7%
Agree	25.0%	39.5%	34.6%
Neither Agree nor Disagree	30.0%	21.1%	21.5%
Disagree	25.0%	21.1%	26.2%
Strongly Disagree	15.0%	2.6%	6.5%
Don't Know	5.0%	10.5%	7.5%
	N = 21 M = 3.3	N = 38 M = 2.7	N = 107 M = 3.0

In summation, responses to attitudes regarding the origin of chemical dependency varied between groups. This variety is evidence that professionals from different occupations differ in their attitudinal orientation, the perspectives each have regarding chemical dependency, and the specific concepts to which different professionals subscribe. As mentioned previously, diverse attitudes can act as enlightenment and enrichment of understanding or can act as barriers depending on the openness of professionals to each other and the desire to reach consensus on behalf of those in need. It is likely chemically dependent individuals are aware of the diverse and sometimes contradictory attitudes of professionals. Some of these individuals may capitalize on these varying attitudes by abusing the health care system. The increased incidence of dual addiction is an example. Alcoholic individuals may seek assistance

from a professional that prescribes medication for abuse of alcohol. However those chemically dependent individuals who sincerely seek help may experience further stigma and denial when they are confronted with diverse and sometimes contradictory attitudes regarding the origin of chemical dependency.

Table III-11: PROPORTION OF RESPONDENTS WHO AGREE WITH ITEMS ABOUT THE ORIGIN OF CHEMICAL DEPENDENCY

1. CD is a result of a personality flaw
2. CD is a result of a moral weakness
3. CD is a result of a reaction to losses
4. CD a reaction to stress can lead to CD
5. CD is affected by the availability of drugs
6. CD is a learned behaviour
7. CD is hereditary

	Community Health Workers	Employee Assistance Personnel	Nurses
1.	30%	5%	15%
2.	--	8%	7%
3.	50%	27%	68%
4.	95%	84%	94%
5.	60%	54%	73%
6.	55%	58%	69%
7.	25%	45%	38%
	N = 21	N = 38	N = 107

Note: CD is an abbreviation for chemical dependency.

B. ATTITUDES REGARDING TREATMENT AND RECOVERY

Respondents were asked to respond to three questions that explored gender differences in seeking treatment for chemical dependency. The first

question asked,, "In your opinion, which gender is more reluctant to seek treatment for chemical dependency?" The findings demonstrated in Table III-12 reveal that Nurses were of the opinion that women are more reluctant to seek treatment. In contrast, 57% of the Community Health Workers and 45% of the Employee Assistance Personnel held the opinion, there was no difference between men and women.

Since Nurses believe women are more reluctant to seek treatment, it is logical that Nurses would either expend more or less time and effort in referring women than men to treatment for chemical dependency. More or less effort would depend on Nurses commitment to women. In contrast, Community Health Workers and Employee Assistance Personnel would spend equal amounts of time and effort with both genders in referring them to treatment. Equal or less time and effort would not meet the needs of chemically dependent women. Women face special barriers related to treatment (Beckman and Amaro, 1984). They experience more hardships than men from their employment, families, and friends when they enter treatment. As well, women have great difficulty securing adequate child care for their children. Consequently, professionals should expend more time and effort on women than men in order to combat these special barriers. If professionals are not aware of these barriers, they may label women more reluctant to seek treatment and expend less time and effort on motivating chemically dependent women to seek treatment.

TABLE III-12: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 32: IN YOUR OPINION, WHICH GENDER IS MORE RELUCTANT TO SEEK TREATMENT FOR CHEMICAL DEPENDENCY?

Responses	Community Health Workers	Employee Assistance	Nurses
Men	19.0%	26.3%	28.3%
Women	23.8%	28.9%	41.5%
No difference	57.1%	44.7%	30.2%
	N = 21	N = 38	N = 107

The second question that respondents were asked was, "If both men and women received treatment for chemical dependency, which gender do you believe is more likely to recover?" As demonstrated in Table III-13, the majority of Community Health Workers (52%) rated women more likely to recover. In contrast, the majority of the Employee Assistance Personnel and the Nurses responded there was no difference between gender. However their next most common response favoured women to recover.

TABLE III-13: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 33: IF BOTH MEN AND WOMEN RECEIVED TREATMENT FOR CHEMICAL DEPENDENCY WHICH GENDER DO YOU BELIEVE IS MORE LIKELY TO RECOVER?

Responses	Community Health Workers	Employee Assistance	Nurses
Men	9.5%	8.3%	19.0%
Women	52.4%	22.2%	32.4%
No difference	38.1%	66.7%	47.6%
	N = 21	N = 38	N = 107

The following question (number 34) asked respondents again to comment on their beliefs regarding recovery for men and women. This time the response categories varied. Respondents were asked What percentage of people do you believe recover from drug related problems after seeking treatment? As illustrated in Table III-14, thirty percent of the respondents of both the Employee Assistance Personnel and Nurses responded that 30% or less of men and women recover. Thirty percent of the Community Health Workers responded that 20% or less of men recover while 40% or less of women recover. In comparison, two thirds of the respondents of Community Health Workers responded that 40% or less of men and 70% or less of women recover. Two thirds of the Employee Assistance Personnel responded that 60% or less of men recover, and 65% or less of women recover. Two thirds of the Nurses responded that 50% or less of men recover and 60% or less of women recover. These findings reveal an opinion that women are more likely to recover than men. Once again, Community Health Workers hold this opinion the strongest. Although questions 33 and 34 are worded differently, the findings are consistent.

TABLE III-14: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO:

Question 34: WHAT PERCENTAGE OF PEOPLE DO YOU BELIEVE RECOVER FROM DRUG-RELATED PROBLEMS AFTER SEEKING TREATMENT?

Responses		Community Health Workers	Employee Assistance	Nurses
1/3 of the Respondents	M	20% or less	30% or less	30% or less
	F	40% or less	30% or less	30% or less
2/3 of the Respondents	M	40% or less	60% or less	50% or less
	F	70% or less	65% or less	60% or less
		N = 21	N = 38	N = 107

In summation, their appears to exist varying attitudes regarding treatment and recovery. Some of these attitudes are conducive to treatment for chemically dependent women and some are not. An example of an attitude that may not be conducive is there is no difference between men and women in their reluctance to seek treatment. This attitude reflects a broader negative societal attitude that prevails. This negative attitude is treatment programs designed for men are suitable for women. An attitude that is conducive to treatment for chemically dependent women is women are more likely to recover than men after seeking treatment. This attitude was held most strongly by Community Health Workers as illustrated in Tables III-13 and 14. However, the other two groups also supported this attitude. This finding contradicts the commonly held conception that women's prognosis for recovery is poorer than that of men (Women and Alcohol, 1984).

Of the three groups, it appears that Community Health Workers hold more positive attitudes regarding treatment and recovery for women. Second

is Employee Assistance Personnel and third is Nurses. If these positive attitudes affect referral behaviour, it is likely that Community Health Workers refer the most chemically dependent women to treatment. Employee Assistance Personnel would refer the most next. Nurses would refer the least.

C. KNOWLEDGE OF CHEMICAL DEPENDENCY

Researcher chose to measure three dimensions of knowledge. The first dimension measured congruency with the Alcoholism Foundation of Manitoba's definition of chemical dependency (AFM, 1985). In particular, the aspects of illness, progression, and blamelessness were measured. The second dimension of knowledge determined respondents familiarities with recent research findings about drug use and pregnancy and the incidence of women's chemical dependency. The third dimension of knowledge was respondents awareness about residential treatment services.

Congruency with the Alcoholism Foundation of Manitoba's definition of chemical dependency was tested by asking respondents to respond to three statements. The first statement was "Chemical dependency is an illness or disease". As illustrated in Table III-15, there was very little difference in responses. In all three groups the majority strongly agreed with this statement. The "Nurses" were the only group which had respondents that disagreed or strongly disagreed (5%).

TABLE III-15: PERCENTAGE DISTRIBUTION OF RESPONDENTS RESPONSES TO QUESTION 27.

Question 27: CHEMICAL DEPENDENCY IS AN ILLNESS OR DISEASE

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	60.0%	63.2%	53.3%
Agree	20.0%	26.3%	35.5%
Neither Agree nor Disagree	5.0%	10.5%	5.6%
Disagree	--	--	2.8%
Strongly Disagree	--	--	1.9%
Don't Know	5.0%	--	0.9%
	N = 21	N = 38	N = 107

The statement - "If a chemically dependent person does not get help, their chemical dependency is likely to get worse and worse," covers the dimension of progressiveness that is inherent in the Alcoholism Foundation of Manitoba's concept of disease. In other words, chemical dependency is a pathological process with a definite and independent evolution that can be arrested only with treatment. The findings shown in Table III-16 reveal four differences among the groups. The majority of respondents in all three groups strongly agreed. Such strong agreement with the progressive aspect of chemical dependency implies that the majority of the respondents believe chemical dependency can be arrested by "help". It logically follows that the respondents should see their role as essential referral agents. Without their involvement, chemical dependent individuals would continue the progressive path of chemical dependency.

TABLE III-16: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO QUESTION 41.

Question 41: IF A CHEMICALLY DEPENDENT PERSON DOES NOT GET HELP, THEIR CHEMICAL DEPENDENCY IS LIKELY TO GET WORSE AND WORSE.

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	57.1%	57.9%	55.2%
Agree	38.1%	36.8%	36.2%
Neither Agree nor Disagree	4.8%	5.3%	6.7%
Disagree	--	--	1.9%
Strongly Disagree	--	--	--
Don't Know	--	--	1.0%
	N = 21	N = 38	N = 107

Question 39 is the last of the three questions that represent the concepts of the Alcoholism Foundation of Manitoba's definition of chemical dependency. The statement addresses the issue lack of "willpower" - a sign of moral weakness. Responses that are congruent with the Alcoholism Foundation of Manitoba's definition of chemical dependency are strongly disagree and disagree. The findings shown in Table III-17 indicate that the majority of respondents from the three groups disagree with the statement. A noticeable difference among the groups is 14% of Community Health Workers agreed and strongly agreed with the statement. This may indicate there is some ambiguity as to whether chemical dependency is a disease or a sign of moral weakness. Reed believes there is a great degree of ambiguity in the public's mind (1983). This ambiguity is best expressed in the following quotation.

"Although many Americans accept the disease concept of alcoholism, this acceptance is still very superficial. When asked directly, the same people who agree that alcoholism is a disease also feel that it's a disease that happens to weak and/or immoral people and that it is self inflicted." (Blume, 1988, p.18)

TABLE III-17: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO QUESTION 39.

Question 39: CHEMICALLY DEPENDENT INDIVIDUALS COULD EASILY "PULL THEMSELVES TOGETHER" AND STOP USING DRUGS IF THEY WANTED TO.

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	9.5%	2.6%	1.0%
Agree	4.8%	--	--
Neither Agree nor Disagree	--	5.3%	2.9%
Disagree	23.8%	44.4%	39.0%
Strongly Disagree	61.9%	47.4%	57.1%
Don't Know	--	--	--
	N = 21	N = 38	N = 107

This ambiguity makes chemical dependency the "loneliest" disease. Women use the denial of their drug problems, even to themselves, as a defense mechanism against the stigma.

In summation, the findings from the three questions that relate to the Alcoholism Foundation of Manitoba's definition of chemical dependency

reveal congruence in knowledge. There is high agreement regarding chemical dependency being a blameless disease that progresses without treatment. It logically follows that respondents' knowledge would predispose them to respond to chemically dependent individuals by offering help.

The second dimension of knowledge measured respondents familiarity with recent research findings. Question 40 was A woman's use of unprescribed drugs (alcohol included) during pregnancy can affect the unborn child. This statement queried respondents' views on a pregnant women's use of drugs. This question was based on research that concludes drug use by a pregnant woman has negative effects on the fetus. The following excerpt from Alcohol/Drug Dependent Women (1988) summarizes the deleterious effects that can happen.

> "In addition to the fully - expressed fetal alcohol syndrome, drinking during pregnancy can result in a wide variety of other problems for the fetus, ranging from miscarriage to low birth weight and birth defects. . . . These effects can be observed in women with social or non-problem drinking. . . . Opiates haven't been shown to cause birth defects similar to FAS. However, women physically dependent on opiates at the time of delivery put their infants at risk for neonatal withdrawal syndrome. They also increase the risk of stillbirth and complicated labour. Stimulants such as amphetamines and cocaine have been reported to cause miscarriage, premature labour, and other obstetric complications. Infants of mothers who have used these drugs may be jittery and irritable at first, and later depressed. Marijuana use has been suspected as a contributor to birth defects and may act in conjunction with other factors such as alcohol and malnutrition. Cigarette smoking has been associated with decreased birth weight and prematurity.Sedative drugs, including sleeping pills and tranquillizers, can also present significant problems for pregnant women. Use of Diazepam (Valium) early in pregnancy

> has been implicated in birth defects in animals, as have barbiturates. All sedatives, if used in large doses up until delivery, can produce infant drowsiness and poor feeding, followed by a neonatal withdrawal syndrome that will cause continuing distress and will interfere with mother-infant bonding." (Reed 1983 p. 13-14).

Conclusively it can be stated that a woman's use of unprescribed drugs during pregnancy can affect the unborn child. Furthermore, the treatment of a chemically dependent pregnant woman should be considered a medical emergency and given the highest priority.

Table III-18 demonstrates that over 90% of the three groups responded with strongly agree or agree. Another finding was 3% of Employee Assistance Personnel and 4% of Nurses strongly disagreed with the statement. This indicates the existence of the myth - a few drinks to celebrate your pregnancy can't hurt anybody. It is noteworthy that 4% of Nurses responded with strongly disagreed. Nurses are the most highly educated group and a group that should be well-informed about the physical effects of drugs on a fetus. This noteworthy finding substantiates the need for nurses to receive more education regarding chemical dependency. Nurses who do not believe unprescribed drugs can affect the fetus are unlikely to refer chemically dependent pregnant woman to treatment. This can be extremely tragic. Due to the nurses' lack of knowledge, chemically dependent pregnant women may not be given a powerful motivator for treatment, namely, protecting the health of her unborn child.

TABLE III-18: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO QUESTION 40.

Question 40: A WOMAN'S USE OF UNPRESCRIBED DRUGS (ALCOHOL INCLUDED) DURING PREGNANCY CAN AFFECT THE UNBORN CHILD.

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	100.0%	78.9%	91.4%
Agree	--	18.4%	4.8%
Neither Agree nor Disagree	--	--	--
Disagree	--	--	--
Strongly Disagree	--	2.6%	3.8%
Don't Know	--	--	--
	N = 21	N = 38	N = 107

Respondents were asked to respond to the statement, Almost all chemical dependents are men; there are very few women that are chemical dependent. This question (38) refers to the latest research mentioned in Chapter 2 which implied there may be as many women as men who are chemically dependent. Responses that are congruent with the research would be strongly disagree or disagree. The findings shown on Table III-19 reveal the majority strongly disagree. Combining strongly disagree and disagree, all three groups responded in the ninety percentile. There are very few differences in responses even with those who agree or strongly agreed. Five percent of Community Health Workers strongly agreed, and 3% of both Nurses and Employee Assistance Personnel agreed or strongly agreed. This finding indicates the respondents are knowledgeable that women and men they see may be "chemically dependent".

TABLE III-19: PERCENTAGE DISTRIBUTION OF RESPONDENTS' RESPONSES TO QUESTION 38.

Question 38: ALMOST ALL CHEMICAL DEPENDENTS ARE MEN; THERE ARE VERY FEW WOMEN THAT ARE CHEMICALLY DEPENDENT?

Responses	Community Health Workers	Employee Assistance	Nurses
Strongly Agree	4.8%	--	1.9%
Agree	--	2.7%	1.0%
Neither Agree nor Disagree	--	--	1.0%
Disagree	38.1%	37.8%	37.1%
Strongly Disagree	57.1%	56.8%	59.0%
Don't Know	--	2.7%	1.0%
	N = 21	N = 38	N = 107

The last dimension of knowledge measured was familiarity with residential treatment programs. Respondents were asked to list the names of three residential chemical dependency programs that they know. The findings as shown in Table III-20 reveal Community Health Workers could identify the most residential programs for chemically dependent men and women. Between the other groups, Employee Assistance Personnel could identify more residential programs than Nurses. Utilizing the t-test, the group means between Nurses and Community Health Workers differed significantly. The probability level of statistical significance for awareness for men's residential program was .003 and for awareness of women's residential programs was .001. Although the following findings did not reach conventional significance, the group means of Employee Assistance Personnel and Nurses differed; for women's programs the probability level was .08 and for men's programs it was .087.

TABLE III-20: MEAN KNOWLEDGE SCORES FOR QUESTIONS 22 AND 23

Questions 22 & 23: WHAT RESIDENTIAL CHEMICAL DEPENDENCY PROGRAMS ARE YOU AWARE OF IN WINNIPEG FOR MEN/WOMEN LIST THREE FOR EACH.

	Community Health Workers		Employee Assistance Personnel		Nurses	
	M	F	M	F	M	F
Mean Knowledge	2.14	1.95	1.60	1.42	1.30	1.17
	N = 21		N = 38		N = 107	

With all three groups, there were more responses for men's treatment programs than women's. From the listing of residential programs in the Manual of Social Services 1987-88 (1988), there appears to be an equally number of programs for men and women. If community health professions are not aware of women's treatment services, they will not refer women. This lack of knowledge results in the lack of treatment for chemically dependent women.

Employee Assistance Personnel rated second in their familiarity with residential programs. This was surprising to the author as she expected this group to be the most familiar since their primary role is referral to the appropriate services. This role is not primary for the other two groups. An explanation may be Employee Assistance Personnel prefer to refer to non-residential programs so there is less absenteeism from work. Employee Assistance Personnel were more Knowledgable about men's than women's residential programs. This indicates working women who are chemically dependent do not have the same opportunity for residential

treatment as men.

In summation regarding knowledge of respondents, it appears the majority of respondents support the definition of illness, are aware of recent research regarding prevalence and drug use of pregnant women, and are somewhat unfamiliar with residential treatment programs especially for women. There appears to be a missing factor. This factor would explain why respondents who acknowledge chemical dependency exists equally in men and women and who strongly believe treatment is required, are not familiar with residential treatment programs. This lack of awareness reveals that knowledge does not always lead to further knowledge. In other words, these respondents did not use their existing knowledge to develop knowledge regarding residential treatment programs. Without this understanding, respondents' ability to refer individuals to treatment would be limited.

Questions 11 and 12 requested respondents to clarify what knowledge they based their assessment of chemical dependency in their clients. Respondents were asked, In your opinion, what are some indicators that lead you to suspect a client is chemically dependent. Table III-22 presents the indicators that reveal a woman is chemically dependent. All three groups most frequently identified the indicator - personality and behaviourial changes. Community Health Workers rated abuse of health care system as the next most common indicator. In contrast, Employee Assistance Personnel rated absenteeism from employment and Nurses rated unkempt appearance.

It is interesting to note that unkempt appearances was also tied for fifth place by Employee Assistance Personnel. This indicator is very subjective; the evaluation regarding unkempt appearance is determined by the standards or values held by the respondent. This indicator is a stereotype; it assumes all chemically dependent women have an unkempt appearance. This stereotype makes health professionals less likely to suspect chemical dependency in well-dressed, socially competent female clients.

Although Nurses are knowledgeable about physical health from their educational background they rated physical health decline sixth. This implies Nurses are not knowledgeable that chemically dependent women are more vulnerable to some of the late-stage physical complications of alcoholism than men. "Compared to men, alcoholic women have been found to develop fatty liver and hepatic cirrhosis, as well as hypertension, anaemia, malnutrition, and gastrointestinal haemorrhage, at lower levels of alcohol intake (even correcting for differences in body weight) for fewer years." (Blume, 1988 p.10).

Why then would Nurses rate physical health decline as the sixth and unkempt appearance as the second most common indicator of chemical dependency. Is observance of unkempt appearance more readily available than medical tests? Are medically tests not done because it is not believed women's medical concerns are not real? Or are chemically dependent women hiding their physical problems in fear they will be diagnosed as a problem drug user? These are questions that are important and should be used to direct further research.

Employee Assistance Personnel and Community Health Workers rated the physical health decline as the fifth most common indicator. Because Community Health Workers rated abuse of the health care system as the second most frequent indicator, this implies women utilize the health care system. However their use is termed abuse. Is this because chemically dependent women's health concerns are not acknowledged by Community Health Workers?

TABLE III-22: RANK ORDER OF ITEMS IN RESPONSE TO:

Question 11: IN YOUR OPINION, WHAT ARE SOME INDICATORS THAT LEAD YOU TO SUSPECT A WOMAN IS CHEMICALLY DEPENDENT?

This is a partial listing in descending order. * denotes a tie.

Community Health Workers	Employee Assistance Personnel	Nurses
personality and behavioral changes	personality and behavioral changes	personality and behavioral changes
abuse of health care system	absenteeism from employment	unkempt appearance
*frequency of drug use	decrease in work record and performance	visible evidence of drug use
*isolated	defensive and evasive behaviour	isolated
*physical health decline	*unkept appearance	defensive and evasive behaviour
	*interpersonal problems	
	*physical health decline	physical health decline
N = 21	N = 38	N = 107

Table 111-23 presents the indicators respondents believe indicate chemical dependency in men. There exists some variation between Table 111-23 and Table 111-23. This implies that respondents within the three groups believe there are different indicators to asses chemical dependency in men and women.

TABLE III-23: RANK ORDER OF ITEMS IN RESPONSE TO:

Question 12: IN YOUR OPINION, WHAT ARE SOME INDICATORS THAT LEAD YOU TO SUSPECT A MAN IS CHEMICALLY DEPENDENT?

This is a partial listing in descending order. There are two ties that are depicted by * and • respectively.

Community Health Workers	Employee Assistance Personnel	Nurses
personality and behavioral changes	absenteeism from employment behavioral	personality and changes
*visible evidence of drug use	decrease in work record and performance	visible evidence of drug use
*interpersonal problems	interpersonal problems	unkempt appearance
•level of anxiety	defensive and evasive behaviour	absenteeism from employment
•physical health decline	frequency of drug use	defensive and evasive behaviour
N = 21	N = 38	N = 107

Community Health Workers were the only group that rated the indicators - personality and behavioral change and physical health decline - in the same order of frequency for men and women. Employee Assistance Personnel had three indicators that were rated in the top five that were common for both men and women. However their order of frequency varied for men and women. An indicator that was mentioned for men and not women was frequency of drug use. The indicator mentioned for women and not men were personality and behavioral changes, unkempt appearance, and physical health decline. As mentioned earlier " unkempt appearance" has been called a stereotype indicator. It appears Employee Assistance Personnel hold this

sex-role stereotype for women. Similarly, personality and behavioral changes may be considered acceptable changes for women and not men. As mentioned earlier, the EAP group had the highest percentage of male respondents. It is likely this factor influenced their responses.

Nurses had four indicators in common for men and women. One of these was unkempt appearance. It was the second ranked indicator for women and the third ranked indicator for men. The indicator that was identified for men and not women was absenteeism from work. These indicators - isolated and physical health decline - were identified by Nurses for women and not men.

One conclusion that can be drawn from these findings is the three groups of community health professionals diagnose chemical dependency differently for both men and women. Since there is variation within each group for indicators for men and women, one may question the effect that organized social context may have on indicators. In other words, the environment in which the professionals work may influence their opinions regarding indicators of chemical dependency.

This concludes the chapter on survey findings. By viewing the survey findings from two perspectives - namely descriptive and comparative - some major findings were revealed. The ensuing chapter elaborates on these major findings and their implications. In addition, commentary on how these findings affected my learning will be included.

CHAPTER IV

MAJOR FINDINGS AND IMPLICATIONS

This survey produced a number of findings that are of interest. A detailed discussion of these findings can be found in Chapter III, Survey Findings. This chapter highlights the major findings and their implications. Furthermore an account of how these major findings and implications have affected my learning is given.

Respondents' knowledge was measured with the Alcoholism Foundation of Manitoba's definition of chemical dependency, recent research findings, and awareness of residential programs. The survey findings revealed that the knowledge of nearly all the respondents in each of the three subsamples was congruent with the AFM's definition of chemical dependency. In addition, the findings indicated the level of agreement was consistent between the subsamples for congruency with AFM's definition as well as familiarity with recent research.

The presence of knowledge in the surveyed community health professionals implied a certain behaviour would exist. This behaviour is referral behaviour. The professional would view her responsibility to treat a client who is ill. The professional would work with the client, openly and without subterfuge or prejudice to assist the client in exploring her chemical problems, to break through denial, and to offer appropriate treatment for chemical dependency. This referral behaviour was shown by Sandmaier in 1980 not to exist if knowledge of chemical dependency was lacking.

The third measured dimension of knowledge was awareness of residential treatment programs. The findings revealed respondents from the three groups were minimally aware. For each gender, the total group could identify 1.5 out of three residential programs for men and 1.3 out of three residential programs for women. Comparing the findings between the three groups, Community Health Workers were found to be the most knowledgeable of residential treatment programs for men and women. Employee Assistance Personnel and Nurses followed respectively after Community Health Workers. Each of these groups identified more residential programs for men than women. For a more detailed account refer to Table III-20.

This indicator of knowledge (residential treatment program) differed from the other indicator of knowledge. It was the only indicator that revealed a visible difference in knowledge among the three groups. Furthermore the group means between Nurses and Community Health Workers were significantly different for awareness of both men's and women's residential treatment programs. This difference may affect referral behaviour if limited awareness of residential treatment programs can be equated with limited treatment opportunities. Since women's residential treatment programs were the lesser known, chemically dependent women may lack residential treatment opportunities because of lack of knowledge on the part of the community health professionals.

Respondents' attitudes were measured with their responses to statements regarding the origin of chemical dependency and treatment of chemical dependency. In contrast to knowledge responses, attitude responses revealed a greater range of responses. The range of responses and the varying levels of strength was visible between and within the three subsamples. These varying responses to the origin of chemical dependency supports an earlier identified problem for community health professionals. This problem is the lack of a common definition and a lack of an adequate causational approach to chemical dependency. Without a common definition and an adequate causational approach, various beliefs exist and, in turn, spawn various attitudes.

Responses to the statement - Chemical dependency is a result of a reaction to losses revealed a great variation in responses as shown in Table III-6. In particular, the Employee Assistance Personnel group mean was statistically different from the Nurses mean ($P>.001$). This statement refers to the belief that chemical dependency is the outcome of unhealthy coping behaviour. The findings reveal that Nurses adhere to this belief while Employee Assistant Workers do not. This implies that Employee Assistance Workers and Nurses may differ in their focus and treatment strategy for chemically dependent individuals.

Responses to the statement - A reaction to stress can lead to chemical dependency displayed that Employee Assistance Personnel have an attitude that varied from the other groups. Utilizing the t-test, it was found that the Employee Assistance Personnel's mean significantly differed from the Nurses' ($P>.003$) and Community Health Workers' ($P>.03$). This

implied that Employee Assistance Personnel may also vary in their behaviours related to referral practices.

With reference to attitudes regarding recovery, there was a noteworthy finding. This finding is related to the question - If both men and women received treatment for chemical dependency, which gender do you believe is more likely to recover? Although differences did not reach conventional significance, there appeared to be a difference in group means regarding this question ($P>.07$). This implies that different groups of community health professionals may vary in their attitude regarding chemically dependent women's and men's potential for recovery. Such an attitude could affect the client's opportunity for referral behaviour from the professional. Furthermore a biased attitude regarding recovery could lead to a self-fulfilling prophecy. Thus any attempt to understand and/or induce change in referral practices must begin with further study of attitudes.

This practicum has affected my learning in the areas of knowledge and skill. I believe that my understanding of chemical dependency has been broadened. Although I thought I understood and accepted the controversy regarding chemical dependency, I was surprised to visually see the diversity of attitudes that exist. This realization has deepened my respect for varying attitudes. I am now more committed to discovering the underlying attitudes before entering into a debate. Similarly, I have made a commitment in educational settings to focus on attitudes as well as knowledge. I have realized that changing referral practices is a complex endeavour. This study's focus on professionals and their referral

practices revealed that a broader perspective is required. The influence of education, employment, and professionals roles on attitudes and knowledge is readily apparent. Consequently, changing referral practices requires consulting the socially-organized character of those judgmental activities and administrative considerations which are involved and which result in the discovery, treatment, and consequent effects. This understanding, in turn, illuminates the importance of research as it is the vehicle to such consultation.

I believe my skill development has been increased and enhanced by this practicum. I have a greater perception of the range and nature of research questions that are related to referral behaviour. Also, I have learned many important considerations in designing, implementing, and analyzing survey research. Practical experience with computer analysis has developed in myself an unknown skill. Furthermore, I have become more familiar with my working habits. In particular, I have realized some strengths and weaknesses I have when I am involved in a part-time independent study. In other words, through exploratory learning, I have learned many tangible and intangible aspects of my learned self. I believe my development of knowledge and skill in myself has increased my ability to be a competent and skilled social worker.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This practicum studied community health professional's knowledge and attitudes pertaining to chemically dependent women. A goal of the practicum was to identify the knowledge and attitudes that may be prerequisites to community health professionals referring chemically dependent women to treatment. By identifying the knowledge and attitudes that are associated with referral behaviour, it was believed recommendations could be developed to increase the referral of chemically dependent women to treatment services.

When respondents' knowledge was measured, they were found to have a high level of knowledge. Over 3/4 of the respondents from each of the subgroups responded in congruence to the three statements that represented the AFM definition of chemical dependency. These statements addressed the progressiveness, loss of control, and illness attributes of chemical dependency. Furthermore, over 3/4 of the respondents were found to be knowledgeable about the prevalence of women with chemical dependency and the effects chemicals have on foetuses.

These findings implied community health professionals would assume the responsibility in treating women who are victims of the illness - chemical dependency. However when respondents were asked to identify

residential treatment program this knowledge was lacking. This lack of knowledge regarding programs can detrimentally affect the helping relationship. I recommend that community health professionals who lack the educational preparation of referral behaviour, seek and obtain such education.

Attitudes measurements, in contrast to knowledge measurements, revealed a wider range of responses with variation between and within the three groups. On one occasion, two similar questions had varying responses from two subsamples. These findings clearly revealed the measurement and analysis of attitudes is complex. It is possible that the interrelationships of varying attitudes are greater than the sum of the parts. Also it is possible that certain attitudes may nullify certain knowledge. In other words, individuals who adhere to the understanding that chemical dependency is an illness may have an attitude that nullifies the disease concept. I recommend that more attention be given to attitudes by researchers, educators, policy makers and treatment providers. I strongly believe attitude research is necessary in the search for understanding why chemically dependent women have long gone under-recognized and under-treated.

Respondents were asked to list the indicators that lead them to suspect a person is chemically dependent. Analysis of the combined lists revealed that the varying groups of respondents held varying signs depending on gender. In particular, the indicator - unkempt appearance - was readily used by Nurses and Employee Assistance Personnel to identify chemically dependent women. Rather than utilizing indicators that are

related to their area of expertise (health and employment), these groups chose indicators fraught with cultural, ethnic and sexual bias. Such bias enriches stereotyping and stigmatizing. All of which are professionally made barriers to the recognition of chemical dependency. It is therefore important that community health professionals examine their own attitudes regarding chemical dependency and treatment, and assess the potential for these attitudes having undesirable effects on the helping services they provide. According to Stanley Einstein (1986):

> We are bond to fail in our intervention if unrealistic, insensitive, disabling, and rejecting social community attitudes continue to permeate what we do. The computer industry paraphrased this quite succinctly: Garbage in-garbage out. Perhaps the time has come for those who choose to work in the field of drug use intervention to consider whether we are the collectors of society's "garbage", trapped alchemists,or creative and effective innovators and initiators who can carry out our roles only when the needed attitudinal support system is available and active. To do this, we, with the help of others, will have to determine what types of attitudes are conducive to the creation and carrying out of effective needed intervention. Once this is achieved - and it is achievable - we will have to learn to make such facilitating attitudes part of the rubric of intervention. (Einstein, 1986, page 411).

Attitudes regarding the etiology of chemical dependency were found to vary between the groups and within the three groups. I am of the opinion that these varying attitudes regarding the origin of chemical dependency play a major role in the lack of utilization of treatment services. I believe a professionals' attitude will affect the presence or absence of referral practices. Furthermore, I believe a professional's attitude may affect the choice of treatment. In Manitoba, the AFM offers

treatment services to all Manitobans based on the illness theory. This may limit professionals referral practices. I conclude that a variety of treatment programs with differing philosophies and modalities would be warmly welcomed by social service professionals and chemically dependent individuals. Both professionals and chemically dependent individuals may utilize more treatment services especially those treatment services that are congruent with their beliefs, opinions, and attitudes about chemical dependency. Increased availability of treatment services that are congruent with the attitudes, of professionals and clients, may also promote the recovery of chemically dependent women.

An approach that may encourage the development of treatment programs with differing philosophies and, in turn, decrease stigmatization is the following. As previously mentioned, chemically dependent women are most likely to seek help from services that are health and family oriented. Consequently, I believe treatment services offered at such agencies would be more effective. These settings would be congruent with the way the chemically dependent woman has identified her problems and her help-seeking behaviour. Stigma would be minimized. Additional services, such as health and family services, could be provided and/or maintained. Furthermore, under-identified chemically dependent women may be more likely recognized in the setting where they eventually seek help. An additional benefit is that social services professionals may develop a less restrictive view of themselves. Rather than seeing themselves as a separate entity that provides a specific service, they would see themselves as part of a system providing a general service. This, in

turn, would promote the philosophy that it is everyone's responsibility to reduce stigma, support enlightened public policies, and ensure adequate funding for prevention and treatment of chemical dependency in women.

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APPENDICES

Appendix 1

COVERING LETTER

ALCOHOLISM FOUNDATION OF MANITOBA

October 18, 1988

Dear

Chemical dependence continues to escalate at an alarming rate. Within your clientele, there may be individuals who are chemically dependent. We don't know how professionals such as yourself, identify and feel about chemical dependence. We believe it is important to hear from you. The information gained may be useful in increasing and improving the referral process of chemically dependent individuals to treatment services.

Your name is one of a small number in which community health workers are being asked to give their opinions on this matter. For this project, community health workers include a variety of social services professionals whose common goal is the promotion of their client's health.

In order that the results will truly represent the thinking of community health workers, it is important that each questionnaire be completed and returned.

You may be assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that we may check your name off the mailing list when your questionnaire is returned. Your name will never be placed on the questionnaire.

You may receive a summary of the results by writing "Copy of Results Requested" on the back of the return envelope, and printing your name and address below it. Please do not put this information on the questionnaire itself.

I would be most happy to answer any questions you might have. Please write or call. My telephone number is . You may also call Rudy Ambtman, Research and Data Systems Coordinator for the Alcoholism Foundation of Manitoba, at 944-6243.

Thank you for your assistance.

Sincerely,

Janice Innes
Project Director

JWI/et
Encl.

1031 Portage Avenue, Winnipeg, Manitoba R3G 0R8 (204) 944-6200

Appendix 2

QUESTIONAIRE

CHEMICAL DEPENDENCE:

A HEALTH CONCERN FOR ALL

ALCOHOLISM FOUNDATION OF MANITOBA
1031 Portage Avenue
Winnipeg, Manitoba,
R3G 0R8

PLEASE READ EACH QUESTION CAREFULLY. COMPLETE OR CIRCLE THE RESPONSE FOR EVERY APPROPRIATE QUESTION.

1. Sex:
   Female...1
   Male ...2

2. What is the highest level of education that you have completed?
   Highschool
   Incomplete ...01
   Complete ...02
   Non-University (Voc/Tech, Nursing Schools)
   Incomplete ...03
   Complete ...04
   University
   Incomplete ...05
   Diploma/Cert. ...06
   Bachelor's Degree ...07
   Master's Degree ...08
   Medical Degree ...09
   Doctorate ...10

3. What is your job title?
   Occupation:_____

   What does the job involve? _____

_____

_____

4. How long have you worked in the current or related position?
   _____ years.

EXPERIENCE/KNOWLEDGE ABOUT CHEMICAL DEPENDENCY

The focus of this study is on chemical dependence. Chemical dependence is a state of psychological and/or physiological reliance on one or more chemical substances. Alcohol and other mood altering drugs are chemical substances.

5. Have you gained knowledge regarding chemical dependence from:

training workshops	yes	no
full courses	yes	no
publications	yes	no
personal experience	yes	no

6. Please identify where the training workshops and/or courses occurred by circling the corresponding number or numbers.

Alcoholism Foundation of Manitoba	... 1
Part of your university studies	... 2
Summer school at university	... 3
Community College	... 4
At your place of employment	... 5
Other	... 6

7. Over all, how would you rate your factual knowledge regarding chemical dependence?

very limited	...1
limited	...2
moderate	...3
extensive	...4
very extensive	...5

8. Over all, how would you rate your factual knowledge about women's chemical dependence?

very limited	...1
limited	...2
moderate	...3
extensive	...4
very extensive	...5

9. How would you rate your factual knowledge about men's chemical dependence?

very limited	...1
limited	...2
moderate	...3
extensive	...4
very extensive	...5

DEFINING WHO IS CHEMICALLY DEPENDENT

Deciding whether or not a person is chemically dependent can often be difficult. Different people believe that different factors or signs are important.

10. Do you routinely ask clients about their chemical use?

yes ... 1
no ... 2

11. In your opinion, what are some indicators that lead you to suspect a woman is chemically dependent?

1. _____
2. _____
3. _____
4. _____
5. _____

12. In your opinion, what are some indicators that lead you to suspect a man is chemically dependent?

1. _____
2. _____
3. _____
4. _____
5. _____

13. Have you seen any clients in the last six months whom you have reason to believe have chemical dependence problems?

yes ... 1 IF YES, PROCEED TO QUESTION 14
no ... 2 IF NO , PROCEED TO QUESTION 22

14. Estimate the number of men _____

Estimate the number of women _____

Estimate the total number of men clients in six months _____

Estimate the total number of women clients in six months _____

15. In the past six months, how many clients that you have reason to believe have chemical dependence problems, did you:

1. initiate discussion of chemical dependence problems
   how many men? _____
   how many women? _____

2. refer to Alcoholics Anonymous or Narcotics Anonymous?
   how many men? _____
   how many women? _____

16. Please circle the response (often, rarely, never) for each of the following statements that may express your reason(s) for discussing chemical dependence with a client and/or for referring a client to chemical dependence program(s).

a) I was sure the person was chemically dependent	often	rarely	never
b) I knew how to initiate the discussion	often	rarely	never
c) It's my responsibility	often	rarely	never
d) I knew what treatment services were available	often	rarely	never
e) I knew the person would appreciate my efforts and continue to use my services again	often	rarely	never
f) I have no difficulty attaining access to treatment programs	often	rarely	never

g) Other (specify) _____

_____

17. Over the last six months, how many clients have you suspected of having a chemical dependence problem but did not discuss this with them?

how many men? _____

how many women? _____

18. Do you plan to say anything to them at a later date?

yes ...1

no ...2

not sure ...3

19. If you did not discuss their chemical dependence with clients, please circle the response (often, rarely, never) for each of the following explanations:

a) I was not sure the person was chemically dependent	often	rarely	never
b) I did not know how to initiate the discussion	often	rarely	never
c) It is not my responsiblity	often	rarely	never
d) I did not know what treatment services were available	often	rarely	never
e) I thought the person(s) would get angry and not use my services again	often	rarely	never
f) I have had difficulty attaining access to treatment programs	often	rarely	never

g) other (specify) _____

_____

20. Please list the treatment services for chemical dependence to which you have referred men in the last six months.

_____

_____

_____

21. Please list the treatment services for chemical dependence to which you have referred women in the last six months.

_____

_____

_____

22. What residential chemical dependence programs are you aware of in Winnipeg for men?

_____

_____

_____

23. What residential chemical dependence programs are you aware of in Winnipeg for women?

_____

_____

_____

CHEMICAL DEPENDENCE LOCUS OF ORIGIN

We would like to know your opinion on why some people become chemical dependents and others don't. What are contributing factors to chemical dependence? After each of the following statements fill in the blank with the number from the scale that best describes your opinion.

1	2	3	4	5	8
strongly agree	agree	neither agree nor disagree	disagree	strongly disagree	don't know

24. Chemical dependence is a result of a moral weakness _____
25. Chemical dependence is a result of a personality flaw _____
26. A reaction to stress can lead to chemical dependence _____
27. Chemical dependence is an illness or disease _____
28. Chemical dependence is affected by the availability of drugs _____
29. Chemical dependence is hereditary _____
30. Chemical dependence is a result of a reaction to losses _____
31. Chemical dependence is a learned behaviour _____

BELIEFS ABOUT TREATMENT

32. In your opinion, which sex is more reluctant to seek treatment for chemical dependence?

Men	_____1
Women	_____2
No difference	_____3

33. If both men and women received treatment for chemical dependency, which sex do you believe is more likely to recover?

Men	_____1
Women	_____2
No difference	_____3

34. What percentage of people do you believe recover from drug related problems after seeking treatment?

Men	_____%
Women	_____%

Please fill in the blanks with a number from the scale that best describes your opinion for each of the following statements. In cases where you don't completely agree or completely disagree, give the answer that most reflects your opinion.

1	2	3	4	5	8
strongly agree	agree	undecided	disagree	strongly disagree	don't know

35. Chemically dependent women need separate, not co-ed, treatment programs._____

36. The spouses of chemically dependent women are more likely to oppose treatment than the spouses of chemically dependent men. _____

37. The most effective counsellor for a woman is another woman. _____

38. Almost all chemical dependents are men; there are very few women that are chemically dependent. _____

39. Chemically dependent individuals could easily "pull themselves together" and stop using drugs if they wanted to. _____

40. A woman's use of unprescribed drugs (alcohol included) during pregnancy can affect the unborn child. _____

41. If a chemically dependent person does not get help, their chemical dependency is likely to get worse & worse. _____

Any comments you wish to make that you think may help us in future efforts to know community health workers' opinions on chemical dependence will be appreciated, either here or in separate letter.

Your contribution to this effort is very greatly appreciated. If you would like a summary of results, please print your name and address on the back of the return envelope (NOT ON THIS QUESTIONNAIRE). We will see that you get a copy of the results.

Appendix 3

POSTCARD REMINDER

October 26, 1988

Last week a questionnaire seeking your understanding of chemical dependence was mailed to you. Your name was drawn in a random sample of Community Health Workers in Winnipeg.

If you have already completed and returned it to us,please accept our sincere thanks. If not, please do so today. Because it has been sent to only a small, but representative, sample of Community Health Workers it is extremely important that yours also be included in the study if the results are to accurately represent the opinions of Community Health Workers.

If by some chance you did not receive the questionnaire, or it got misplaced, please call me right now, ( ), and I will get another one in the mail to you today.

Sincerely,

Janice Innes, Project Director

Appendix 4

LETTER SENT IN THE THIRD WEEK

ALCOHOLISM FOUNDATION OF MANITOBA

November 8, 1988

Dear :

About three weeks ago I wrote to you seeking your opinion on chemical dependence. As of today, we have not yet received your completed questionnaire.

We have undertaken this study because of the belief that professional opinions should be taken into account in the effort to increase and improve the referral process of chemically dependent individuals to treatment services.

I am writing to you again because of the significance each questionnaire has to the usefulness of this study. In order for the results of this study to be truly representative of the opinions of all community health workers it is essential that each person in the sample return their questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed.

Your co-operation is greatly appreciated.

Cordially,

Janice Innes
Project Director

/et
Encls.

1031 Portage Avenue, Winnipeg, Manitoba R3G 0R8 (204) 944-6200
Fax No. only (204) 786-7768

AMALGAMATED LIST OF SURVEY FINDINGS

Demographics

Highest Level of Education	Highest % of Female Respondents	Most Common Occupation	Longest work history
"Nurses" 84%	"Nurses" 100%	Nursing "Nurses"	EAP 8 years or less
CHW 38%	CHW 67%	Nursing CHW	*"Nurses" 4 years or less
EAP 21%	EAP 53%	Counselling EAP	* CHW

Ways of Knowing About Chemical Dependency

Publications	Training Workshops	Personal Experience	Full Course
*CHW 100%	EAP 97%	EAP 78%	EAP 78%
*EAP 100%	CHW 83%	"Nurses" 77%	CHW 36%
"Nurses" 93%	"Nurses" 59%	CHW 64%	"Nurses" 26%

Attitudes

Re Origin of Chemical Dependency

Result of a Personality Flaw (Disagreement)	Result of a Moral Weakness (Disagreement)	Result of a Reaction to Loss (Agreement)	A reaction to stress (Agreement)	Affected by Availability of Drugs (Agreement)	Is hereditary (Agreement)	Learned Behaviour (Agreement)
EAP 76%	EAP 89%	"Nurses" 68%	CHW 95%	EAP 74%	EAP 45%	"Nurses" 69%
"Nurses" 57%	CHW 80%	CHW 50%	"Nurses" 94%	"Nurses" 73%	"Nurses" 38%	EAP 58%
CHW 55%	"Nurses" 74%	EAP 27%	EAP 84%	CHW 60%	CHW 25%	CHW 55%
		note some % of EAP disagreed			note majority of CHW & EAP disagreed	

Re Treatment

Women rated more reluctant to seek TX	Women rated most likely to recover	Highest % re Women's Recovery
"Nurses" 41%	CHW 52%	CHW 70% or less
No difference	No difference	EAP 65% or less
No difference	No difference	"Nurses" 60% or less

Code: *denotes tie

CHW = Community Health Worker

EAP = Employee Assistance Personnel

Knowledge

Chemical Dependency is an illness (Agreement)	Chemical Dependency is Progressive (Agreement)	Chemical Dependents could "pull" themselves together. (Disagreement)	Affect of drugs on foetus (Agreement)	Almost all Chemical Dependents are men (Disagreement)
* EAP 89%	* CHW 95%	"Nurses" 96%	CHW 100%	"Nurses" 96%
* "Nurses" 89%	* EAP 95%	EAP 92%	EAP 97%	EAP 95%
CHW 80%	"Nurses" 91%	CHW 86%	"Nurses" 96%	CHW 95%

Code: *denotes tie

CHW = Community Health Worker

EAP = Employee Assistance Personnel

Referring Behaviour

Noticed Routinely Ask Clients re Chemical Use	Recognized Mean Score for Women's Indicators	Assessed Seen Clients who are Chemically Dependent	Responded To Females with Chemical Dependency	Treated Mean Score of Referral to Women's Treatment Centre
CHW 67%	"Nurses" 2.2	CHW 76%	CHW 62%	CHW 1.0
EAP 60%	EAP 2.1	EAP 66%	EAP 61%	EAP .9
"Nurses" 30%	CHW 2.0	"Nurses"59%	"Nurses"50%	"Nurses" .5