What impact does education and experience have on the harm reduction attitudes of professionals working in homeless services?

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Abstract

Harm reduction in relation to illegal drugs is regularly the subject of research. Since the 1990's Ireland has taken a harm reduction approach to illegal drug use but without in depth policy debate on the topic. Drug policy can be a controversial topic, both in Ireland and internationally, with harm reduction and abstinence approaches often seen as mutually exclusive.

According to several previous studies people who are experiencing homelessness are more likely to have a drug addiction compared to the non homeless population and more at risk from the harms associated with drug use. Therefore, professionals in homeless services are likely to work with people with a drug addiction and are responsible for interventions relating to the support of these individuals, which could include providing advice, enforcing service rules and signposting to specialist addiction services. It is unclear whether professionals working in such important roles agree with the national drug policy of harm reduction. There has been limited research relating to the professionals who work in services that provide harm reduction services, especially in an Irish context.

The research question of this study is 'What impact does education and experience have on the harm reduction attitudes of professionals working in homeless services?'. This study used a quantitative approach to conduct surveys of professionals working in an organisation that operates a broad range of services and accommodation for people experiencing homelessness. The study measured each respondent's level of harm reduction acceptability on the Harm Reduction Acceptability Scale and compared these scores to participants' experience and education to identify whether there is a correlation. Overall staff were inclined towards a harm reduction approach and the variables of education level, position held in the organisation and the length of time working in homeless services predicted a more favourable attitude to harm reduction. Limitations and areas of future research are discussed.

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Table of Contents

Abstract i

Acknowledgements iii

Table of Contents iv

List of Tables v

List of Appendices vi

List of Abbreviations vii

Chapter 1: Literature Review 1

Chapter 2: Research Question 13

Chapter 3: Methodology 15

Chapter 4: Analysis and Findings 23

Chapter 5: Discussion 36

Chapter 6: Conclusion 40

References 41

Appendices 50

List of Tables

Table 1: Age range of participants

Table 2: Nationality breakdown of participants

Table 3: Breakdown of how respondents described where they live

Table 4: Breakdown of positions of participants

Table 5: Breakdown of highest qualifications achieved by participants

Table 6: List of subjects studied at diploma, degree or masters level by participants

Table 7: Breakdown of sources of information where participants state they learn about drugs and

Table 8: Breakdown of age categories of participants

Table 9: Participants who stated they have had a close personal relationship with anyone who had a drug addiction

Table 10: Participants who stated they have encountered illegal drug use while in work

Table 11: Participants response to the question; Comfortable discussing drug use with a client in work?

Table 12: The frequency that harm reduction interventions related to drug use in work are carried out by participants

Table 13: Participants who stated that they turned a blind eye/ignored illegal drug use.

Table 14: I have the knowledge and skills to deal with clients who are addicted to drugs in this service.

Table 15: I know how to advise a client who wants treatment for dug addiction

Table 16: Highest education level attained by participants, the mean HRAS score categorised

Table 17 Breakdown of the top 5 subject areas of participants

List of Appendices

Appendix 1: Goddard's Harm Reduction Acceptability Scale

Appendix 2: Questionnaire sent to respondents in current study

Appendix 3: Participant Information

List of Abbreviations

AIDs: Acquired immunodeficiency syndrome

DCC: Dublin City Council

ETHOS: European Typology of Homelessness and Housing Exclusion

HIV: Human Immunodeficiency Virus

HRAS: Harm Reduction Assessment Scale

IT: Information Technology

NCI: National College of Ireland

QQI: Quality and Qualifications Ireland

SPSS: Statistical Package for the Social Sciences

STA: Supported Temporary Accommodation

UK: United Kingdom

US: United States

Chapter 1: Literature Review

Homelessness in Ireland

The definition of homelessness in Ireland comes from the 1988 Housing Act; somebody who has no reasonable accommodation to live in or available to them or lives in a hospital, institution or night shelter or other institution because of a lack of home. ETHOS (European Typology of Homelessness and Housing Exclusion) defines four categories of homelessness or housing exclusion. These range from roofless; which includes sleeping rough in a public place, houseless; includes living in a homeless hostel, insecure; including support accommodation for homeless people, no legal tenancy or staying with friends, and the final category is inadequate; including people living in over crowded housing (FEANTSA, 2005). This categorisation of homelessness is much broader than the Irish government's definition and there is no research into how many people may fall into the ETHOS categories of homelessness in Ireland.

According to figures released by the Department of Housing in November 2019 there was 6,696 adults homeless in Ireland, 4,509 of these people were homeless in Dublin, and 2,314 of this population were placed in Supported Temporary Accommodation (STA), where there are professional staff on site (Department Housing, Planning and Local Government, 2019). Therefore, approximately 1 in 3 adults that are homeless in Ireland are accommodated in a STA in Dublin. The rest of the people included in these figures are accommodated in private accommodation like hotels where no, or minimal, on site staff support is provided. People who are sleeping rough are not included in the official homeless figures in Ireland. The official winter count of people sleeping rough in Dublin on one night was 92 people, on the 27th of November 2019.

According to Dublin City Council (DCC) *'... an STA facility will provide a dedicated programme for residents that takes an interventionist approach to stabilise a person's lifestyle with a view to*

ameliorating any behaviour associated with mental ill-health and addiction, including harm reduction approaches to the misuse of alcohol and drugs (prescribed and illicit)' (Dublin City Council, 2014, p. 10).

Homelessness and Drug Use

There is a lot of research relating to drug use and homelessness, with figures ranging from 10% to 70% (Manning & Greenwood, 2019; Testoni, *et al.*, 2018). This variance in percentage can in part be attributed to different definitions of homelessness in studies, different reporting practices; observed drug use, self reported drug use, medical records and dual diagnosis where addiction is present with mental illness and in general to the complex nature of homelessness and addiction (Tsemberis *et al*., 2006). Given the unstable nature of homelessness people who are homeless and who use illegal drugs are more vulnerable to the harms associated with drug use including blood borne diseases, stigma and overdoses (Cheung, 2004; Shannon *et al.*, 2006; Fischer *et al*., 2010)

In the Irish context a recent study of 601 individuals who were homeless found 412 people with an addiction and of this group 59 % reported their addiction was to drugs (41% to opiates) and 41% reported to being addicted to alcohol (O'Reilly *et al.*, 2015).

Compared to the general population one study found that 74% of people who were attending a homeless specific service had a substance dependence, compared with 19% of patients attending a general adult service (Dunne, Duggan and O'Mahony, 012). Cannabis, heroin and street benzodiazepines were the most common drugs used among those who were homeless in Dublin and who were actively using illegal drugs (Glynn, 2016).

There is a lack of research relating to when people who are accommodated in homeless services begin to use drugs. There is some debate whether drug addiction is a cause of homelessness or a symptom of being homeless (Didenko and Pankratz, 2007).

People who use illegal drugs may engage with a broad range of services for support directly or indirectly associated with their drug use or addiction; harm reduction programs, treatment for addiction, mental health support or counselling, physical health, employment support and housing supports to list a few of these possible services. For some of these services that deal directly with drug use or addiction, professionals in these services could be expected to understand that discussion of drug addiction, treatment options and harm reduction supports would be part of their role. For other indirect services like employment supports and mental health supports that are likely to be brief, time limited appointments, discussion of drug use and treatment is likely to require a referral to a specialist service. Housing supports could range from visiting support in independent accommodation, emergency short term accommodation, long term supported accommodation and outreach with people sleeping rough on the streets.

As discussed, people who are experiencing homelessness are more likely to have a drug addiction compared to the non homeless population (O'Reilly et al., 2015; Manning & Greenwood, 2019) and more at risk from the harms associated with drug use (Cheung, 2004; Shannon *et al.*, 2006; *Fischer et al.*, 2010).

Therefore, professionals in homeless services are likely to work with people with a drug addiction and are responsible for interventions relating to the support of these individuals, which could include providing advice, enforcing service rules and completing referrals to specialist services. Most homeless services are focused on supporting the individuals they work with to exit homeless into independent living or in long term accommodation the target is related to sustaining the individual's current accommodation. It is unclear from existing research, especially in Ireland, how equipped professionals are to support this population with their addiction and whether they support the prevailing Irish drug policy of harm reduction.

Drug Use

Drug use in Ireland among the general population appears to be on the rise, this increased from 2002 to 2014 (European Monitoring Centre for Drugs and Drug Addiction, 2019; Health Research Board 2012). According to research carried out by the Health Research Board (2012) the percentage of the general population that used any illegal drug increased from 18.5% in 2002, to 24% in 2006 and 27% in 2012. The most common illegal drug consumed was cannabis (24%) followed by ecstasy (7.8%) and cocaine (6.6%) (National Advisory Committee on Drugs and Alcohol, 2016).

There has been an increase in poly drug use between the years 2005 to 2012 alongside an increase in injecting drug use (Bates, 2017). Between the years 2004 to 2014 there was 6,697 drug related deaths in Ireland, 58% due to poisoning, and two thirds of poisoning deaths involved poly drug use, Benzodiazepines were the most common drug type involved in poly drug deaths (Health Research Board, 2016). Toxicology reports show that 94% of the drug induced deaths in Ireland in 2015 had opioids present, frequently found alongside alcohol and prescribed medication (European Monitoring Centre for Drugs and Drug Addiction, 2019)

Treatment for drug addiction in Ireland has been through a lot of changes in the last 30 years, shifting from abstinence based in the 1980's to introduction of harm reduction measures in the 1990's (Comiskey, 2020).

Harm Reduction

Harm reduction refers policies and practices which aim to reduce the the negative health, social and legal impacts associated with drug use (International Harm Reduction Association, 2015). Drug use can continue during harm reduction interventions but abstinence is not rejected as a long term goal, but if abstinence is not achieved harm reduction can still be successful (Egan & Kiely, 2000). Prior to the

harm reduction approach becoming well known in public health and drug policy the main approaches stemmed from either prohibition or advocating for the legalisation of drugs (Erickson, 1997).

Initiating the practice of harm reduction has been attributed to the Netherlands in the 1970's (Roe, 2005; Hawdon, & Kleiman, 2011). The government decided that criminal intervention was not always appropriate for certain drug offences, especially when they repeatedly impacted on an isolated section of society, so in partnership with advocacy groups they changed drug policies, established needle exchanges to reduce risk of spreading blood borne viruses and improved access to health care for those using drugs (Roe, 2005; Hawdon, & Kleiman, 2011). In the the United Kingdom in the early 1980's Merseyside Medical Authority started a needle provision service and prescribed injectable opiates in response to increased opiate use among the local population (Riely & O'Hare, 2000).

The outbreak of AIDs in the 1980's paved the way for harm reduction strategies to become part of public health approaches in Western Europe, Australia and Canada (Roe, 2005; Hawdon, & Kleiman, 2011). The United States (US) took a different approach where harm reduction strategies meet a lot of political pressure. The policy in the US has consistently had two approaches to drug control, either a zero tolerance approach from a policing point of view or treatment for addiction from a medical model, which is usually abstinence based (Hawdon, & Kleiman, 2011). The US government banned the use of federal money to support needle exchange programs nearly continuously from 1988 until 2015 (Green *et al.*, 2012; Showalter, 2018). Conversely methadone has been used in the US for several decades as the main treatment for opiate addiction, although it's provision and availability are limited depending on local government restrictions and limited insurance coverage (Rettig & Yarmolinsky, 1995; Jones *et al.* 2015).

In the UK services could provide clean needles and syringes from the 1980's but could not legally provide any other items that could be used to prepare or administer illegal drugs, this changed in 2002 and since then they can provide filters, citric acid, cooking pots and sterile water (Beynon, *et al.,* 2007). Butler and Maycock (2005) refer to harm reduction as a broad church, and this is highlighted by the

disparities in how it has been applied in different jurisdictions over the last three decades. This shows that harm reduction is an evolving strategy, not always evolving towards a more liberal approach, for example Russia's banning of methadone in Crimea in 2015 (Walker, 2015). In this broad church of harm reduction Nutt (2012) expands on 16 different kinds of harm associated with drug use, divided between harms to the user of the drugs and harms to others, ranging from death and harm to environmental damage to economic cost.

There is a lot of research into the benefits of harm reduction related to drug addiction including the reduction of transmission of blood borne diseases, prevention of overdoses, increase in engagement with services, reduction in crime (Room, 2005; Amato, *et al.*, 2005; Pauly, *et al.*, 2013).

Harm Reduction in Ireland

Comiskey (2020) has summarised Ireland's response to drug use as abstinence based in the 1980's, to needle exchange and substitution treatment (methadone) in the 1990's and through to the 2000's where the focus was on removing stigma and improving the wellbeing for the individuals involved.

Ireland's first specialised clinic for addiction, National Drug Advisory & Treatment Centre at Jervis Street Hospital, was opened in 1970 as an out patient service and in 1975 a 9 bed detoxification unit was opened (Kelly, 1983). In 1973 the country's first voluntary treatment centre was opened by Coolmine Therapeutic Community (Butler, 2016). At Coolmine abstinence was seen as the only goal for treatment, addiction was viewed as a personality disorder, potential patients had to scream for help before they were admitted and any misbehaviour resulted in ones' head being shaved (Butler, 2016). From the late 1990s Coolmine changed its structure and practices; it stopped the confrontational approach to treatment, insisted all staff had formal training and engaged with statutory government bodies in the way of service level agreements (Butler, 2016).

In contrast to the abstinence approach of Coolmine Therapeutic Community, another approach was gaining a foothold in Irish drug policy. Harm reduction policies were first introduced in Ireland in the mid 1980's in response to the the high rates of HIV among intravenous drug users; this included needle exchange programmes and methadone maintenance (Butler and Maycock, 2005). The country's first needle exchange opened in 1989 former Eastern Health Board AIDS Resource Centre in Baggot Street, Dublin (Bingham *et al*., 2015). The Irish Government first formally acknowledged the need for harm reduction in relation to drug addiction in 1991 (National Co-ordinating Committee on Drug Abuse, 1991).

Harm reduction in Ireland has been mainly implicit, it has rarely been openly discussed by policy makers even though it is a core aspect of drug treatment in the country, this implicitness may have been functional but also may have contributed to stifling broader harm reduction methods being introduced (Butler and Maycock, 2005).

In Andrè Lyder's (2005) history of Dublin's anti-drugs movement during the 1980's and 1990's he criticised the harm reduction approach taken in Ireland. Lyder's main criticisms of harm reduction was that through this approach the State was abandoning people from working class communities and leaving them on methadone for years without a continuum of care and a severe lack of detoxification beds in the health system (Lyder, 2005). In 1996 the government acknowledged that the level of services available in Dublin were inadequate, highlighting the need to eliminate waiting lists for methadone and to increase the amount of detoxification programmes (Ministerial Task Force on Measures to Reduce the the Demands for Drugs 1996).

The anti-drugs movement decreased its activity in the mid 1990's for several reasons including the improvement in government's drug policies but methadone still remained controversial among some who refer to it as 'handcuffs' because of the challenges of being addicted to it for long periods of time (Freyne, 2017).

This covert method of introducing harm reduction practices did not facilitate discussion and attitudinal change (Butler, 2002; O'Mahony 2008). This public harm reduction debate has been ignited in Ireland recently due to the planned supervised drug injecting facility at Merchants Quay. Out of 53 submissions to the planning authority relating to the centre; 51 were opposed, which highlights how contentious harm reduction practices and ideology can be (Kilraine, 2019; Deegan, 2020).

The latest drug strategy by the Irish government is 'Reducing Harm, Supporting Recovery- A health led response to drug and alcohol use in Ireland 2017-2025'. This is the Irish government's third national drug strategy, it describes drug addiction as a public health issue instead of a criminal justice issue and places Ireland among the progressive countries in the world in relation to drug policy (Health Research Board, 2017).

Staff

There have been several studies related to working in homeless services and staff burnout and their training (Olivet, McGraw & Bassuk 2010; Clifasefi, *et al.*,, 2016). Research into homeless services staff attitudes and opinions is limited.

According to Doyle (2009) the social care practitioner will require regular on-going training in relation to new trends in drugs and treatment to adequately negative impacts of addiction on the individual and the wider community.

Goddard (2003) found that educating staff in relation to harm reduction methods can change their attitude to drug treatment. It has been found that even when harm reduction measures are implemented in services there can be blocks to comprehensive application due to staff attitude and organisational policy that can lead to risks for service users (Pauly, Wallace, and Barber, 2018). Harm reduction interventions can raise ethical issues for the staff directly involved with the individual using the drugs (Buchman and Lynch, 2018).

The staff involved in this current research are all employed in one organisation. The roles that will be invited to complete the survey will be frontline client facing staff, including cooks, support workers, project workers, supervisors and managers. For all roles with the exception of cooks all of the staff require a minimum qualification of QQI Level 5 on the National Level of Qualifications framework.

Harm Reduction and Staff

There is limited research completed in relation to the values and knowledge of homeless service staff undertaking harm reduction interventions. As homeless staff can work in services where someone who uses drugs lives then their engagement in relation to drugs can include specific discussions in relation to treatment to witnessing individuals inject drugs but who do not want to discuss their use with the staff member. The staff members' knowledge, confidence, values and opinions can determine the type of support and advice that the client receives in relation to several issues including drugs and harm reduction (Clifasefi *et al.*, 2016). If harm reduction is a contentious issue in society then research relating to the attitudes and values of professionals working directly with people who use drugs is necessary.

McCarthy *et al.* (2004) undertook research in relation to service providers' views of harm reduction services in Ireland, which involved telephone interviews with 16 staff members who provide harm reduction services. This study stated that at the time of their research there was no published information about the professionals delivering harm reduction services and that it would be beneficial to gather primary data about day to day work undertaken in Irish harm reduction services (McCarthy *et al.* 2004). Most of the questions in McCarthy et al.'s study related to an overview of each of the participant's services; who their client group was, what they offered, referral process, targets, opening hours and also asking about challenges and suggested improvements to their service (2004). In this author's opinion this study was the first of it's kind in Ireland and therefore important but most of the questions could have been answered by a brochure or a central database of harm reduction services, which is available today at www.drugs.ie. The McCarthy *et al.* (2004) study identified a lack of training in harm reduction

as an issue for staff but did not gauge if the participants agreed with harm reduction principles in the first place.

Kyser (2010) used the Harm Reduction Assessment Scale (HRAS) in an American context with counsellors (American Counselling Association members) to assess their attitudes towards harm reduction and compare it to variables such as spirituality, years of experience and location of work and home. This study found that counsellors in the study had a neutral to slightly favourable attitude to harm reduction approaches for the treatment of addiction while the majority of treatment available for addiction in the US is abstinence based. Kyser (2010) found that participants' level of spirituality did not effect their attitude to harm reduction but the variables that did have an impact towards harm reduction favourability were if the participant lived in an urban setting, if they had a close relationship with an addiction and their years working as a counsellor; the more years working increased favourability towards harm reduction.

One of the largest studies into the harm reduction attitudes among staff was conducted by Deren, *et al.* (2011) which surveyed 114 staff members across 8 methadone clinics in New York and New Jersey. This research found that 81% supported providing safe syringe disposal services while 68% supported providing a needle exchange service (Deren *et al.* 2011). This study did not use HRAS, instead they developed their own questionnaire asking demographic and education questions, HIV knowledge, and questions relating to services at their methadone clinics ranging from medical services, vocational training and needle exchanges and disposals (Deren *et al.* 2011). Participants with higher levels of education and with HIV knowledge were found to be more favourable towards harm reduction approaches (Deren *et al*. 2011).

In one qualitative study in Seattle in the US, in a Housing First service where previously homeless clients were housed and then provided with supports, Clifasefi *et al.* (2016) found that there was a difference between the concept of harm reduction in theory and how it's actually implemented with clients, and that it was up to some staff members' judgements and values whether harm reduction

approaches were implemented. A Canadian study based on nurses working supervised injecting service discussed the ethical challenges that a nurse may encounter from society or other nurses while providing harm reduction equipment and advice but the authors assumed that the nurses involved agreed with all of the harm reduction principles in the first place (Pauly *et al.* 2007).

Matheson, Bond and Tinelli (2007) found that pharmacists' attitudes towards needle exchange became significantly more positive between 2000 to 2006 than in the preceding years without a change in the level of training. So they discussed the impact that experience of providing a needle exchange service and exposure to people with a drug addiction to account for their improved attitude of harm reduction (Matheson *et al.* 2007).

The majority of the research that has been completed are in a questionnaire type format. Given how controversial harm reduction or abstinence based treatment can be depending on the political context it could be difficult to complete such research using a qualitative interview approach because participants may not be comfortable favouring one approach, especially if the other approach is the norm in that organisation or country. This issue could also arise in anonymous questionnaires as Kyser (2010) discusses social desirability in their research highlighting that some counsellors may answer questions depending on how they thought other colleagues or wider society expected them to respond. In an Irish setting this social pressure was discussed by Lyder (2005) that anyone who disagreed with harm reductionism would be 'branded by every liberal within earshot as some sort of right wing fundamentalist' (Lyder, p. 180, 2005). In some of the previous studies discussed it is assumed that professionals involved with a harm reduction service agree with the principles of ham reduction, in this authors opinion this assumption could ignore professionals that don't agree with some harm reduction principles or could miss out on learning more about why certain professionals agree with these principles.

Conclusion

To summarise, the rate of drug use is higher among homeless populations, with cannabis and heroin being the most commonly used illegal drugs. The treatment of drug addiction has been through major changes in Ireland over the last 30 years, moving from an abstinence only approach to harm reduction. This shift in policy has generally been informal but the Irish government's latest national drug strategy highlights the important role harm reduction and recovery play in the treatment of drug addiction. The move from abstinence to harm reduction has been controversial at times both internationally and within Ireland.

The staff in homeless services play an important role in the support of everyone who engages with their services, including people experiencing drug addiction. The way in which staff engage and respond to addiction and drug use while in homeless services can have an impact on the decisions those engaging with their services make in relation to drug use and treatment options. The way staff respond to drug use and what they think about drug addiction are topics lacking in research, especially in an Irish context where a lot has changed regarding drug policies over recent decades without much discussion. It is important to understand if professionals working with people experiencing drug addiction agree with the overarching national approach to addiction. Furthermore, it is important to understand what influences this approach from the professionals' point of view so that further training or policy can be implemented, where necessary, to support them in their work. If professional attitudes in the workplace are not in line with the national drug strategies, then these strategies will not be fully implemented and therefore impact on the support and care that those in addiction receive.

Chapter 2: Research Question

From reviewing the existing research, the author found that there is a lack of research about the harm reduction attitudes of professionals, especially for professionals working in housing support services or homeless services. There is also a lack of research exploring the factors that make professionals more inclined towards a harm reduction approach or an abstinence based approach.

The research completed by Matheson *et al.* (2007) and Deren *et al*. (2011) show the potential impact of drug related experience and education on a professional's attitude towards harm reduction.

Ireland's recent shift in policies and culture relating to drug addiction from an abstinence focused and anti-drug movements through to harm reduction and health led interventions makes research into professionals' harm reduction attitudes important.

The author of this study aims to research several factors related to harm reduction attitudes of professionals in a homeless organisation. The objectives of this study are to establish how the respondents to the survey measure on the harm reduction acceptability scale, and then using these measurements to identify whether there is correlation between respondents' harm reduction attitudes and their education and experience.

The question underpinning this research is 'what impact does education and experience have on the harm reduction attitudes of professionals working in homeless services?' Three hypotheses were developed to assist in answering that question.

Hypothesis 1

Professionals in the selected homeless organisation are inclined towards a harm reduction approach instead of an abstinence based approach in relation to drug addiction.

Hypothesis 2

The professionals' level and area of education impacts on their HRAS score.

Hypothesis 3

The type and length of experience in relation to drug addiction that a professional has will impact on the HRAS score.

Chapter 3: Methodology

Research philosophy

Research philosophy relates to the philosophical position of the knowledge garnered from the research and should be clear throughout the research process (Quinlan, 2011). Ontology is the first step in selecting a research philosophy, this refers to the nature of reality and whether one sees the world as objective or subjective (Quinlan, 2011; O'Gorman & MacIntosh, 2014). The next step in research is epistemology which deals with what constitutes acceptable knowledge, for objectivism this would include knowledge such as facts or numbers whereas with subjectivism data would include opinions and narratives (Saunders, Lewis and Thornhill, 2016).

Two of the main epistemological positions are positivism and interpretivism (Quinlan, 2011). Green and Thorogood (2009) describe positivism philosophy as one that assumes there is a constant reality and that things exist whether they are being looked at or not, or even if they are understood or not. According to Baskarada and Koronios (2018) positivism assumes that social research is the same as natural sciences and therefore should seek predictions and explanations. Positivism is generally associated with quantitative research and uses methods such as closed questionnaires and surveys. The core principals of positivism include objectivism with absolute truths, objectivity, measurement, and a strict predetermined design structure (Sarantakos, 2005). Whereas interpretivism sees people as unpredictable and concedes that there could be multiple realities depending on people's interpretations of their world (Green & Thorogood, 2009; Burnet & Lingam, 2012). Interpretivism is usually associated with qualitative research and utilises methods such as in depth or semi structured interviews and focus groups (Green & Thorogood, 2009).

There has been criticism for the quantitative research and positivism approach in social sciences as they do not take into consideration political or subjective viewpoints or contexts (Green & Thorogood, 2009)

and quantitative marketing research can have limited relevance and lifespan because ‘background contexts and consumer behaviours are in perpetual flux’ (Robertshaw, P. 11, 2007).

Despite the criticism for positivism and quantitative methodology, they have dominated the social and behavioural sciences (Baskarada & Koronios, 2018).

Selected Research Approach

After reviewing the available literature and the previous studies related to the research topic the author decided that using a positivism approach in quantitative research would be the most effective in gathering data and this approach has been used by other researchers (Kyser, 2010; Tzemis *et al*., 2013). Other studies with similar topics to this research question have used a combination of quantitative and qualitative research where they interviewed a number of the participants after the survey stage to explore answers further (Sheridan *et al.*, 2018; Moore & Mattaini, 2014). Given the time constraints of this research and to avoid the author/ researcher influencing the participants in qualitative interviews, as the author is a direct supervisor to some of the participants, it was decided that a mixed methodology approach was not suitable in this scenario.

The research question is ‘what impact does education and experience have on harm reduction attitudes of professionals working in homeless services’. The variables in quantitative research need to be isolated, defined and measured (Hohnman, 2006 in Curtis & Drennan, p. 137, 2013). The variables in this research are the participants’ education and experience and also their attitude to harm reduction attitude. These variables will be defined later in this this section. This research is cross sectional in design as it will study particular variables at a particular time, people employed in a homeless service at the time of the research (Saunders, Lewis, and Thornhill 2016).

Sampling

According to O'Dwyer and Bernauer (2014) sampling is the process of choosing a sample from a population that will be used in the research. The population for this current research are people who are currently employed in homeless services. In order to get as large a sample size as possible and with as broad a range of client experiences; the author selected a sample of 190 client facing employees of a large organisation that provides accommodation and services for people who are currently experiencing homelessness or have experienced long term homelessness. All of the participants are employed in one organisation, this organisation provided ethical approval for the research to proceed. This will be described in more detail later in this section.

The author used non probability purposive sampling, specifically homogenous sampling. In this technique the author selected certain subgroups of employees in a homeless organisation. The researcher used their judgement to select participants based on specific characteristics who they think will help answer their research question (Curtis & Drennan, 2013; Saunders *et al.*, 2016). The participants in this research all work in frontline client facing roles in homeless services. Purposive sampling cannot be considered to be statistically representative of the population as those included in the study may have different opinions from those in the wider population who weren't involved in the research (Curtis & Drennan, 2013; Saunders *et al.*, 2016). This sampling technique will provide access to a highly specialised group that can be difficult to access for relatively low cost, compared to employing probability sampling (Barratt, Ferris and Lenton, 2014). If the focus was on getting a large enough sample for this study to be statistically representative of the wider population then this study would not be feasible in the current context. This could lead to hard to engage groups being ignored by research because of limited sample sizes (Crosby *et al.* 2010).

As a result of the difficulties in using purposive sampling to represent the wider population this research is not aiming to do that, instead this study aims to show the relationships between the variables of education and experience within the sample population (Barrat *et al*., 2014).

Other sampling techniques, such as snowball sampling and convenience sampling, were considered by the author for this study. Such sampling would have meant that the participants in the study would not be limited to working in a homeless service. By not selecting participants based on their employment in a homeless service the researcher would have collected data about a wider population of people but not those who have regular experience of harm reduction work. This data would be interesting but not as applicable to the homeless population or the homeless organisation where the participants are employed.

Questionnaire Design

The questionnaire in this study comprised of three sections; Harm Reduction Acceptability Scale (HRAS), questions about participants' experience of drugs in their workplace and demographic questions.

Harm Reduction Acceptability Scale

The Harm Reduction Acceptability Scale is a 25 item questionnaire developed by Perilou Goddard with high internal consistency, Cronbach alpha of .877 (Goddard, 2003). Cronbach alpha is a technique to check the validity of a statement and to assess internal consistency of a questionnaire, values over 0.7 are considered to indicate uniformity (Fisher & Buglear, 2007; Curtis & Drennan, 2013). This questionnaire uses a 5 point Likert scale, ranging from 1 representing Strongly Agree to 5 representing Strongly Disagree. Items 1, 4, 6, 9, 12, 14, 19, 21 23, and 25 are reversed scored. The Likert scale is commonly used for researching people's attitudes (May 2001; Sarantakos 2005).

Three of the 25 questions were removed by the author for the purpose of this study as two related to bleaching syringes and needles as a form of cleaning them and this practice is controversial, it's effectiveness has been questioned and not common or recommended when needle provision is available (World Health Organisation, 2007; Merchants Quay Ireland, 2007). A third question was removed as it

related to alcohol abstinence and this research is only focused on illegal drugs. Goddard's HRAS can be seen in Appendix 1.

Experience of drugs in the workplace

The author developed 11 questions for the questionnaire that related to the participants' experience about illegal drug use in their place of work. Alongside the demographic questions, these questions gauged each participant's experience of illegal drugs in work. The questions related to the following statements:

- I have encountered illegal drug use while in work.
- I am comfortable discussing drug use with a client in my service.
- Illegal drug use is common in my work place.
- I have the knowledge and skills to deal with clients who are addicted to drugs in this service.
- In my service the rules are too lenient in relation to drug use
- I know how to advise a client who wants treatment for drug addiction.
- The frequency that I carry out harm reduction interventions related to drug use in work is:
- The rules in my work place are too strict in relation to clients who use drugs.
- I have turned a blind eye/ignored illegal drug use in my work place.
- Why have you turned a blind eye/ignored illegal drug use? Select all that apply.
- A supervised injecting service for those who inject drugs is a good idea.

The full questionnaire is attached in Appendix 2.

Demographics

The demographic questions are similar to questions asked in other studies about drug related knowledge (Kyser, 2010; Bryan *et al.*, 2000). The author included questions about education, both formal and informal, to measure what effect, if any, that had on the attitude to harm reduction.

Piloting a questionnaire can be fundamental to it's success and help to identity numerous issues (Curtis & Drennan, 2013). This questionnaire was piloted among five of the potential participants, and these participants were not included in the actual research to avoid bias in their responses. This pilot process resulted in changes to the format such as less questions per section, clearer wording of some questions and the inclusion of more college course options in the demographics section.

Ethical Considerations

This research was approved by the NCI Ethics Committee and the homeless organisation where the research took place. The author wrote a proposal to the organisation's policy department and requested the approval of each senior manager of each department where the employees the would be asked to partake in the research worked.

Each participant received an email from the author explaining the research, explaining that participation was voluntary and that that all information submitted would be anonymous. As the researcher was a direct supervisor to some of the potential participants it was important that participants were reassured that their surveys would be anonymous for fear it might impact on their relationship in work.

Organisational Approval

To get access to employees of the organisation for this research the author applied for organisational approval. This involved providing the ethical approval from the National College of Ireland, providing

risk mitigation steps for any potential harm to the participants and agreeing to a research contract. Once the organisation approved the research the author received permission to contact frontline employees asking them to take part in this research.

Questionnaire Distribution

After reviewing several options, the author decided to use Google Forms for the questionnaire which was emailed to all the participants. Other online applications were considered and tested by the author. During this process other applications were deemed unsuitable because of their layout, data collection process or accessibility issues; as some were blocked by the organisation's IT system.

The author included participant information in the body of the email and at the first section of the questionnaire to ensure that all participants understood what they were being asked to undertake and that they provided their informed consent. To ensure informed consent was received by all participants the participant information section had to be agreed to before the rest of the questionnaire loaded on the application. The participant information is attached in Appendix 3.

The questionnaire was emailed to participants in July 2020 and responses were accepted for a 2-week period. The total number of participants invited to complete the questionnaire was 190.

Data Analysis

The data from the questionnaires was transferred from Excel to be analysed by the computer statistical software; Statistical Package for the Social Sciences (SPSS) version 26. Descriptive analysis, correlation analysis and regression analysis were utilised by the author.

Each of the participants' HRAS statement responses were calculated and provided a HRAS score. This was done by adding up the values of their response on the Likert scale; 1 equalling strongly agree through to 5 equalling strongly disagree. The following items were reverse scored 2, 4, 6, 9, 12, 14, 19,

21 and 23. A mean score of 3 or lower indicates a positive attitude towards harm reduction and a mean score above 3 indicates a positive attitude towards abstinence (Kyser, 2010).

Out of 190 participants invited to take part in the research, 71 completed the questionnaire, representing a response rate of 37%.

Chapter 4: Analysis and Findings

This chapter will present and analyse the findings from the data collection in an attempt to respond to this study's three hypotheses and ultimately answering the research question, 'what impact does education and experience have on the harm reduction attitudes of professionals working in homeless services?'. This section will discuss the internal validity of the questionnaire, describe the characteristics of the respondents and the response rate, and then the educational and experience of the respondents will be analysed for any relationship with the HRAS scores.

Internal Consistency

As explained above, the author adapted Goddard's HRAS by removing three questions that were not relevant or were out of date in the Irish context. Cronbach's alpha for this adapted questionnaire was .81 therefore indicating a relatively high level of internal consistency as the value is greater than .7 (Fisher & Buglear, 2007; Curtis & Drennan, 2013).

Response rate

71 people responded to the questionnaire, therefore N equals 71. 190 professionals were invited to complete the questionnaire, therefore this study had a response rate of just over 37%.

The demographics of participants including their educational backgrounds and their experiences with drugs is highlighted below. These demographics will then be analysed in relation to their effect on harm reduction attitudes.

Demographics of Participants

Table 1: Age range of participants

	N	%
22-25	14	19.7
26-30	20	28.2
31-40	22	31.0
41-50	9	12.7
51 and older	5	7.0
Prefer not to say	1	1.4

The mean age category for the 70 respondents who provided their age would be the 33-40 category.

Table 2: Nationality breakdown of participants

	N	%
Irish	49	69.0
Spanish	12	16.9
Other EU	5	7.0
Non EU	5	7.0

Table 3: Breakdown of how respondents described where they live

	N	%
Rural	5	7.0
Urban	41	57.7
Suburban	25	35.2

Table 4: Breakdown of positions of participants

	N	%
Project Worker	13	18.3
Support Worker	41	57.7
Manager	8	11.3
Supervisor	4	5.6
Full Time Volunteer	5	7.0

No cooks responded to the questionnaire, there was approximately 10 individuals who were in these categories when the questionnaire was distributed.

Table 5: Breakdown of highest qualifications achieved by participants

	N	%
Leaving Certificate	3	4.2
Diploma	7	9.9
Degree	37	52.1
Masters	24	33.8

Table 6: List of subjects studied at diploma, degree or masters level by participants

	N	%
Psychology	16	22.5
Social Care	23	32.4
Social Work	6	8.5
Arts	3	4.2

	Addiction	5	7.0
	Education	3	4.2
	Sociology and Social Policy	7 5	9.9 7.0
	Other		
	Missing Values	3	4.2

Table 7: Breakdown of sources of information where participants state they learn about drugs and addiction

(Select as many as relevant)	% of respondents who selected each option
Speaking with clients	83%
Colleagues	80%
Books & Internet	69%
Policies in Work	63%
College	60%
Work Training	57%
Personal Experience	47%
External Training	45%

Formal training sources were the least selected along with personal experience.

Informal sources of education such as speaking with clients and speaking colleagues were the most selected options.

Table 8: Breakdown of age categories of participants

	N	%
Less than 1 year	19	26.8
1-2 years	18	25.4
2-5 years	20	28.2
5-10 years	6	8.5
More than 10 years	8	11.3

The mean category for this group is 2-5 years worked in homeless services.

Experiences of drug use

The questions and statements on the questionnaire related to the participants' experiences of drug use will be highlighted below.

Table 9: Close personal relationship (friend or family) with anyone who had a drug addiction?

		N	%
	Yes	46	64.8
	No	25	35.2

Table 10: Encountered illegal drug use while in work

		N	%
	Yes	64	90.1
	No	7	9.9

The 7 respondents who responded ‘No’ to the above statement were not asked the following questions because they stated they did not encounter illegal drugs in their work place, this will show as 7 missing values in the following tables.

Table 11: Comfortable discussing drug use with a client in work

		N	%
	Strongly Agree	38	53.5
	Agree	21	29.6
	Neither agree nor disagree	2	2.8
	Disagree	1	1.4
	Strongly Disagree	2	2.8
	Missing Values	7	9.9

This table shows that 83% of the respondents are comfortable discussing drug use with clients, whereas only 12.7% of staff are not comfortable discussing drug use.

Table 12: The frequency that harm reduction interventions related to drug use in work are carried out

		N	%
	Never	4	5.6
	Rarely	11	15.5
	A couple of times a month	17	23.9
	Once a week	11	15.5
	On most shifts	21	29.6
	Missing Values	7	9.9

This table shows that 45% of staff state that they engage in harm reduction interventions at least once a week, whereas just over 5% of staff who do encounter drugs in work state they never engage in harm reduction interventions.

Table 13: Turned a blind eye/ignored illegal drug use in service.

		N	%
	Strongly Agree	7	9.9
	Agree	20	28.2
	Neither agree nor disagree	5	7.0
	Disagree	21	29.6
	Strongly Disagree	11	15.5
	Missing Values		9.9

This table shows that just over 45% of respondents' state that they have not ignored illegal drug use in their service, whereas 40% state that they have.

Out of the 32 people who responded in agreement or neutral to the statement in relation to ignoring drug use in their service; the top two reasons for not engaging with the client were that the drug use observed was part of a harm reduction plan (14 respondents cited this) and they did not want to compromise the relation with the client (10 respondents cited this). Among the other reasons cited by more than one respondent why illegal drug use was ignored were; unsure how to respond (3 respondents), easier to ignore than challenge (4 respondents), placement sustainment; did not want client to loose accommodation (3 respondents), illegal drug use is allowed in their service (4 respondents).

Table 14: I have the knowledge and skills to deal with clients who are addicted to drugs in this service.

		N	%
	Strongly Agree	15	21.1
	Agree	37	52.1
	Neither agree nor disagree	8	11.3
	Disagree	2	2.8
	Strongly Disagree	2	2.8
	Missing Values	7	9.9

Table 15: I know how to advise a client who wants treatment for dug addiction

	Strongly Agree	12	16.9
	Agree	38	53.5
	Neither agree nor disagree	7	9.9
	Disagree	5	7.0
	Strongly Disagree	2	2.8
	Missing Values	7	9.9

Table 14 and 15 contain similar responses in relation to how participants feel about their knowledge in relation to working with people who have a drug addiction. 52 participants report that they have the knowledge to deal with clients with addiction and 50 participants report that they know how to advise a client about treatment. This would indicate that participants' understanding of dealing with someone with an addiction is closely related to knowing how to advise them about treatment options.

Harm Reduction Acceptability Scale (HRAS)

The adapted 22 point HRAS was used to measure the respondents' inclination towards either harm reduction approaches or abstinence approaches. Amongst the 71 respondents in the study the mean HRAS score was 1.9. The lowest HRAS score was 1.05, and the highest was 2.95, with standard deviation of 0.4. A mean score of 3 or lower indicates a favourable attitude towards harm reduction, and a mean score above 3 indicates a favourable attitude towards abstinence. Therefore, all 71 respondents in this study measured as being favourable towards harm reduction. This proves that the first hypothesis of this study is correct, that the professionals working in the selected organisation are more inclined towards a harm reduction approach than an abstinence approach.

This mean score is lower than in previous research that have used the HRAS. Kyser's (2010) study of counsellors in the US found that the mean in her study was 2.69, and Goddard's (2003) study, also in the US, found an average HRAS score of 2.55.

HRAS and Education

This analysis will help answer the hypothesis as to whether education impacts on harm reduction attitudes of the target population.

Table 16: Highest education level attained by participants, the mean HRAS score categorised by education level, and the number of participants in each category

Qualification Level	Mean HRAS Score	N
Leaving Certificate	2.24	3
Diploma	2.36	7
Degree	1.91	37
Masters	1.97	24

Regression analysis on the highest education level attained and HRAS scores calculated that when compared to Diploma HRAS scores; both Masters HRAS scores and Degree HRAS scores were statistically significantly lower; negative .39 and negative .45 respectively.

Table 17: Breakdown of the top 5 subject areas of participants; Mean HRAS score for all participants who studied each subject and total number of participants who studies each subject

Course	Mean HRAS Score	N
Addiction	1.98	5
Social Care	2.10	23
Psychology	1.93	16
Sociology and social policy	1.70	7
Social Work	1.86	6

There was no statistically significant difference in the regression analysis results when the areas of study were evaluated for their effect on the HRAS. This proves the second hypothesis partly confirmed, that the level and subject of education impacts on their HRAS score. In this study the level of education had a statistically significant impact on the HRAS score but the subject of education did not.

Harm Reduction and Experience

This analysis will help answer the hypothesis as to whether experience impacts on harm reduction attitudes.

Multiple regression analysis with HRAS scores and respondent age groups was conducted to evaluate the relationship between age and harm reduction attitude. Age groups were found not to have a statistically significant effect on the HRAS score, as all the p values for each of the age groups was larger than 0.05.

Multiple regression analysis was conducted for the variable 'length of time working in homeless services' and the HRAS scores to evaluate whether the length of an individual's experience in homeless services has a relationship to their attitude towards harm reduction. In SPSS the p value for all of the 'length of time working in homeless service' was .041, which is less than .05. This means this variable is statistically significant and this value also indicates that the null hypothesis is incorrect; that all the variables have no impact on the HRAS scores.

The length of years working variable with the lowest p value was for respondents who worked in homeless service for 10 years or longer. This p value was .03 meaning that it is statistically significant, as it is less than .05. The unstandardized coefficients table shows that respondents in this study with 10 or more years' experience lowered the overall mean HRAS score by .5, with other independent variables being fixed.

The independent variables of whether the respondents stated that they lived in rural, urban or suburban, or the frequency of harm reduction interventions did not have a statistical significant impact on the HRAS scores according to the regression analysis. The regression analysis of the independent variable relating to participants' having a close relationship with someone who had a drug addiction and HRAS scores produced a p value of .486 meaning that it is not statistically significant.

According to the regression analysis and the variable of 'position/roles' in the organisation, the only role that had a statistically significant impact on the overall HRAS mean scores was Project Workers, with a p value of .006. Project Workers had a mean HRAS score .35 lower than Support Workers, .41 lower than Supervisors and .43 lower than Managers.

This confirms the third hypothesis; that the type and length of experience in relation to drug addiction that a professional has will impact on the HRAS score.

The variables that are demonstrated in having an impact on HRAS scores for professionals in the selected homeless organisation were; the length of time staff worked in services, the level of education

and the role or position in the organisation. Project Workers, staff who have worked 10 or more years in homeless services and staff with a degree or masters had the lowest mean HRAS scores.

Summary of findings

The variables 'length of time staff worked in services', 'the level of education' and the 'role or position in the organisation' had an impact on the harm reduction attitude of staff working in homeless services. This confirms the first and third hypothesis of the study and partially confirms the second hypothesis.

These findings differ from Kyser's (2010) research into counsellors' harm reduction attitudes as she found personal relationship with someone who had a drug addiction and urban home environment did have a significant effect on the professionals' harm reduction attitude. A commonality between this current study and Kyser's is that both found that the longer the experience of working in counselling/homeless setting then the more favourable the participants were towards harm reduction.

The data from this study also shows that all of the respondents scored under 3 on the HRAS which means that according to that scale they are all favourable towards harm reduction.

The response rate for this research was low at 37% which must be taken into consideration when reviewing the findings. The fact that 100% of the respondents scored under 3 on the HRAS is interesting and that the mean HRAS scores were lower than previous HRAS studies. Although this could mean that those who were interested in harm reduction ideology wanted to complete the questionnaire and those who did not share the same ideology choose not to complete it; but choosing not complete the questionnaire is not an indicator of either type of ideology; harm reduction or abstinence. The different contexts between this study and previous HRAS studies could be a factor for the lower mean HRAS scores in this study. Previous HRAS studies have been conducted in the US where this author has already discussed the overarching preference for an abstinence approach over harm reduction in the treatment of drug addiction. Whereas in Ireland harm reduction has been an important tool in the

response to drug addiction for the last three decades (Comiskey, 2020). For future studies in this area it would be important to increase the response rate

Chapter 5: Discussion

The author will discuss the significance of the findings in this study, namely that 100% of the respondents in the research measured as being inclined towards the harm reduction ideology and that education and experience had an impact on the harm reduction attitudes of the participants.

All of the participants measured as having a positive attitude towards harm reduction on the HRAS. This does not mean that all of the professionals working in the chosen organisation have a similar attitude. The response rate for this research was 37%, a total of 71 professionals responded to the questionnaire, which is low and is therefore a limitation of this research. This population group is highly specialised as it relates to professionals working in homeless services, therefore they are harder to source and engage compared to research relating to the general population. Kyser's (2010) research into similar topic and similar target population had a response rate of 11%.

Taking into consideration the response rate in this study it highlights several limitations and areas for future research. It could be possible that members of the target population who had a positive attitude towards harm reduction were more inclined to engage in a study of that subject. Whereas other professionals in this population who did not have a positive attitude towards the subject, or a neutral attitude, and were therefore less inclined to engage. One way to overcome or exclude this potential issue in future research is to use systematic sampling techniques that picks specific members of the population to include in the study.

Another limitation of this study is that the HRAS measurements and the information about participants' experiences of drugs in their services are self reported. Further study is warranted to fully explore what the participants meant when they indicated that they have the knowledge to advise a client about drug treatment. This further research should involve the clients' point of view and take referrals and outcomes to specialist harm reduction services and treatment services into consideration.

Kyser (2010) discusses social desirability issue as a potential limitation in her research which could be an issue in this study as well. This could mean members of this target population could have responded to items in the questionnaire in a way that they think professionals in their occupation should respond, not necessarily how they really thought, even though their responses were anonymous.

The HRAS is one of the few tools for measuring harm reduction attitudes in a standardised way and which has been utilised in research involving similar target populations, mainly in the US (Kyser, 2010; Goddard 2003). As previously discussed the US and Ireland have different approaches, at national policy level, towards the response and treatment of drug addiction. Therefore, in this author's opinion, some of the items on the HRAS could be out of date and in need of updating, especially in the Irish context where needle exchange and methadone provision for drug treatment are older than 50% of the respondents in this study. Items on the HRAS such as providing bleach tablets to clean needles is not relevant in Irish context due to the extent of needle exchange provision. Instead items relating to crack pipe provision, rectal administration of drugs and supervised injecting centres are and could improve the accuracy of measurement of harm reduction attitudes.

Despite this issue it is positive that the respondents in this study all measured as having a favourable attitude towards harm reduction. This is the first study of this topic in Ireland and it reveals that the professionals who engaged in the research aligned themselves with the same principles, of harm reduction, that underpin the national drug strategy. It is important that the individuals who are addicted to illegal drugs and engaging with homeless services and specialised drug services receive consistent messaging about harm reduction and treatment, or at least not conflicting information. This finding is an indicator that there is a relatively consistent attitude towards harm reduction, at least in one organisation. Future research should consider a larger target population, using systematic sampling, and involve several frontline organisations to expand on the finding of this current study.

The finding that education and qualification is similar to previous research relating to harm reduction attitudes and professionals (Kyser, 2010; Goddard 2003). Although in this current research some of the

specific education and experience variables that had a significant impact on the HRAS score were different to the previous studies. The population sample in this current study is too small to make broad assumptions or recommendations about specific education and experience factors that could be replicated externally. Despite this limitation this could be an area to expand on in future research. A combination of quantitative research and qualitative research which would allow for deeper investigation into why certain categories of the respondents were more inclined towards harm reduction compared to the general target population.

Years experience and harm reduction attitude

In this study respondents who worked in homeless services for ten years or more had significantly lower HRAS scores than others (indicating they were more inclined towards harm reduction). Kyser (2010) had a similar finding where counsellors with the longest period of professional experience had a significantly lower HRAS score to others, in her study HRAS decreased incrementally the longer people worked in the field, up to 36 years. One study found that the longer professionals (pharmacists) worked with people with a drug addiction their attitude's about drug addiction improved, and no specific training took place between the two periods to account for the changed attitude (Matheson *et al.* 2007).

This correlation between length of professional experience and harm reduction should be explored further, in interview style for example, to identify patterns that could be used in the training of newer staff on harm reduction.

Level of education and harm reduction attitude

This study found that respondents with a degree or a masters had a significantly lower HRAS score when compared to respondents who had a diploma. Between masters and degree holders, degree holders had slightly lower HRAS scores on average compared to respondents with a masters. Deren *et al.* (2011)

had a similar finding in their study when they found that staff working in methadone clinics who had higher education levels showed more favourable attitudes towards harm reduction compared with others in the study. This is line with Goddard's (2003) research that demonstrated that a 2-hour training session about harm reduction resulted in significantly lower HRAS scores post training compared to pre test HRAS scores. Therefore, education appears to be an important factor in improving attitudes about harm reduction. In this current study it was found when staff selected their sources of information about drugs and addiction formal training sources were the least selected, instead informal sources such as speaking with clients and speaking colleagues were the respondents most selected options. This current study did not find a significant correlation between the type of subject studied at the college and harm reduction attitudes.

The frequency in which participants in this study engage in harm reduction interventions underpins the prevalence of drug addiction in homeless services and how involved professionals are who are working in this services. An area for further research is how the attitudes of professionals impact on the harm reduction or treatment outcomes for clients.

Chapter 6: Conclusion

A significant proportion of the people professionals working in homeless services support may be addicted to illegal drugs. This means that professionals in homeless services are likely to interact with people experiencing acute addiction and be exposed to illegal drug use in their work place. How professionals respond to this addiction can play an important part in the support of the individuals' addiction, for better or worse. The approach most prevalent in Ireland is harm reduction, which has slowly come to the fore of official government policy in recent years after being in practice for the last three decades. Harm reduction can be a controversial topic, in Ireland and abroad and there has been limited research into the attitudes of frontline professionals who have to action its' principles.

This study set out to answer the question; 'What impact does education and experience have on the harm reduction attitudes of professionals working in homeless services?' To answer this question a highly specialised target population were studied by the means of quantitative research to ascertain if they were inclined towards the harm reduction approach or not, and what impact the variables of education and education had on their inclination. This study found that out of the target population all who engaged in the study demonstrated a preference for harm reduction over abstinence. Level of education, position and length of experience emerged from the research as significant indicators for an increased favourability of harm reduction.

This has been the first study of harm reduction attitudes of professionals working in homeless services in Ireland and it provides a starting point from where future research can explore further. This provides a baseline of harm reduction attitudes amongst a highly relevant population and should inform future drug awareness training. Further research is required to study the reasons why these variables had a positive impact on harm reduction attitudes as it several of these variables have been identified in previous research in as predictors to positive attitudes towards harm reduction and wider drug policy. This is important as improved professional attitudes will have a positive effect for clients the professionals work with; such as improved engagement and improved outcomes.

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Appendices

Appendix 1

Goddard's 'Harm Reduction Assessment Scale'

Directions: Indicate the number that corresponds to your personal attitude.

1 Strongly Agree
2 Agree
3 Neither agree or disagree
4 Disagree
5 Strongly Disagree

1. People with alcohol or drug problems who will not accept abstinence as their treatment goal are in denial.

2. It is not acceptable to teach injecting drug users how to use bleach to sterilize their injecting equipment.

3. A choice of treatment outcome goals (for example, abstinence, reduced use of drugs or alcohol, safer use of drugs or alcohol) should be discussed with all people seeking help for drug or alcohol problems.

4. People who live in government-funded housing must be drug and alcohol free.

5. Doctors should be permitted to prescribe heroin and similar drugs to treat drug addiction as long as doing so reduces problems such as crime and health risks.

6. Even if their drug use is stable, women who use illicit drugs cannot be good mothers to infants and young children.

7. Drug users should be given honest information about how illicit drugs may be used more safely (for example, how overdose or related health hazards may be avoided).

8. People with drug or alcohol problems who are not willing to accept abstinence as their treatment outcome goal should be offered treatment that aims to reduce the harm associated with their continued drug or alcohol use.

9. In most cases, nothing can be done to motivate clients in denial except to wait for them to “hit bottom”.

10. It is acceptable to prescribe substitute drugs such as methadone in order to reduce crime and other social problems associated with illicit drug use.

11. Prisons should not provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.

12. As long as clients are making progress towards their treatment goals, methadone maintenance programs should not kick clients out of treatment for using street drugs.

13. Measures designed to reduce the harm associated with drug or alcohol use are acceptable only if they eventually lead clients to pursue abstinence.

14. People with drug and alcohol problems may be more likely to seek professional help if they are offered at least some treatment options that do not focus on abstinence.

15. The prescription of substitute drugs such as methadone should be forbidden.

16. People whose drug use is stable should be trained to teach other drug users how to use drugs more safely (for example, how to inject safely).

17. Making clean injecting equipment available to injecting drug users is likely to reduce the rate of HIV infection.

18. Abstinence is the only acceptable treatment option for people who are physically dependent on alcohol.

19. It is possible to use drugs without necessarily misusing or abusing drugs.

20. Pamphlets for educating drug users about safer drug use and safer sex should be detailed and explicit, even if these pamphlets would be offensive to some people.

21. Opiate users should only be prescribed methadone for a limited period of time.

22. Drug injectors who are not willing to accept abstinence as a treatment goal at the beginning of treatment should be given easy access to clean injecting equipment

to reduce the spread of HIV and other blood-borne diseases.

23. Women who use illicit drugs during pregnancy should automatically lose custody of their babies.

24. People with alcohol or drug problems should be praised for making changes such

as cutting down on their alcohol consumption or switching from injectable drugs to oral drugs.

25. Abstinence is the only acceptable treatment goal for people who use illicit drugs.

Appendix 2.

Survey: Drugs and HarmReduction

- This research is about illegal drugs and harm reduction.
- The main researcher is Ciarán King.

- All answers are anonymous.
- Participation is voluntary.
- If you choose to complete this survey then thank you for your time.
- If any of the topics cause distress please discuss with your manager, HR or the researcher.

- This survey will take approximately 10 minutes to complete, please read each question carefully.

To participate:

- I understand that participation in this survey involves answering questions relating to my personal attitude in relation to illegal drugs and harm reduction.
- I understand that all responses are anonymous.

Contact details of researcher: Email:
x18124976@student.ncirl.ie
* Required

1. I agree to participate in this research. *

☐ Yes

1/5

2. A supervised injecting service for those who inject drugs is a good idea. *

- ◯ Strongly disagree Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly agree

3. People addicted to drugs who will not accept abstinence as their treatment goal are in denial. *

- Strongly disagree Disagree
- Neutral
- Agree
- Strongly agree

4. A choice of treatment outcome goals (for example, abstinence, reduced use of drugs, safer use of drugs) should be discussed with all people seeking help for drug addiction. *

- Strongly disagree Disagree
- Neutral
- Agree
- Strongly agree

5. People who live in social housing must be drug free. *

- Strongly disagree Disagree
- Neutral
- Agree
- Strongly Agree

6. Doctors should be permitted to prescribe heroin and similar drugs to treat drug addiction as long as doing so reduces problems such as crime and health risks. *

- Strongly disagree Disagree
- Neutral
- Agree
- Strongly agree

7. Even if their drug use is stable, women who use illicit drugs cannot be good mothers to infants and young children. *

- [ ] Strongly disagree Disagree
- [ ] Neutral
- [ ] Agree
- [ ] Strongly agree

8. People who use drugs should be given honest information about how illicit drugs may be used more safely (for example, how overdose or related health hazards may be avoided). *

- [ ] Strongly disagree Disagree
- [ ] Neutral
- [ ] Agree
- [ ] Strongly agree

9. People addicted to drugs who are not willing to accept abstinence as their treatment outcome goal should be offered treatment that aims to reduce theharm associated with their continued drug use. *

- Strongly disagree Disagree
- Neutral
- Agree
- Strongly agree

10. In most cases, nothing can be done to motivate clients in denial except to wait for them to “hit bottom”.*

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

11. It is acceptable to prescribe substitute drugs such as methadone in order to reduce crime and other social problems associated with illicit drug use. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

/

12. As long as clients are making progress towards their treatment goals, methadone maintenance programs should not kick clients out of treatment for using street drugs. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

13. Measures designed to reduce the harm associated with drug use are acceptable only if they eventually lead clients to pursue abstinence. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

14. People experiencing drug addiction may be more likely to seek professional help if they are offered at least some treatment options that do not focus on abstinence. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

15. The prescription of substitute drugs such as methadone should be forbidden. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

16. People whose drug use is stable should be trained to teach other drug users how to use drugs more safely (for example, how to inject safely). *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

17. Making clean injecting equipment available to people who inject drugs is likely to reduce the rate of HIV infection. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

18. It is possible to use drugs without necessarily misusing or abusing drugs. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

19. Pamphlets for educating people who use drugs about safer drug use and safer sex should be detailed and explicit, even if these pamphlets would be offensive to some people. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

20. Opiate users should only be prescribed methadone for a limited period of time. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

21. People who inject drugs who are not willing to accept abstinence as a treatment goal at the beginning of treatment should be given easy access to clean injecting equipment to reduce the spread of HIV and other blood-borne diseases. *

Mark only one oval.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

22. Women who use illicit drugs during pregnancy should automatically lose custody of their babies. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

23. People addicted to drugs should be praised for making changes such as cutting down on their consumption or switching from injectable drugs to oral drugs. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

24. Abstinence is the only acceptable treatment goal for people who use illicit drugs. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

2/5

25. I have encountered illegal drug use while in work. *

- Yes *Skip to question 26*
- No *Skip to question 35*

3/5

26. I am comfortable discussing drug use with a client in my service. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

27. Illegal drug use is common in my work place. *

Mark only one oval.

- Yes
- No

/

28. I have the knowledge and skills to deal with clients who are addicted to drugs in this service. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

29. In my service the rules are too lenient in relation to drug use *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

30. I know how to advise a client who wants treatment for drug addiction. *

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

31. The frequency that I carry out harm reduction interventions related to drug use in work is: *

- Never
- Rarely
- A couple of times a month Once a
- week
- On most shifts

32. The rules in my work place are too strict in relation to clients who use drugs. *

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

33. I have turned a blind eye/ignored illegal drug use in my work place. *

- Strongly disagree *Skip to question 35*
- Disagree *Skip to question 35*
- Neutral *Skip to question 34*
- Agree *Skip to question 34*
- Strongly agree *Skip to question 34*

34. Why have you turned a blind eye/ignored illegal drug use? Select all that apply.

Check all that apply.

- [ ] Unsure how to respond
- [ ] Did not want to compromise relationship with client Easier to
- [ ] ignore than challenge
- [ ] Drug use observed was part of client's specific harm reduction support plan None of the
- [ ] above

Other: [ ] _____

5/5

Demographics

35. What is your position? *

- ( ) Project Worker
- ( ) Support Worker
- ( ) Supervisor Manager
- ( ) Cook
- ( ) Other: _____

36. Nationality *

- ( ) Irish
- ( ) Other: _____

37. What age areyou?

- 18-21
- 22-25
- 26-30
- 31-40
- 41-50
- 51 and older Prefer
- not to say

38. Highest qualification *

Mark only one oval.

- Leaving Certificate *Skip to question 40*
- Diploma
- Degree Masters
-

Area of Study

39. Main area of study *

Mark only one oval.

- Psychology
- Social Care
- Social Work
- Sociology/Social Policy
- Arts
- Business
- Other: _____

Demographics

40. What are your sources of information about drugs and addiction? Select as many as required. *

Check all that apply.

- [ ] College module Work
- [ ] training course
- [ ] External training course
- [ ] Speaking with clients
- [ ] Personal experience Work
- [ ] policies
- [ ] Books and internet Learning
- [ ] from colleagues

Other: [ ] _____

41. Have you ever had a close personal relationship (friend or family) with anyone who had a drug addiction? *

- ( ) Yes
- ( ) No

42. Which best describes where you live? *

- ( ) Rural Suburban
- ( ) Urban
- ( )

43. How many years have you worked in homeless services? *

Mark only one oval.

- Less than 1 year
- 1-2 years
- 2-5 years
- 5-10 years
- More than 10 years

Appendix 3.

Participant Information

Dear colleague,

I would like to invite you to complete a questionnaire which is part of my thesis for a MSc in Management in the National College of Ireland (NCI).

About the Research

This research explores the effect that education and experience have on people's attitudes in relation to harm reduction.

What is involved in taking part?

Taking part involves completing an anonymous online questionnaire. The questionnaire will take approximately 10 minutes. Please take your time when answering each question.

Your name will not be recorded during the research therefore all participants will remain anonymous throughout the process. Any identifiable details you provide in any open text answers will be anonymised by the researcher.

Do you have to participate?

Participation is optional and there is no obligation for you to complete the questionnaire.

What happens after you complete the questionnaire?

The questionnaires will be studied by the researcher in relation to variables to identify patterns. This information will be included in a dissertation by the researcher.

Providing Consent

At the start of the questionnaire you will be asked to provide consent by ticking a box agreeing to take part. Ticking this box will mean that you are consenting for your data to be collected and used in relation to the aforementioned study.

Thank you for taking an interest in this research project.

Ciarán King