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ABSTRACT

The document presents a comprehensive review of the Health Professions Drug Abuse Education Project (HPDAEP), which provided training programs for over 1,800 interdisciplinary health professionals with little formalized education in chemical dependency. Chapters include: (1) Conclusions and Recommendations; (2) Background and Project Development, providing an overview of organizational setting, staff, advisory activities, evaluation, interdisciplinary nature, geographic coverage, and objectives; (3) Program Development, reviewing all educational programs offered by HPDAEP, with program content, educational methods, role of small group discussions, and technical assistance capabilities discussed; (4) Recruitment, outlining the development of a recruiting model; (5) Evaluation, outlining the basic evaluation model and summarizing outcomes; and (6) Special Programs, reporting on three adaptions of the general seminar content to special audiences. Eighteen appendixes are contained in part 2, and provide information regarding: the general seminar objectives and agenda; pre-workshop packet material; specialty workshop agendas, program materials and a bibliography; sample data and facilitator feedback reports; a biographical data sheet; outcomes; a table regarding job-related, personal, and community change; and various questionnaires, surveys, evaluation forms, and instruments. (LH)

Social, Prescription and Illicit Drugs: Topics in Interdisciplinary Health Education

A Final Report of the
Health Professionals Drug Abuse Education Project

July 1972 — September 1975

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NIDA Training Grant # 1T15-MH13254
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ABSTRACT

Social, Prescription and Illicit Drugs:*
Topics in Interdisciplinary Health Education
A Final Report of the Health Professionals Drug Abuse Education Project

Problem Statement

To what extent is it possible for an interdisciplinary health professional education project to:

1. *Encourage a more responsive attitude on the part of practicing health professionals toward alcohol/drug users and abusers.*
2. *Teach basic skills for the diagnosis and referral of chemical dependency programs.*
3. *Promote change in the health professional's family, practice setting and community with regard to alcohol/drug problems.*
4. *Promote interdisciplinary involvement and cooperation so as to potentiate institutional change in participants' health care institutions.*

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*Social Drugs — e.g., alcohol, nicotine, caffeine
Prescription Drugs — e.g., minor tranquilizers, sleeping medications
Illicit Drugs — e.g., marijuana, cocaine, heroin

Methodology

The project was funded by the National Institute on Drug Abuse in 1972. Training programs were developed and implemented in a five-state area (Minnesota, Iowa, Wisconsin, North Dakota and South Dakota).

Target audience was physicians, nurses, social workers, pharmacists, mental health professionals, health administrators, health educators, clergy and other helping professionals.

Extensive recruitment efforts were necessary to attract appropriate interdisciplinary audiences to the major training component — a two-and-a-half-day seminar. A full-time recruiter traveled to health care institutions throughout the five-state area and made personal contact with over 1,800 professionals through inservice programs.

More than 1,000 health professionals participated in the two-and-a-half-day general seminar. The final model of this program involved 20 contact hours of didactic, small group discussion, skill building and consultation sessions. Program content included topics such as attitudes of the health professional, the effect of those attitudes on health care to clients/patients with drug problems, interviewing techniques for diagnosing chemical dependency, attitudes towards intoxication and different types of drug use, the variety of treatment modalities available, and intervention alternatives. Interdisciplinary small group discussion was an integral part of the seminar to help participants share attitudes and personal and professional problems. Twenty-two seminars involved practicing health professionals. One seminar was implemented for health science students and faculty at the University of Minnesota. Another seminar was adapted for a community in northern Minnesota involving key civic and community members. Specialty workshops were made available to individuals who were unable to attend the general seminar. Over 700 people participated in workshops of 4 to 9 hours in length. Topics included variations of general seminar content, counseling techniques, detoxification and other areas.

An extensive evaluation effort was employed to determine the effectiveness of the general seminar. Pre- and post-conference cognitive, attitude and participant response instruments were used as well as a six month follow-up questionnaire.

Six months after each seminar, participants were mailed the follow-up questionnaire. A random sample from the total population was drawn for in-person and telephone interviews to validate mailed responses.

Results

The project was successful in attracting multi-disciplinary audiences to the seminars. Results indicate that the workshops had an equally significant impact on all professional groups. Knowledge and attitude changes

were significant and consistent over all conferences. Responses to the follow-up questionnaire suggest that changes were most apparent in the health professional's personal and family life. One-fourth of all participants reported a decrease in their own drug use. Nearly three-fourths of the participants were able to cite specific examples of how the seminar was helpful in family or social relationships. The seminar made significant impact on half of the participants who viewed themselves as capable of making professional practice changes. These changes included more routine assessment of clients for drug-related problems, increased and more appropriate referrals, and decrease in the use of prescription psychoactive drugs.

Analysis of the data showed that knowledge and attitudinal changes had the highest correlation with eventual behavioral change. Those who increased their knowledge most or whose attitudes changed to a more positive acceptance of those who use drugs tended to make the most changes in their personal/professional lives.

Based on the experience of implementing this project and analysis of its outcome data, the following recommendations were made:

- *—Future efforts should be concentrated in smaller geographical areas to maximize institutional and community change.*
- —Interdisciplinary emphasis *in programs on chemical dependency for health professionals is useful and should be undertaken by other projects.*
- *—Future programs should address personal issues to equip participants with skills to make changes in family and social circles.*
- *—State and federal resources should provide categorical funding to continue training health professional audiences in early intervention and prevention of chemical dependency problems.*

FOREWORD

The Health Professionals Drug Abuse Education Project was established on two major premises: (1) that health care professionals and institutions are necessary targets for chemical dependency education and training, and (2) that the response of the health care delivery system to prevention and treatment of drug[1] problems is critical to alleviating one of the main public health problems in America.[2]

The Health Professionals Drug Abuse Education Project (HPDAEP) was funded in 1972 by the National Institute on Drug Abuse. The task was to provide training programs for an audience (practicing health pro-

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[1]The term drug will be used throughout this report. This includes alcohol, caffeine, nicotine, psychoactive prescription drugs and illicit substances (marijuana, cocaine, heroin, etc.). Chemical dependency is defined as when the use of chemicals causes repetitive negative consequences in an individual's life (family, job, legal, social and interpersonal relationships, health, etc.).

[2]It is estimated that six to ten percent of American adults have significant problems with the use of alcohol or other drugs. Chemical dependency is at least the third largest health problem in America (it may be number one, considering the documented evidence of cigarette smoking and coffee drinking related to two major health problems – heart disease and cancer). Fifteen to twenty percent of all hospital inpatients may have chemical dependency problems, although it is rarely diagnosed except in late stage complications. Conservatively, it is estimated that six to eight percent of all hospital admissions are for iatrogenic (physician induced) diseases related to the use of prescription drugs. Minor tranquilizers are the most commonly prescribed group of drugs, and Valium is the largest selling brand name prescription drug.

fessionals) which had little formalized education in chemical dependency. It was felt that the attitudes and responses of health care institutions need to be changed so that more effective services will be provided to chemically dependent patients. This report describes and evaluates HPDAEP's techniques for achieving this change.

There are four major purposes of this report. The first is to provide a comprehensive review of the programming and recruitment activities of HPDAEP from January 1973 to Summer 1975. The second is to report the results attained by the project as determined by an extensive evaluation effort. This report also provides a resource of program material for other chemical dependency education programs. Finally, it will report on the difficulties and successes involved in providing drug education for interdisciplinary groups of practicing health professionals.

In order to ease the burden for the reader, the material is presented as two volumes: main report and appendices. Each chapter begins with an abstract so the reader can decide which sections to pursue in depth.

All materials developed by HPDAEP are in the public domain. A complete list of written and audio-visual resource materials can be found in Appendix 4.

Additional copies of the final report are available for $7.50 per copy. Make checks payable to University of Minnesota. Order from:

Health Sciences Continuing Education
7208 Powell Hall
University of Minnesota
Minneapolis, Minnesota 55455
(612) 373-8973

Staff resources, consultants and additional programs are available from:

Community Resources for Education, Alternative Treatments and Evaluation, Inc. (CREATE)
430 Oak Grove, Suite 404
Minneapolis, Minnesota 55403
(612) 874-9811

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1. Institutional change is far more apparent in settings where a number of professionals from a restricted area attended a HPDAEP seminar. Programs which drew from a large area realized the lowest outcome scores.

   It is highly recommended that future projects of this type concentrate their efforts in smaller geographic areas to maximize institutional and community change. Specific health care institutions should be targeted prior to program implementation. Adequate funds should be allocated at the beginning of the project for intense recruitment efforts, with decreasing efforts as word-of-mouth colleague recruitment begins. Technical assistance should be funded as a high priority once recruitment is well under way. HPDAEP evaluation suggests that programs will be more effective if the geographic area is limited to attract sufficient professionals from a given institution to an ongoing series of workshops (e.g., offering five successive workshops in a geographic target area; recruitment in a given institution would concentrate on getting 4 to 5 health professional participants from that institution to each workshop).

2. The project deliberately recruited into its programs a representative sample of all those health professionals who had a need to know about chemical dependency diagnosis, referral and treatment. Subject matter for the workshops was uniformly applicable across most, if not all, of these professional practice areas. Anecdotal responses from the follow-up interviews give support to the effectiveness of interdisciplinary education in stimulating the team approach to patient care.

Nearly 60% of participants reported that the workshop experience helped them get more involved with an interdisciplinary team approach to health care.

It is recommended, therefore, that when the desired outcome for continuing education programs is a team approach to health care, the program should be interdisciplinary to the extent that it involves those health professionals who will work as a team in their practice setting.

3. In evaluating participants who rated themselves as capable of making professional changes, it appears that HPDAEP programs influenced significant behavioral change in over half of the group.

It is recommended that future projects of this type use the follow-up instrument developed by HPDAEP as a pre-conference test to:

- —screen out participants who are already performing desired behaviors in their professional practices.
- —gather further data on those professionals who feel that particular outcome areas do not apply to them (for example: do some nurses feel pre-conference that interviewing patients for possible problems does not apply to their role and, as a result of the conference, feel that it is an appropriate role).

4. HPDAEP programs appear to have had more impact on change in a participant's personal life (family, friends, own drug use), than on institutional change (diagnosis, referral, inservice, use of prescription drugs, etc.), and least of all in causing change in the community. Statistical and anecdotal information in some areas suggest changes surpassing expectations of program planners.

It is therefore recommended that chemical dependency training programs for health professionals be sensitive to and address personal issues to equip participants with skills to make changes in family and social circles. Program planners should recognize that personal change must be accomplished before other changes can be expected.

It is also recommended that when community change is a desired outcome, all the potential participants who must take some form of action to produce change should receive coordinated training.

5. As a result of the workshop more than 40% of all participants increased their routine screening efforts with clients and families. There was long-term increase in the confidence of participants to obtain relevant information. Of the participants who were in a position to make referrals, nearly 50% noted an increase in the number of clients referred as well as an increase in utilization of different referral agencies. Of the people who felt that questions were applicable,

nearly half reported a decrease in the utilization of psychoactive prescription drugs, and three-fourths are now recommending alternative therapies to prescription drug use.

It is therefore recommended that pre-service and inservice training programs for gatekeeper audiences (physicians, nurses, social workers, teachers, pharmacists, law enforcement officers, counselors, clergy and other helping professionals) teach early intervention and prevention skills (interviewing techniques for routine assessment of all clients, use of multi-modality referrals, community education, attitude and value awareness, alternatives to psychoactive prescription drug use, etc.).

6. Nearly 75% of participants were able to cite specific examples as to how the workshop was helpful in handling family or friend situations. More than 25% of participants decreased their use of social, prescription or illicit drugs as a result of the workshop.

It is therefore recommended that federal or state agencies provide funds for offering the seminars as a primary prevention model. Modifications in emphasis could easily be made if the programs were to be offered to community members and their families.

7. Low attendance by physicians at HPDAEP programs does not appear to have hampered changes within health care settings. Nurses, pharmacists, social workers and other professionals accomplished significant changes even in the area of psychoactive prescription drug utilization.

It is recommended that future projects of this type should not spend energies attempting to recruit professionals who are unreceptive to change or unwilling to attend programs in the area of drug misuse. HPDAEP evaluation suggests that it is possible to realize change within health care settings by training health professionals who are open to the changes.

It is also recommended that studies be undertaken to determine the potential different health professionals may have for responding to drug problems in the patient population. Assessment and referral patterns should be analyzed and conveyed to the public so that appropriate professionals might be utilized in the intervention of chemical dependency problems.

8. The attitudinal emphasis of the HPDAEP seminar helped health professionals appreciate the effect their attitudes have on patient care. Knowledge and attitudinal changes were the highest correlates with behavioral outcomes. Appreciation of the concept of chemical dependency, comfortableness in small group discussion and self ratings of attitude changes were also high correlate factors.

It is therefore recommended that training programs for health

and helping disciplines (gatekeepers) emphasize changing attitudes towards social, prescription and illicit drug use. Small group discussion appears to be a necessary method for achieving change in these attitudes as well as for dealing with personal issues. Knowledge of behavior problems resulting from drug use, diagnostic interviewing skills, referral information and appreciation of multi-modality treatment also appear to be necessary areas for pre-service and inservice training.

9. The project uncovered significant gaps in cognition/attitudes and skills in health professionals as they relate to appropriate diagnosis, referral and treatment of patients with incipient or frank chemical dependency. The health professional stands in the middle, between early education to prevent chemical dependency and the treatment of chemical dependency. If they were properly trained, health professionals could play a critical role in preventing expenditures of large sums of money for treatment, through the early diagnosis and referral of patients having problems with the use of social, illicit or prescription drugs. This is not an accepted or popular form of continuing education, however, since it involves training in diagnosis and referral to non-traditional agencies rather than diagnosis and treatment through traditional means. In spite of the potential for human and financial savings, there has been little acceptance by those involved in continuing education for health professionals or by health professional societies of the need for training in these areas.

It is recommended, therefore, that federal and state agencies provide categorical funding for the development and presentation of continuing education programs for health professionals. Techniques for the early intervention and prevention of chemical dependency problems should be priority program areas.

Chapter 2

Background and Project Development

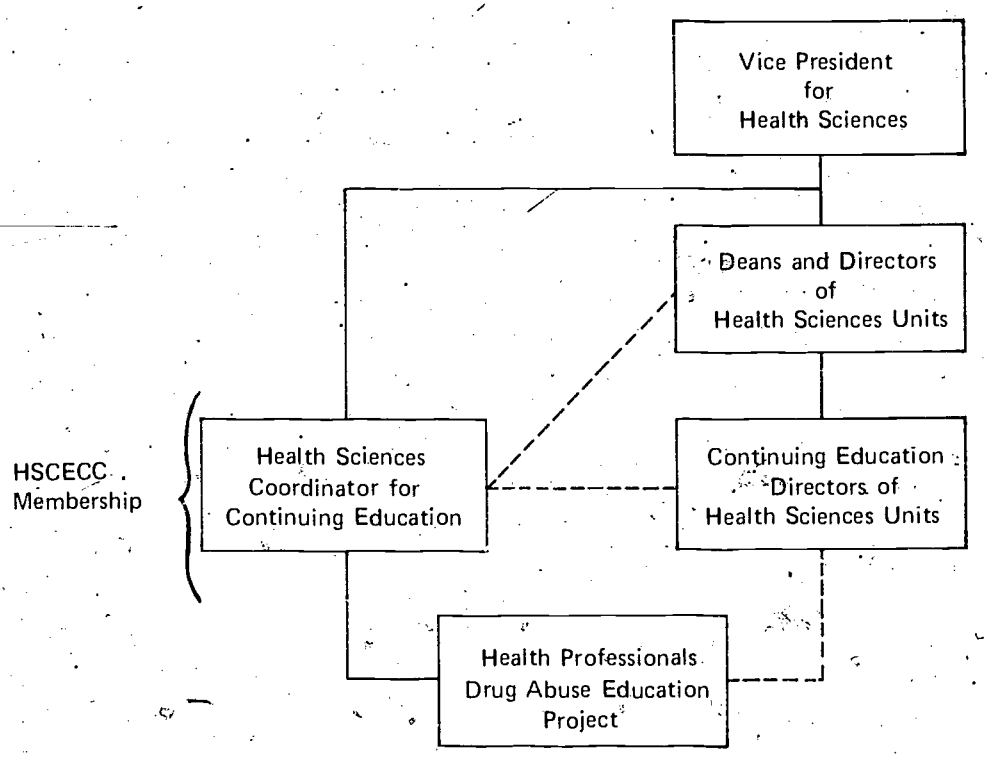
This chapter provides an overview of the project. It describes the rationale for the grant application, the organizational setting into which the grant was placed, and the project's development in terms of its staff, advisory activities, evaluation, interdisciplinary nature, and geographic coverage. Finally, the original objectives, as written in the grant application, are presented.

BACKGROUND

The Health Professionals Drug Abuse Education Project (HPDAEP) was conceived at a time when society's reaction to the abuse of drugs was at its peak and when the Health Sciences Center at the University of Minnesota, created by the Board of Regents in 1970, was little more than a neonate. Drug misuse and the public's reaction to drug misuse led several faculty members and one collegiate unit[1] to respond to the need for accurate information on drugs and their action through community-oriented programs. In addition, the School of Public Health and the College of Education had developed course offerings for the University student body. Naming of a coordinator for health sciences continuing education in January 1972 brought together the continuing education activities of Dentistry, Medicine, Nursing, Pharmacy, Public Health, University Hospitals, Veterinary Medicine and Allied Health. The coordinator reported to the Vice President for Health Sciences and, as one of his first actions, directed

[1] The College of Pharmacy, through its student body and a faculty advisor (the director of the HPDAEP grant), had initiated a drug information course and a public speakers program in the fall of 1969. This program, in its evolutionary form, continues today.

the writing of the grant proposal for HPDAEP. This proposal was submitted to the National Institute of Mental Health on February 14, 1972. By July 1972, when the grant had been approved and funded, the Health Sciences Continuing Education Coordinating Council (HSCECC) had been formed; it was made up of the directors of continuing education from each unit of the health sciences. Because HPDAEP's programs were intended to be interdisciplinary, responsibility for the project was placed in the coordinator's office. It was expected that HSCECC members would counsel the HPDAEP staff on recruitment and on the relevancy of content and format for their disciplines. In function, however, only intermittent involvement, usually at the request of the project staff, was obtained from council members. Figure 1 depicts reporting and functional relationships for the health sciences and indicates the position of HPDAEP within the organizaiton.



Solid lines (_____) represent reporting relationships.

Dotted lines (_ _ _ _) represent functional relationships.

Figure 1. Organizational Chart for the Health Sciences, University of Minnesota

Initially, the major goals of HSCECC were to bring the health sciences concepts of interdisciplinary education and team health care to the professional-in-practice. Although these concepts were espoused by the academic units of the health sciences, little positive action had been taken by that date to implement them for professionals-in-training. The grant application was the first attempt by health sciences continuing education to bring professionals from medicine, nursing, pharmacy, public health, social work and related disciplines into an interdisciplinary program.

DRUG ABUSE AND THE HEALTH PROFESSIONAL

Health professionals traditionally receive unitary education experiences which develop isolationary practice and reinforce individual decision making. The field of drug abuse provides an example of why it is difficult for health professionals to deal with a problem which crosses disciplinary lines. The drug abuse field also presents significant opportunities to stimulate change — both in the format of education and in the interaction of professions. Observations on the use of and opinions toward psychoactive drugs, the diagnosis, referral and treatment patterns of health professionals, and the minimal interaction among health professionals lead to the conclusion that the patient is not always receiving optimal health care under this type of system. When this system is combined with the attitudes which many health care providers hold toward illicit drug use, individuals who use illicit drugs — and particularly those who exhibit life styles which are unacceptable to health providers — do not seem to receive even the same quality of health care which the rest of the population receives. This situation, in turn, has led many individuals to seek emergency care and counseling from nontraditional sources or to turn to self care. A number of crisis intervention centers and telephone and walk-in counseling centers have developed to meet the needs of a population which do not, or can not, enter the traditional health care system.

At the time the grant was written, it was the opinion of the writers that several objectives could be achieved by bringing the health care and helping disciplines[2] together for educational programs on a subject which called for a "team approach." The traditional "team" in which physicians directed every phase of patient care was being called into question. Treatment of the patient with drug-related problems provided an opportunity to explore the team approach where each professional would use his or her skills in patient care and counseling on a relatively independent and yet interrelated basis. The "team" might consist of a physician, social worker, chemical dependency counselor on one occasion and a pharmacist, nurse, clergy (or any combination of health professionals) on another.

[2] Hereinafter referred to as "health professionals"

First, it was expected that the interest levels of health professionals would be raised so that they would be interested in obtaining the skills necessary to deal with patients who were present or potential misusers of drugs. Second, it was expected that they would recognize the difference between attitude and fact, and develop and demonstrate nonjudgmental attitudes towards those who misused drugs, thus improving the quality of care for these individuals. Third, it was believed that the health professional, armed with new skills and attitudes, would return to his or her community and use these talents to stimulate the development of prevention and treatment programs. Fourth, it was hoped that health professionals would appreciate that their own professional activities could sometimes contribute to drug misuse.

PROJECT DEVELOPMENT

At the time the grant was written, drug education was just what the title implied — education about drugs. The project was conceived as a nontraditional approach to the subject of drug abuse. Health professionals would receive training as noted above instead of receiving lectures on the pharmacology of drugs. This decision led, in turn, to two important subsequent decisions: (1) project staff would not be restricted to traditional sources, and (2) evaluation would be a major component of the project.

STAFFING

Project staff were recruited from a variety of sources. The original concept was that they should complement each other through knowledge of the educational process, the field of drug abuse and the nature and function of the health professional. Thus the first staff members were drawn from a University drug information program, a Veterans Administration program which reviewed veterans drug treatment units, and from a street crisis intervention program. Creative interaction with minimal supervision from the project director and a consensus method of decision making was the intended operational style for the first several months of project operation. The management philosophy was that maximum freedom to experiment, in a field where there were few benchmarks for action, would provide creative people with the greatest potential for success. Inherent in this philosophy was the possibility that organizational development might not follow traditional patterns and that individual role comfort might be minimal. As is the case in most short-term projects, the pressure to produce results on a "today rather than tomorrow" basis was a significant factor in staff interaction. Philosophical differences on the part of the staff relative to program development were aggravated by varying perceptions of management style. As a result, a significant portion of the project director's time during the first twelve months had to be devoted to working with interpersonal problems and providing program direction.

Program development was somewhat erratic during this phase and was further inhibited by difficulties in establishing appropriate recruitment procedures. The commitment to an interdisciplinary audience made it necessary to entice physicians, pharmacists, nurses and a number of other types of health professionals into the project's seminars. The early method used to provide this interdisciplinary audience usually involved transferring this responsibility to local cooperating agencies. This proved to be an ineffective procedure. Health professionals attended the programs, but the mix of attendees was not consistent with the intentions of the project. Project evaluation, therefore, could move no further than the process level until these problems were solved.

Within the first six months, staff turnover began. A complete replacement of original staff was accomplished within the first eighteen months. As this changeover was in process, the management philosophy did not change but the operational style was altered. Instead of co-leadership, a program director was name with responsibility for program development and staff supervision. The recruitment function was assigned to an assistant director, and an additional staff position for evaluation was designated. Under the leadership of the program director, the philosophical base was reaffirmed and program development accelerated. With specific responsibility for recruitment assigned to one position, more planned and logical recruitment activities also developed. Given a solid base of development, evaluation was then put into its proper context and longer range planning could proceed. Due to the creative nature of the project, the need for immediate productivity, and the few years of organization experience which characterized the staff, there were still occasions of intense staff interaction. That these interactions became progressively more constructive is an indication of their commitment to the project and to their basic abilities.

ADVISORY ACTIVITIES

From the initiation of the project an advisory body provided counsel and guidance. Through the first year, this body was actively involved, with membership selected from HSCECC, community agencies, the University and health professional organizations. During the second year, as the project redefined its goals and shifted personnel, the full advisory body was inactive. Instead, three individual members, Messrs. Heinecke, Kurzman and Schoener, provided input to the decision making process. As the project moved into its third year, the advisory body was reactivated with expanded membership.

EVALUATION

As originally conceived, the project was intended to work with the attitudes and behavior of health professionals. Little could be found in the

literature to provide guidance for program development, and even less could be found relative to attitudes of health professionals on illicit drug use. Thus, a significant percentage of the grant monies were designated for intense evaluation of the process which would be used and the outcomes which might be achieved. It was decided that evaluation would be carried out on a contract basis, with the evaluator residing outside of the project in order to maintain maximum objectivity. Internal assistance would be provided through a full-time staff position assigned to the evaluation function.

During the first phase of project activity, the role of the external evaluator was as gatekeeper for formulation of objectives. As process became more important, the evaluator frequently attended programs in order to assure the completion of evaluation instruments and to obtain first-hand interviews. As program development proceeded, checking the reliability and validity of the instruments became more pertinent, as did training of the internal evaluation assistant. Finally, coordination of follow-up data collection was the responsibility of the evaluator. Thus evaluation moved with project development as an integral part of planning and function. The evaluator did not make project decisions but provided data to aid in decision making by project staff.

FIVE-STATE INTERDISCIPLINARY OPERATION

Logistics of project operation were complicated by its five-state operation. It was decided that cooperation should be sought from each of the single state agency directors or their counterparts in governmental bodies in all five states. Interaction with health professional organizations was also multiplied by a factor of five. These relationships were developed wherever possible. As the project's accomplishments became known, these interactions became easier. Near the time of project termination, project staff were being sought for assistance by individuals and health professionals and community organizations which were previously cool or unapproachable. Requests for assistance in developing programs and for individual consultation and speaking engagements became routine during the last months.

One of the most difficult tasks of the project was to entice an interdisciplinary audience into participation in the project's programs. There are few successful examples of interdisciplinary health professional audience participation in the health sciences. From a discouraging beginning the project moved through a variety of recruiting techniques to final development and use of a more successful recruitment model. Adaptions

of these techniques will be useful for the health sciences, not only at the University of Minnesota but throughout the country.

ORIGINAL PROJECT OBJECTIVES

The objectives as stated in the grant application are as follows:

1. Provide short-term training for health professionals so that they will utilize appropriate procedures in the emergency treatment of drug reactions.

2. Present experiences and training for health professionals so that they will demonstrate a nonjudgmental attitude toward narcotic addicts and other drug users.

3. Stimulate health professionals' interest and participation in a training program on narcotic addiction and drug abuse through sensitization experiences.

4. Teach communication and group process skills to health professionals so that they may catalyze and facilitate community action leading to the design and production of narcotic addiction and drug abuse treatment and prevention programs.

5. Present information and training experiences to health professionals so that they may understand the full range of drug misuse, their role in its cause, and various treatment methods.

6. Provide involvement in currently operating narcotic addiction, drug abuse, and youth assistance programs so that health professionals may adapt the skills and techniques obtained from these experiences to the needs in their home communities.

7. Provide evaluation of project actions and results. Communicate the findings on this model in a manner so that other agencies may utilize the findings in their own programs.

The following chapters detail how these objectives evolved and were implemented during the three-year project period.

Chapter 3
Program Development

This chapter is a review of all educational programs offered by HPDAEP. Program content, educational methods, the role of small group discussions and technical assistance capabilities are explored in detail.

PROJECT GOALS

Changes within HPDAEP educational programs were a direct result of changes in the direction of the project. At a staff retreat early in 1973, four project goals were articulated:

1. Provide training experiences for health and helping professionals in a five-state area.
2. Encourage a more responsive attitude toward drug users.
3. Teach basic skills in drug-related treatment.
4. Promote community involvement.

Based upon staff experience and debriefing during meetings held in late 1973, the goals were changed to:

1. Encourage a more responsive attitude on the part of health professionals toward drug users and abusers.
2. Teach basic skills for the diagnosis and referral of chemical dependency problems.
3. Promote change in the health professional's family, practice setting and respective community.
4. Promote interdisciplinary involvement and cooperation.

Changes in Project Goals

Although the wording remained the same, there was a significant shift in program emphasis regarding "responsive attitude toward drug users/abusers." The original translation of this goal led to a heavy program emphasis on youth, nontraditional life styles and the use of street drugs. Changes in staff and their philosophies resulted in a change of program emphasis to dealing with all drugs that are used/misused in our society. HPDAEP programs began to discuss use/abuse of alcohol, caffeine, nicotine and psychoactive prescription drugs as well as illegal substances. The title and emphasis of the three-day general seminar became "The Use and Abuse of Social, Prescription and Illicit Drugs." Issues discussed in the seminar revolved around the assumption that more than 90 percent of American adults use at least one psychoactive drug and that most attitudes toward different drug use are based on personal experience, values, cultural beliefs and rituals and *not* on scientific fact (which most people would like to believe).

Another major change in program emphasis was in the area of basic skills. Original HPDAEP staff promoted the teaching of drug crisis intervention — first aid. Because of the program's original emphasis on street drugs, early participants were reinforced in their beliefs that the drug problem was primarily youth having bad trips, overdoses or other reactions to illegal drugs. Accompanying the change in emphasis to all drug use came the change in skill development to diagnosis, intervention and referral of chemical dependency problems.

Another early project goal was revised in the spring of 1974 based upon staff experiences in recruitment, training programs and early evaluation data. The original grant proposal emphasized influencing the health professional to use information gained at workshops to achieve change in the community. Early workshops attempted to train participants in community organization and development. However, workshop experience suggested that health professionals at best perceive their role as change agents within their institutional setting apart from the rest of the community. In order to maximize program impact, training to facilitate change in the health professional's family and practice setting replaced the emphasis on community organization.

Finally, and perhaps most importantly in terms of project direction, the goal of promoting interdisciplinary involvement and cooperation was articulated. HPDAEP's educational programs became the first effective interdisciplinary continuing education sponsored by Health Sciences of the University of Minnesota. Recruiting an interdisciplinary audience for HPDAEP programs became a full-time job (see Chapter 4). The commitment to offer only interdisciplinary programs was based on the following assumptions:

1. Interdisciplinary involvement and cooperation cannot be promoted by offering programs specific to each discipline. In other words, one cannot adequately promote interdisciplinary coperation in a workshop just for physicians, even if one of the lectures is on interdisciplinary cooperation.
2. Problems of chemical dependency in health care settings can be dealt with more effectively only by utilizing team concepts and communication.
3. Communication among health team members can be enhanced best by having representatives of these disciplines all in the same workshop.

Anticipated Behavioral Outcomes

Programs offered in 1973 were expected to be experimental in nature, providing the staff with a variety of participant contact and program experiences. At the end of that year, the staff held a two-day retreat and, based on their experiences, articulated formal commitments to the desired outcomes of the project. The following information was compiled at that time.

Assumption on Which HPDAEP Is Based. A composite of health professionals' attitudes, skills and knowledge about drugs, drug users and drug abusers affects the delivery of health care to individuals who use/abuse drugs. ("Health care" in this context includes prevention, appropriate utilization of prescription psychoactive drugs, diagnosis, referral and treatment of alcohol/drug problems.)

Implications for Programs. It is important to provide a structure in which attitudes can be freely identified and discussed and in which attitudes inconsistent with good treatment and/or prevention can be discarded or changed. Through increased knowledge and skill training, health professionals can provide better health care to drug users/abusers.

Criteria for program content:

—Should have wide applicability to target audience (interdisciplinary group of health professionals).

—Must have a relationship to the behavior desirable for health professionals out in the community.

—Should serve as a catalyst prompting participants to seek more information.

Implications for Participants' Anticipated Behavioral Outcomes. Participants should report on six-month follow-up questionnaire:

—Use of appropriate drug history-taking techniques.

—Increased number of and more appropriate referrals for drug problems.

—Routine assessment of drug problems in clients.

—Increased involvement with community drug agencies.

—Communicating and disseminating seminar material to other health professionals.

—Seeking further information and training about drug use/abuse.

—Changing agency procedures and policies with regard to chemical dependency problems.

—Use of seminar material in helpful ways with family members and friends.

—Helping to make changes in their community's response to drug use and drug problems.

—Increased comfort and effectiveness in handling drug-related problems.

—More appropriate prescribing, recommending and utilization of psychoactive prescription drugs.

—More awareness and utilization of the interdisciplinary approach to health care.

—Increased awareness of how their own drug taking behavior affects themselves and others.

—Increased understanding of their attitudes toward drugs, drug users and drug abusers.

As the project developed, changes were made in each of the program functions. The four original functions were short-term Sensitization Workshops, two-and-a-half-day General Seminars, Specialty Workshops, and Traineeships (clinical experience) and other technical assistance.

SENSITIZATION WORKSHOPS

In the original grant proposal, two goals were stated for short-term sensitization workshops:

1. To alert practicing health professionals to the drug problem in their community.
2. To stimulate health professionals to pursue a more intense training experience.

Feedback from the first few sensitization workshops was mostly unfavorable, and the workshops were not successful in recruiting participants for HPDAEP's general seminar.

Table 1. Summary of Sensitization Workshops (SW)

Format	Number Implemented	Number of Participants
SW-1 3-hour	7	168
SW-2 3-hour	6	329
SW-3 3-hour	7	650
SW-4 Inservice programs (2-4 hours each)	47	690
	Total: 67	Total: 1,837

Areas Covered	Approximate % of Time Spent			
	SW-1 % Time	SW-2 % Time	SW-3 % Time	SW-4 % Time
Pharmacology	17%	0%	0%	0%
Health professional as change agent	17%	17%	17%	30%
Identifying community problems and resources	17%	50%	40%	0%
Attitudes toward the drug problem	34%	17%	17%	15%
Further training offered by HPDAEP	2%	4%	9%	35%
Introduction, summaries, testing, breaks, informal questions and answers	6%	3%	20%	20%
Diagnostic skills	0%	9%	0%	0%

Educational Method	SW-1	SW-2	SW-3	SW-4
Didactic presentations	x	x	x	x
Small groups		x	x	
Informal questions and answers	x	x	x	x
Panel presentations		x	x	
Media	x	x	x	

In June 1973, objectives were revised and the format was changed. The pharmacology content was dropped and additional emphasis was put on attitude awareness and health professionals as agents of change. Staff changes in November 1973 added expertise in defining goals and objectives; emphasis remained somewhat constant.

Staff experiences in presenting this version of the sensitization workshop were mostly frustrating. The content was important but too difficult to cover adequately in a three-hour program. Although evaluation of subsequent three-hour workshops appeared favorable, the desired outcomes were not realized. The goal of these programs was to stimulate health professionals to attend the more intensive general seminar, and appropriate interdisciplinary audiences were not being influenced to pursue further HPDAEP programs. Changes had to be made and the recruitment function of HPDAEP had to become better defined. The title "Sensitization Workshop" was replaced by "Inservice Program." Chapter 4, "Recruitment," contains further information on this program area.

These programs ranged in length from two-to-four hours. Prior to each regional general seminar, HPDAEP used these inservice programs to stimulate interest in attending the general seminar.

Major Objectives

1. To assist participants in understanding why health professionals need to be better informed about chemical dependency.
2. To help participants develop an interest in attending an upcoming general seminar.
3. To help participants understand the importance of interdisciplinary representation from their institution at the general seminar.

Agenda

Agenda consisted of attitudinal discussions, presentation of information on the upcoming HPDAEP general seminar, and informal questions and answers to facilitate getting the best possible change agents and interdisciplinary representation from the institution.

GENERAL SEMINAR

This section will explore the development of HPDAEP's major programmatic function — the general seminar. As was the case with the sensitization workshop, significant changes in program objectives and emphasis were made in developing the final general seminar model. Tables 2-4 in this chapter summarize the nature of the programs.

General Seminar Format #1 (March 1973)

Thirty-five participants and ninetten staff were involved in the first general seminar held March 29-31, 1973, at a YMCA camp in Sturgeon Lake, Minnesota (90 miles north of Minneapolis). Participants were mostly from Duluth and surrounding communities. The seminar emphasized

pharmacology information, illicit drug use, alternative life styles, treatment modalities, drug crisis overdose first-aid, intervention techniques and community problem solving. The conference addressed pertinent community issues in an attempt to provide a framework for needs assessment and planning of community changes. Little time was spent addressing personal issues through small group discussion.

The staff anticipated making major changes in the first few workshops offered, and this was the only workshop completed using this model.

Table 2. Educational Methods Used in the HPDAEP General Seminar

Educational Method in Hours	Program Format					
	#1	#2	#3	#4	#5	#6
Large group didactic or media presentations	9.75	11.0	11.50	9.25	8.25	7.75
Small group discussion	2.0	1.0	4.25	6.0	6.75	5.75
Role play practice sessions	1.5	1.75	2.0	1.25	2.0	3.0
Small group special interest workshops	3.0	0	0	1.5	1.5	1.25
Demonstrations	1.25	1.25	0	.50	.75	1.0
Simulation games		2.5	2.0	.25	.25	.25
Total Contact Time	17.25	17.5	19.75	18.75	19.50	19.00

General Seminar Format #2 (May 1973)

After reviewing evaluation data from the first conference, the staff implemented changes for the second general seminar held May 17-19, 1973, at the Episcopal Camp Center in Boone, Iowa. Thirty-five participants and twenty staff were involved in this two-and-a-half day conference. Changes in format included the following major additions:

.5 hour multimedia presentation to total group

1.25 hour session on values clarification

2.0 hour simulation session on community development

Major subtractions included:

1.5 hours less in small group discussion (now only 1.0 total for conference)

1.0 hour panel on community resources

3.0 hours of Friday evening specialty workshops

This was the only workshop to use this particular model. A five-day seminar developed during summer 1973 for an audience in Wisconsin had program objectives similar to the May 1973 Iowa conference, but content was explored in a more in-depth manner. An entire day was devoted to the NIMH "Community at the Crossroads" simulation game.

Table 3. Percentage of General Seminar Time Spent in Each Content Area

Content Area	Program Format					
	#1	#2	#3	#4	#5	#6
Defining goals and expectations	–	–	–	9	9	6
Attitude awareness and effect on behavior	3	16	11	24	30	26
Drug first aid - emergency treatment	15	13	10	0	0	0
Treatment modalities	7	8	10	8	7	7
Participant as change agent	4	3	14	3	7	7
Group process and communication skills	9	8	8	8	0	0
Diagnostic interviewing	0	0	5	15	18	16
Intervention and referral	16	17	4	5	5	14
Understanding intoxication	6	6	5	5	5	5
Role of the law	–	–	7	7	6	7
Specialty workshops	17[1]	0	0	8[2]	7[2]	7[2]
Defining terms used in field	–	–	5	4	4	4
Development of community resources	10	14	14	0	0	0
Pharmacology	8	9	0	0	0	0
Health care delivery system	–	–	2	–	–	–
Introduction, summaries	5	6	5	4	2	3
Total	100%	100%	100%	100%	100%	100%

[1] Small group special interest workshops on Values Clarification, Psychoactive Prescription Drugs, Treatment of Acute Drug Overdose, Social Seminar Films, Rap with High School Students.

[2] Small group special interest workshops on Theories of Chemical Dependency, Psychoactive Prescription Drugs, Further Education and Training, Treatment of Acute Drug Overdose, Consultation on Innovative Treatment Efforts, Legal Concerns, and Development of Community Prevention Programs.

General Seminar Format #3 (September 1973)

Based on their experiences in implementing three different general seminars, the staff agreed to finalize objectives and format for a period of at least three months. Subsequently, program evaluation data were reviewed quarterly and appropriate revisions were made in the general seminar.

Major changes implemented at this time were:

1. Small group discussion time was increased (total became 4.25 hours). Staff facilitators became an integral part of the general seminar. Training and debriefing of all facilitators was begun on a formal basis.
2. More emphasis began to be placed on attitudes towards various drugs. The general seminar began to cover use of social and prescription drugs, expanding from the prior emphasis on street drugs.
3. Staff began to develop reading and agenda books for participants. The agenda book contained materials on the project, lecture content and other resources. The original readings book contained seven reprinted articles. By 1975, these books became integral to the program, with the agenda book simulating a training manual for the seminar and the readings book containing 54 articles.

General Seminar Format #4 (January 1974)

A change in staff added expertise in defining learning objectives. Five General Learning Objectives and thirty Specific Learning Objectives were established. Major changes included:

1. Finalizing program's commitment to deal with all drug use in the United States and not just illegal drug use. This included a beginning emphasis on having the participants share and discuss their own drug use (or lack of).
2. Almost total removal of the drug first aid component of the program.
3. Increased emphasis on small group discussion time. Programs in Format #4 included 6.0 hours of small group discussion led by a trained, experienced staff facilitator.
4. Increased emphasis on interviewing techniques for diagnosing chemical dependency. Skill-building sessions were implemented for participants to learn how to conduct a diagnostic interview.

Total staff needs decreased; ten to twelve staff per seminar were required, depending on the number of small group facilitators needed

(small groups ranged from six to eight participants per facilitator).

General Seminar Format #5 (Summer 1974)

Quarterly review sessions continued, and minor adjustments were made in lecture content. The most important change at this time was the emphasis on small group discussions. Program staff and consultants recommended changes in the attitudinal objectives under General Learning Objective #1: "To help participants become aware of how their own attitudes towards drugs, drug users and drug abusers affect the health care they provide to clients with drug-related problems." Instead of having participants identify group process factors that were conducive to discussing attitudes, they were now asked to concentrate on learning and evaluating new attitudes (rather than the process by which attitudes are learned and developed).

Other changes were:

1. The social, prescription and illicit drug categories were added to the learning objectives and format. The title of the three-day program was changed from "General Seminar" to "Critical Issues for the Health Professional: The Abuse of Social, Prescription and Illicit Drugs."
2. Commitment to participant change in behavior increased. Learning objectives and expected behavioral outcomes were distributed to participants during the seminar. Also two new objectives for small group discussion sessions were added:
   A. Participants will be able to list one way in which they feel their day-to-day behavior may change as a result of the workshop.
   B. Participants will be able to describe one way they will attempt to use information gained at the conference to achieve change in their own community and/or work setting.

Six seminars (excluding a conference for students and faculty discussed in Chapter 6, "Special Programs") were offered under this format.

General Seminar Format #6 (January 1975)

Reallocation of some program time allowed more specific attention to intervention alternatives, which the participant can use once an assessment of chemical dependency problems is made. Four additional learning objectives appeared under General Objective #3. Lecture, demonstrations and practice on implementing intervention techniques were added to the program as a unit. Appendix 1 contains the final version of objectives and agenda used by HPDAEP.

Seven workshops (excluding the Brainerd Community Workshop discussed in Chapter 6) were offered under this final format.

Table 4. General Seminars: Dates, Location, Target Area, Number of Participants and Staff

Format	Dates and Location of Seminar	Geographic Target Area	Number of Participants	Approximate Number Part-time and Full-time staff
#1	March 29-31, 1973 YMCA Camp Sturgeon Lake, MN	Duluth, Northwestern Minnesota	35	20
#2	May 17-19, 1973 Episcopal Camp Center Boone, Iowa	Iowa	35	20
	July 29-August 3, 1973 Mt. Senario College Ladysmith, WI	Wisconsin	80	30
#3	September 20-22, 1973 Castaway Club Detroit Lakes, MN	Fargo-Moorhead and surrounding area	32	15
	October 25-27, 1973 YMCA Camp Stillwater, MN	St. Paul-Ramsey Hospital staff	25	14
	November 29-December 1; 1973 Lutheran Retreat Center Onamia, MN	Central Minnesota	45	14
#4	January 17-19, 1974 Camp Ewalu Strawberry Point, Iowa	Eastern Iowa	31	11
	February 28-March 2, 1974 Dunrovin Retreat Center Stillwater, MN	Twin Cities Metropolitan area	19	11
	March 21-23, 1974 Koinonia Retreat Center Buffalo, MN	Anoka and Twin Cities area	20	10
#5	June 20-22, 1974 Morningside College Sioux City, Iowa	Western Iowa	33	11
	June 27-29, 1974 Mt. Senario College Ladysmith, WI	Western Wisconsin	38	12
	September 19-21, 1974 Castaway Club Detroit Lakes, MN	Northwestern Minnesota	58	14

Format	Dates and Location of Seminar	Geographic Target Area	Number of Participants	Approximate Number Part-time and Full-time staff
#5 cont.	October 24-26, 1974 4 Bears Lodge New Town, ND	North Dakota	44	12
	November 14-16, 1974 Episcopal Camp Boone, Iowa	Central Iowa	45	12
	November 21-23, 1974 Camp Courage Annandale, MN	Twin Cities area	46	12
#6	January 16-18, 1975 Dunrovin Retreat Center Stillwater, MN	Twin Cities area	32	11
	February 6-8, 1975 Dunrovin Retreat Center Stillwater, MN	Twin Cities area	36	12
	February 27-March 1, 1975 Camp Courage Annandale, MN	Twin Cities area	41	12
	March 20-22, 1975 Assisi Retreat Center Rochester, MN	Southeastern Minnesota	47	12
	April 24-26, 1975 Mankato State College Mankato MN	Southwestern Minnesota	33	10
	May 15-17, 1975 Black Forest USA Rapid City, SD	Western South Dakota	46	12
	June 5-7, 1975 University of Iowa Iowa City, Iowa	Central and Eastern Iowa	36	11
		Total	867	

Summary: General Seminar Development

Six formats of learning objectives and agendas for the general seminar were employed by HPDAEP. Changes, which are developmental in process, included:

1. Changes in learning objectives, which reflected changes in program content as well as increasing staff ability to articulate objectives.

2. Change from initial emphasis on street drugs to emphasis on all psychoactive drug use (including alcohol, caffeine, nicotine, and psychoactive prescription drugs as well as illicit substances).
3. Change in content and skill orientation of drug crisis first aid techniques to interviewing techniques for diagnosing chemical dependency and intervention alternatives.
4. Increasing emphasis on the role of small group discussions. Trained, experienced staff facilitators became an integral part of program objectives.
5. Increasing ability of program staff to concentrate on helping participants move toward expected six-month behavioral outcomes.

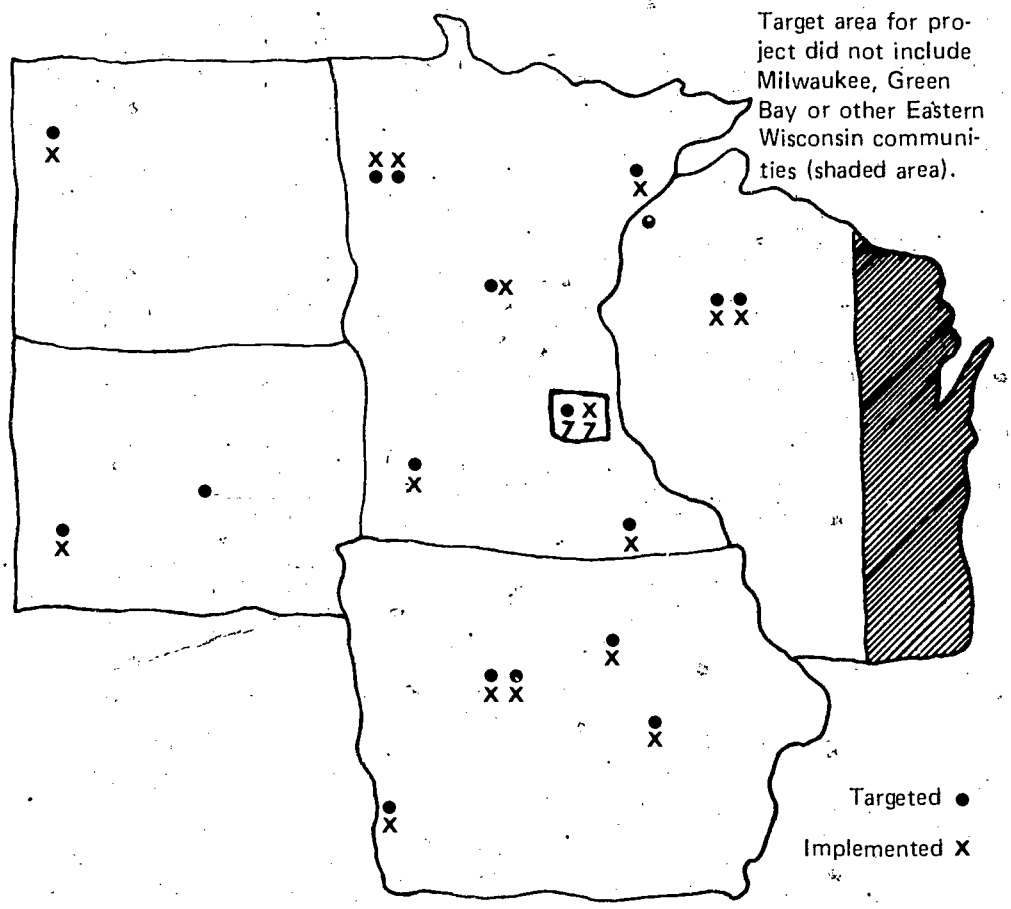


Figure 2. Geographical Target Areas for General Seminar and Implementation

Twenty-two seminars were conducted throughout the five-state area (Minnesota, Wisconsin, Iowa, North and South Dakota). A total of 867 people participated in the seminars with an average of 39 per seminar.

Criteria for Selection of Participants

Deadlines for registration for a general seminar were usually two weeks prior to the actual program. From the registration forms, the staff selected an appropriate audience by:

1. Assuring maximum interdisciplinary representation from the target audience.
2. Assuring representation from as many institutions in the target area as possible.
3. Giving priority to institutions sending representatives from four or more different health care disciplines.

Workshop Materials

Participants selected for the general seminar received a letter of acceptance one to two weeks prior to the seminar. Included with the letter were:

—One-page description of the general seminar.

—*Mystification and Drug Misuse,* a book by Henry L. Lennard and associates.

—"Drugs of Abuse," a pamphlet by Samuel Irwin.

Appendix 2 contains the general seminar description.

During registration at the workshop, each participant filled out a pre-workshop evaluation instrument and was given two books compiled by project staff over a two-year period. The books were:

An Agenda Book, a forty-page manual whose final version included:

—Information on the seminar.

—General and specific learning objectives for the seminar.

—Anticipated behavioral outcomes.

—Notes on each lecture presentation.

—Names and addresses of all participants and staff.

—Reprints of articles specifically related to lecture content.

—Bibliography of suggested readings (over 100 listings).

A Readings Book, which grew from an assortment of seven articles to 54 articles (350 pages, five chapters).

During each workshop a table of printed materials was set up for

participants to use during the conference. Materials included:

- —Various books from the bibliography.
- —Additional articles not contained in the Readings Book.
- —Handouts on other educational programs, treatment and referral resources, film catalogues and other material.

Participants could browse through the reading material and request single copies which were mailed to them after the workshop.

Many participants contacted the project office later to request further information or assistance (see the section of this chapter on Technical Assistance).

Role of Small Groups

Small group interaction during the general seminar evolved into an essential part of the workshop. Each small group discussion was led by a facilitator employed and trained by HPDAEP.

The primary objectives for the small groups were attitudinal. The facilitator was responsible for helping participants:

- —Discuss their attitudes towards drugs, drug users and abusers and how these attitudes affect the health care they provide.
- —Discuss their own personal drug use (or lack of) and how this affects their attitudes toward other drug users.
- —Explore changing their attitudes towards social, prescription and illicit drugs.
- —Articulate how their day-to-day behavior may change as a result of the seminar.
- —Describe how they will use the information gained at the conference to achieve change in their community, work setting or family.

Obviously, an important role was played by the staff facilitators. Many of the objectives considered most conducive to positive change and outcomes were addressed within the small groups.

Facilitators had expertise in different areas of drug problems and were available to participants as resource people during breaks and meal times. They were also skilled in role playing and training and were used during laboratory skill-building sessions.

Composition of Small Groups. Numbers of participants per small group varied, with seven perceived by facilitators as an optimal number. One staff facilitator was assigned to each group. During the workshop

each facilitator used a "Small Group Handbook" which included:

—Learning objectives for the entire workshop and those designated for small group discussion.

—Discussion questions and exercises for each small group session.

—Lists of expected behavioral outcomes.

—Assorted program material (lecture notes, pre/post tests, etc.).

—Space for recording process notes after each small group meeting.

Participants were assigned to small groups prior to each workshop by a HPDAEP staff person. Criteria for assignment included:

—Insuring that each group had participants from as many different professions as possible.

—Attempting to assign equal numbers of participants per small group.

—Attempting to place individuals from the same agency or town in different groups to provide a "safer" environment for discussing personal and professional issues which might be embarrassing with colleagues.

—Distributing male and female participants as equally as possible.

Training of Staff Facilitators. A group of twenty-three facilitators was used by the project staff. Facilitators had varied backgrounds in human service work, legal areas or business. A number of people became interested in HPDAEP and asked to become facilitators. Each person was screened for the position by the program director, and those accepted were added to the facilitator group.

Each facilitator had different levels of experience and skill in small group counseling or training. In order to provide a consistent level of skills, a four-part training program was utilized. Training was ongoing in nature, incorporating new members into the pool as well as providing consistent feedback for more experienced members.

Components of facilitator training:

1. Mandatory involvement in the HPDAEP general seminar as a participant.
2. Training sessions using outside consultants, HPDAEP staff or expertise of individual facilitators. During the second year of the project these sessions were held weekly for ten weeks, three hours per session. A course number was established (HSU 5-286), the course was entitled "Insights: The Effect of Self Behavior on Group Process," and credit was made available through the University of Minnesota.

Utilizing each other's skills, facilitators held sessions in

facilitation techniques (role playing, values clarification, group diagnostic skills, leadership techniques) and content areas (biofeedback, alternative treatment models, etc.).

3. Optional participation in workshop groups as a co-facilitator.
4. Debriefing sessions held nine days after each workshop. Data fed back to facilitators are described in the evaluation section of this report. A two-to-three-hour discussion was held to review data reports, notes made by each facilitator during the workshop and staff observations.

Summary of Rationale for Small Group Discussion. As the staff matured in implementing general seminar content, it became evident that participants needed to understand better the effect of their attitudes on health care delivery. More emphasis was placed on interdisciplinary small group interaction using a trained facilitator so that:

1. Discussion and incorporation of lecture material could take place.
2. Attitudes could be more freely identified and discussed.
3. Feedback on feelings and attitudes could be given.
4. Sharing of personal drug use could occur.
5. Sharing of personal and professional problems could be dealt with more adequately.
6. Participants could more easily discuss and get feedback concerning the workshop's impact on their own behavior and what change they could reasonably accomplish in their families, work settings or communities.

SPECIALITY WORKSHOPS

As a service to agencies and individuals who could not attend the two-and-a-half-day formalized workshop, an option of special programs was made available. A HPDAEP staff person would meet with the individual or group involved in planning a special program. Further involvement of HPDAEP would be determined at the initial meeting, and acceptance of the request was based on its relationship to project goals.

A total of fifteen specialty workshops were designed and implemented during the three-year period. One of the specialty workshops was done three times. All other workshops were individual in nature and expected to be a one-time offering.

Two examples of specialty workshop objectives and agenda are included as Appendix 3. Table 5 shows the number of specialty workshops held in relation to the number of general seminars.

Table 5. Ratio of Specialty Workshops/General Seminars

Year	Number of Specialty Workshops	Number of General Seminars
1973	11	6
1974	2	9
1975 (6 months)	2	7

Specialty workshop offerings decreased in 1974-75, for the following reasons:

1. Staff were spending too much time setting up and participating in specialty workshops at the expense of the major task of developing and implementing general seminars.
2. Project's commitment to offer primarily interdisciplinary workshops (specialty workshops often were directed only at a single discipline).
3. Since each workshop was different, no model program could be field tested with common evaluation instruments and program methodology. Therefore, staff decided to emphasize field testing the general seminar.

Table 6 summarizes the 15 specialty workshops, which included 715 participants.

Table 6. Specialty Workshops

Dates	Target Group	Areas Covered	Total Contact Hours	Number of Participants
February 24, 1973	Free clinic staffs in Twin Cities area	Counseling techniques, assessment and treatment goals	8.0	15
May 1-2, 1973	School nurses in Iowa	Emergency treatment, intervention alternatives	6.0	57
July 1, 1973	Detoxification staff, Hennepin County Receiving Center	Attitudes toward different drug use	7.75	24
July 8, 1973	Detoxification staff, Hennepin County Receiving Center	Emergency treatment Identification and diagnosis	7.75	20
July 15, 1973	Detoxification staff, Hennepin County Receiving Center	Interviewing techniques Crisis intervention theory and techniques	7.75	24
July 19, 1973	Radiologic technicians from Minnesota	Multimedia presentation	1.0	30

Dates	Target Group	Areas Covered	Total Contact Hours	Number of Participants
October 12, 1973	Hospital staff, Hennepin County Medical Center	Effect of attitudes on health care delivery	2.0	54
October 18, 1973	Members of the North Central College Health Association	Street pharmacology Emmergency treatment	3.0	48
October 19, 1973	School nurses in Minnesota	Attitudes – values clarification Emergency treatment – street pharmacology Role of school nurse – alternatives	7.0	135
November 1, 1973	Alcohol and other drug counselors from Wisconsin	Attitudes of alcohol counselors toward other drug problems Emergency treatment	3.0	65
December 6-7, 1973	Staff, Community University Health Care Center	Attitudes toward drug use Psychology of intoxication Chemical dependency Small group discussions Emergency treatment Appropriate referrals for the best treatment	12.0	43
January 23, 31, 1974	Staff, University of Minnesota Hospitals	Multimedia presentation	1.0	115
November 18, 1974 December 16, 1974 March 17, 1975	Public Health Nurses, Ramsey County (see further information in Chapter 6) " " " "	Attitude awareness, treatment modalities, diagnostic interviewing	8.0	40
June 14, 1975	Group home parents	Attitude awareness	2.0	15
June 23, 1975	Para-professional counselors	Attitude awareness, counseling, diagnostic techniques	3.0	30

Table 7. Target Population Served (all programs)[1]

Physicians	145
Registered Nurses	861
Health Care Administrators	128
Social Workers	159
Pharmacists	116
Other Hospital Staff (technicians, secretaries, etc.)	142
Health Educators and Professional Faculty	114
Alcohol and Other Drug Counselors	157
Public Health Nurses	90
Licensed Practical Nurses	143
Psychologists	37
Clergy and other helping professionals	90
Directors of Nursing Service	23
Counselors in Training	30
School Nurses	192
School Counselors/Teachers	58
Nursing Assistant/Orderly	59
College and Health Science Students	88
Other Students/Interested Persons	48
Psychiatric Technicians	17
Group Home Parents	16
Street Agency Staff/Free Clinics	39
Others and Unknown[2]	418

[1] 420 health professionals attended a series of inservice programs in early 1974. Social workers, nurses, physicians, pharmacists and administrators were in attendance but exact professional breakdown was not recorded. Therefore, they are not included in the above list.

[2] Inadequate record keeping during the first year of the project causes this figure to appear inflated. During the last two years of the project, this category also covered other community members who participated in programs (law enforcement personnel, city officials, community program staff, etc.).

TRAINEESHIPS AND OTHER TECHNICAL ASSISTANCE

This was the fourth program area designated in the original grant application. During 1973-74, general seminar participants were informed that traineeship monies were available through HPDAEP to help defray travel and instructional costs they incurred gaining experience. Traineeships and requests for information were handled by the program director after each general seminar. Late in 1974 it became obvious that the numerous requests for additional information simply could not be handled by existing staff.

The technical assistance component of HPDAEP was formalized in February 1975, when a technical assistance coordinator was hired on a part-time basis. A special workshop was offered during the general seminar

to allow the participant and the technical assistance coordinator to work out requests in person. Other requests were encouraged and were handled by letter and phone. Table 8 accounts for technical assistance activities from February to June 1975 (prior to February 1975, only records of internships were kept).

Internships

Six traineeships were completed during the project. Traineeships included a goal-setting process to ascertain what the trainee wanted to accomplish and how these objectives could best be met. Once the strategy was set, the trainee was primarily responsible for the learning process. A follow-up session was held to supply feedback to the staff.

One of the first traineeships was completed by a psychiatrist employed in a student health service. HPDAEP provided money to defray her scholarship expenses at a three-week training and clinical experience at the Johnson Institute in Minneapolis. She felt that the coursework enhanced her abilities in the area of diagnosis and referral and that visiting a chemical dependency treatment unit gave her much needed first hand experience. Six months later she had submitted a grant proposal to the Minnesota Single State Agency and received funds to employ a full-time chemical dependency counselor in the health service.

A family practice physician completed another traineeship by visiting a variety of intervention, detox and treatment services within the Twin Cities area. Afterwards, he felt that by actually seeing different modalities and techniques of treatment, he was able to make better referrals.

One of the participants in a June 1974 general seminar was asked to be head nurse for a new chemical dependency treatment unit in the hospital where she worked. Her application for a HPDAEP traineeship was accepted and goals were set. Her activities included collecting information on patients; staff, and treatment methods from three different kinds of treatment centers and visiting with head nurses on these units to help her identify different roles that nurses on chemical dependency units have. She reported that her traineeship was invaluable and helped get the new unit off the ground. She became even more active in the community by writing a grant proposal for community-wide education in the area of alcohol and other drug misuse.

A faculty person from a University human services training program participated in a HPDAEP traineeship in order to explore more of the treatment issues that were raised in the general seminar. On the basis of her objectives, money was provided for her to attend a training workshop at the Addiction Research Foundation. Her experience was very positive, and she was able to incorporate content into the courses she was teaching as well as some new educational methods.

Another traineeship evolved because a seminar participant wanted to see an operating chemical dependency unit and have a limited role in participating in the treatment provided. She was a psychiatric nurse interested in new career directions and impressed by the seminar presentation on treatment and referral techniques. After designing goals, she was referred to a local treatment facility to spend two weeks observing and entering the actual treatment process as she felt comfortable. During the two weeks, she kept a diary of the thoughts and feelings she was experiencing to share with HPDAEP after completing the traineeship. The outcome of her experience was that she left psychiatric nursing after six years and entered the chemical dependency field. The HPDAEP program director helped her find a job suited to her capabilities, and she became Project Coordinator for Physicians' Education in Chemical Dependency for Minnesota and, later, was employed as HPDAEP's technical assistance coordinator.

A psychologist from Iowa did a traineeship in Minneapolis and St. Paul on crisis intervention and community services. During a week-long stay, he visited a variety of crisis services where he discussed cooperational philosophies and was given the opportunity to view each facility and join in on some groups. A follow-up visit is being planned for him to return and spend a week at the Crisis Intervention Center of Hennepin County Medical Center to expand his clinical skills. He reported having gained excellent information on how to operate a crisis center and a good background on how to reach the target population he needs to address in his area. He is now helping to establish a comprehensive crisis service for his community.

Several other informal traineeships were implemented but are not reported because of their limited nature (½ day visits, for example).

Other Technical Assistance Requests

The most typical request for technical assistance was for a presentation from the general seminar format. The role of the technical assistance coordinator in these instances was to help in defining (1) target audience, (2) goals, (3) learning objectives, and (4) desired outcomes. A workbook was devised to help these individuals or groups see the process of designing and implementing programs. Not all requests for general seminar lecture presentations could be filled in person due to time and money constraints; therefore, video-tapes were made available on request. When reprints or other written information was sent to a past participant, a directory of established, local service agencies was also enclosed in order to encourage use of existing services and community coordination.

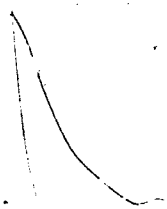
The technical assistance component was not evaluated on a formal basis. Telephone interviews were conducted with ten of the people who made large requests, and results of these interviews are reflected in

Table 8. The fact that people asked for technical assistance is considered a positive outcome reflecting on the entire project.

Table 8. Technical Assistance Activities Other than Traineeships (February – June 1975)

Kind of Assistance Requested	Total Number	Description
Video tape use	4	Lutheran Deaconess Hospital used the Brantner tape as one lecture in a series of three. The response was that the audience preferred in-person lectures. Gillette Hospital in Wyoming purchased all the general seminar tapes and used them in their own inservice. Response was very positive. Outcome is that they are using the tapes as ongoing orientation for staff. The inservice nurse for St. Mary's in Rochester used the Brantner tape for a staff education meeting. She reported low attendance, that those who did attend were impressed and that a lengthy discussion followed the presentation. A complete series of general seminar lecture video tapes is being used by the State of Nevada Department of Alcohol and Drug Abuse as training/education material.
Additional literature	30	Approximately 30 people requested additional information from the literature and resource table set up at each general seminar. The article most requested (15) was "Alternatives to Abstinence" by Linda and Mark Sobell from the *Journal of Addictions,* Canada. The next most requested articles were the drug resumes put out by Metro Drug Awareness and the NIDA workbook on crisis intervention.
Inservice presentations	10	A three-session inservice for all Abbott Hospital staff dealt with attitudes, alternatives, and diagnostic tools. Response was favorable and the staff asked for a return inservice. Abbott Hospital also had HPDAEP do a lecture series for their psychiatric staff. Their main interest was learning how to handle drug problems of the adolescents on their psychiatric unit. Ramsey County Public Health Nurses had HPDAEP do a lecture series on attitudes, treatment, and diagnostic interviewing. Several other people had requests that could not be filled because of lack of time and inconvenience of location. However, HPDAEP helped five of these people get in touch with other resources (such as films or local speakers) for their presentations. There are presently five other requests by people in Iowa and Wisconsin for a complete general seminar of a community-based nature.

Kind of Assistance Requested	Total Number	Description
Miscellaneous —scholarships —agency visits —information on facilities —specific target group information	31	Examples: One person received partial funding to attend a week-long institute on chemical dependency. Ten requests for agency and/or facility visits were handled. Three of these people actually made visits and were satisfied with information they received. The other seven indicated intentions to visit but have extenuating constraints on time and funds. One person is looking into facilities that deal with problems of minorities such as Blacks, Indians, the elderly, women and adolescents.
Establishing a hospital-based chemical dependency screening service	2	After attending a general seminar, an interdisciplinary group of professionals working at Bethesda Hospital sought help in setting up a chemical dependency screening team for their hospital. HPDAEP staff met with the group several times to plan how to operationalize the team. During the first phase of implementation some members of the medical staff apparently became threatened and angry that their patients were being interviewed. In reorganizing and addressing similar concerns the team changed their emphasis to a Chemical Assessment Training Team (CATT) and are providing consultation and training to others throughout the hospital. A number of professionals from other institutions have contacted CATT and former HPDAEP staff to encourage similar efforts in their agencies. Eitel Hospital also decided to try to set up a chemical assessment team. They are now in the process of educating themselves and other staff and are beginning to implement their ideas.



Chapter 4
Recruitment

This chapter outlines the development of a model for recruiting interdisciplinary groups of practicing health professionals from a wide geographic area for drug-related education. It contains a section on the barriers to recruiting appropriate audiences to the HPDAEP general seminar and a section outlining the evolution of the final recruitment model.

BARRIERS TO RECRUITMENT

HPDAEP spent a significant portion of its fiscal and staff resources in attracting appropriate audiences for training. The recruiting function, though it assumed various forms throughout the life of the project, was necessitated by several factors:

—The commitment to deal only with practicing health professionals.

—The commitment to having an interdisciplinary audience.

—The subject matter of the training experience.

—The wide geographic area included in the project's objectives.

—The changing profile of the project until its final year.

—The emphasis on participants as agents of change.

Each of these barriers is explained below.

Commitment to Practicing Health Professionals

HPDAEP attempted to limit its primary target group to the traditional health care professionals, i.e., physician, nurse, pharmacist, hospital and clinic administrator, medical social worker, hospital chaplain, etc. This

commitment created two barriers to recruitment.

Time. It is difficult to motivate health professionals to attend an intensive 2½ day continuing education experience. Many small health care institutions consider themselves understaffed, particularly those hospitals ranging in size from 20 to 100 beds, the majority of those in the HPDAEP target area. Most recruiting efforts in the final year of the project were directed toward hospitals, where the preferred training modality is brief inservice continuing education programs which do not require staff to leave their jobs for more than a few hours at a time.

A telephone survey was conducted with recruitment contact people in hospitals to provide follow-up data to the recruitment effort. Almost sixty percent (59.5%) of respondents indicated that the single biggest barrier to workshop attendance from their respective institutions was time; either the institution could not reschedule staff to allow participation, or staff were unwilling to commit precious personal time for continuing education.

Format. The traditional approach to health professional education includes two principal modalities: didactic presentation and clinical rotation. The HPDAEP general seminar, in addition to didactic presentation, required participation in small discussion groups and laboratory exercises in diagnostic interviewing and intervention techniques. Consequently, recruitment included dealing with the uneasiness of potential participants when they learned of the break with traditional teaching modalities.

Commitment to Interdisciplinary Audiences

This break with traditional methods of health professional education also became a barrier to recruitment of the appropriate target groups. A typical response from hospital personnel was, "It's the physicians who really need this and if you don't get them there, there's no sense in our attending." It was difficult for professionals from hospital-based disciplines to perceive the subject matter of the general seminar as broadly applicable. Consequently, a great deal of time in the final recruitment models was spent detailing the seminar agenda and giving examples of its applicability to various disciplines. Ultimately, registration preference was given to those institutions sending groups representing four or more health care disciplines.

Subject Matter of the Training Experience

Within the health care delivery system, drug use and abuse is viewed in as many different ways as there are health professionals viewing it.

Since chemotherapy is the primary tool of the practitioner for a large number of patient complaints, many health professionals feel threatened by any proposed discussion of drug use and misuse. Many practitioners are

aware that they utilize prescription drugs inappropriately but, recognizing no alternatives to chemical intervention with many maladies, apparently choose not to confront the issue.[1]

Another view held by many health professionals is that they are not responsible for treating drug use and abuse. This position seems particularly prevalent about the use and abuse of illicit and other nonprescription drugs. Or as Chappel states, "Direct conflict with cherished values may lead to a moralistic view of the drug-dependent person as an undesirable patient."[2] The outcome of this view is that any education addressing the issues of drug use and abuse is thought to be not only unimportant but inappropriate.

The health care professions, particularly medicine and nursing, rank high as "at risk" populations concerning their own drug use. "We are particularly vulnerable to the development of drug-dependence problems ourselves. Avoidance or rejection of the drug abuser as a patient may, in some cases, be a reaction formation protecting the [health professional] from his own impulses."[3] Many who recognize the inappropriateness of their personal drug use or that of colleagues are unlikely to attend an educational experience in which they anticipate having that information revealed.

The HPDAEP general seminar is laden with attitudinal material, presented both didactically and in small discussion groups, the emphasis being on ways in which attitudes affect health care delivery. Traditional health professional education has stressed objectivity and the need to keep values and emotions out of the health care delivery system. Many practitioners schooled within the traditional system believe not only that this is possible but that they are doing it. Consequently, any examination of the relationship between attitudes and health care delivery may be suspect to professionals subscribing to this view. Moreover, almost all health professional education is restricted to the cognitive and psychomotor learning domains, with affective education seeming strangely out of place. This was ultimately turned into an advantage in the final recruitment models by contrasting the recruiter's use of caffeine and nicotine with other (and probably less "harmful") forms of drug use about which people commonly have negative attitudes, e.g., occasional use of opiates.

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[1] To do so would call into question the legitimacy of the relationship between patient and professional, as noted by Lennard in *Mystification and Drug Misuse,* Lennard, Henry L. and associates, 1971, Jossey-Bass, Inc.

[2] Chappel, John N., M.D., "Attitudinal Barriers to Physician Involvement With Drug Abusers," JAMA, May 14, 1973, Vol. 224, No. 7, 1011-1013.

[3] Ibid.

It then became easier to demonstrate that attitudes could indeed affect patient care.

Wide Geographic Operation

The number of workshops offered in the target areas were determined on the basis of population. Because of the five-state area covered by HPDAEP, combined with funding for a limited number of workshops, the project was rarely able to conduct more than one workshop is a designated area.

Because the project rarely conducted workshops in the same area, it benefited only marginally from word-of-mouth publicity. Recruiting for each workshop essentially meant beginning the entire publicity process anew. In that sense, the project was never "institutionalized"; goals, expectations, objectives, and background had to be re-established for each new group of potential participants. Exceptions to this were four consecutive general seminars held in the Minnespolis/St. Paul area in late 1974 and early 1975. Recruitment was conducted only for the first of the four programs, on the assumption that the remaining three should fill by word-of-mouth. This proved to be the case.

Changing Profile of Project

During its first two years the project experienced: (1) a *complete* turnover in staff, (2) an evolution from vague, unarticulated outcome objectives to specific and well-defined behavioral areas of concern, (3) a change from an early emphasis on crisis intervention and treatment to the eventual emphasis on diagnosis, intervention and referral, and (4) a gradual expansion from including only "street drugs" and the "youth problem" to including all drug use, licit and illicit, within the parameters of the general seminar. One of the effects was to sacrifice the consistency and predictability that would have assisted participant recruitment.

Emphasis on Participants as Agents of Change

As the anticipated outcomes of the project were better and better articulated, the target group for the general seminar became those health care practitioners who recognized the problems stemming from drug use and abuse in their own practice settings, families and communities and who had become frustrated in their attempts to deal with drug use and abuse within their own patient populations. Implicitly *excluded* from the target group at that point were those health professionals whose family, institutional and social systems were rewarding enough that they would not desire significant changes in those systems and, consequently, did not perceive themselves as change agents.

The ultimate recruitment task, then, became finding those practicing health professionals whose dissatisfaction was such that HPDAEP could

serve as a resource to them in defining their specific needs and facilitating the changes *they* desired.

RECRUITMENT MODELS

HPDAEP's primary emphasis was training, not research. The importance of this distinction arises in terms of the degree of control maintained over both internal and external recruitment variables.

The following pages present the six basic recruitment models used to attract appropriate interdisciplinary health professional groups into the HPDAEP general seminar. Each will be discussed in comprehensive terms, with emphasis on the one or two components differentiating it from the others. It is significant that the recruiting function existed to insure attendance at workshops, not to test recruiting models. The following models did not exist in as pure a fashion as they are discussed but provided the overall structure within which many ongoing recruiting functions occurred.

Three-hour Sensitization Workshop/Community Invesitigation (Winter/Spring 1973)

The sensitization workshop is described in Chapter 3 of this report. Essentially, it was an attempt to alert health professionals to drug use and abuse problems in their own communities. The assumption was that they didn't know what was really happening in their communities concerning drug use and that if someone told them, they would be motivated to attend the HPDAEP general seminar to find answers to the newly discovered problems.

Prior to conducting a sensitization workshop in a community, two (out of three) HPDAEP staff would spend two days in the community researching the local "drug scene." Although preliminary contacts were not restricted to people already working in the field of chemical dependency, they predominated among those who attended the workshops and eventually the general seminar. Though the sensitization workshops were reasonably well-attended, the desired outcome (health professionals' attendance at a general seminar) was not adequately achieved.

Later in the project it was deemed unwise to utilize chemical dependency professionals as initial contacts in an area. Though the assumption was that they would be most helpful in providing the link to the health care community, the outcome was that a large percentage of general seminar participants were those working in drug-related fields. Unfortunately, those already working in drug-related fields were specifically *not* the people with whom the project was funded to work.

Sensitization Workshop/No Community Investigation (Summer 1973)

By June 1973, it became obvious that changes were necessary if the

sensitization workshop was to be continued as a recruiting device. Because appropriate participant groups were not attending the general seminar, three primary changes were made: (1) the community investigation by HPDAEP staff was dropped; (2) because of #1, the burden of needs analysis within the community logically began moving to the workshop participants; and (3) availability of further training through HPDAEP was at least mentioned as a learning objective.

Many contacts were still being made through chemical dependency personnel, and a high percentage of general seminar participants were working in drug-related fields. Recruitment had still not been articulated as a distinct function within the project, though it was becoming apparent that recruitment consumed so much staff time that little remained for the development of other project areas.

Sensitization Workshop/Hospital Organization (Fall 1973)

In October 1973, it was decided that if the target audience was practicing health professionals, it made sense to work directly with them rather than through chemical dependency professionals. The objectives and agenda of the sensitization workshop remained essentially unchanged, but its method of implementation did change.

Major hospitals in the target area were contacted and meetings were arranged with an interdisciplinary group of interested staff in each hospital. The goals and objectives of HPDAEP were explained and the opportunity to organize and sponsor a sensitization workshop for community health professionals was made available. Sensitization workshops were subsequently held in those communities where health professionals had enough interest to organize them.

The advantages to this model were: (1) the primary contact people were practicing, hospital-based health professionals; (2) staff time spent on pre-workshop development was reduced; (3) in those hospitals which chose to sponsor a workshop, an organized and committed group of health care personnel emerged; (4) recruitment was firmly recognized as a separate function within the project; and (5) it worked, as evidenced by the interdisciplinary attendance at the general seminar held in central Minnesota in November 1973.

The two general seminars for which this recruitment model was used represented a definite move toward more appropriate interdisciplinary participant groups. This model provided the basis of the final two recruitment models, described in sections following.

Publicity/Delegation (Winter/Spring 1974)

By December 1973, the project had designated a new staff position with responsibility for recruitment.

Failure to learn from past successes and naivete about health professional continuing education led to a new direction in recruitment efforts, which concentrated on two recruitment methods.

The first was publicity. It was felt that if the project produced some descriptive brochures, health professionals would just naturally respond. Literature was mailed to anyone in a general seminar target area who could be expected to distribute it appropriately. This distribution method represented a step backward, because it relied primarily on chemical dependency professionals. The obvious shortcoming was that health professionals were once again being avoided as primary contacts.

The second component of this model involved contacting people in the workshop target area who were active in the field of chemical dependency. They were requested in turn to contact health professionals in their communities and solicit participation in the HPDAEP general seminar scheduled for their area.

Of the three general seminars which were sponsored utilizing this recruitment model, one had a small inappropriate participant group, and two were cancelled due to lack of registrations.

Printed materials alone proved to be inadequate in speaking to the concerns that most health professionals have relative to attending this workshop. Not having these concerns spoken to directly resulted in lack of participation.

Hospital Inservice (Spring 1974)

After a year and a half of failing to attract desired audiences to the general seminar, it became obvious that radical changes were needed in recruitment. An entirely new approach evolved which included face-to-face recruitment of health professionals as its primary component.

The method involved establishing inservice meetings at eight to twelve target area hospitals approximately six weeks prior to the general seminar. The contact person at each hospital was usually the Inservice Education Director. That person was told about HPDAEP and about the workshop to be held in the area. The contact person was then asked to arrange a small meeting with interested hospital staff of various disciplines at which a HPDAEP staff person could talk in greater depth about the project as well as the objectives and agenda of the upcoming workshop. At the meeting, the HPDAEP staff member was accompanied by an ex-addict whose primary source of supply while addicted was the health care system. This person's role was to share some of the strategies used by drug abusers in obtaining drugs from hospital/clinic situations, in order to demonstrate to the staff some areas of vulnerability which were primarily due to lack of training.

These inservice meetings ranged from 1½ to 4 hours in length. They

were open-ended and would continue as long as the hospital staff attending had questions. The meetings are best described as combination sales/education meetings.

This recruitment approach had a number of advantages: (1) people were impressed that HPDAEP cared enough about their attendance to meet with them in their hospital; (2) the meeting provided an opportunity to discuss the scope of drug abuse problems among hospital patient populations and the number of patients whose presenting symptoms were secondary to their drug use or abuse; (3) the meeting gave health professionals access to someone who had utilized the health care delivery system to maintain a drug supply for many years without detection and who could share with them some ways in which that was probably still occurring in their own institutions; and (4) it gave them a name and a face they could associate with HPDAEP, so that it was no longer an anonymous organization about which little was known.

After this approach was implemented, appropriate audiences began attending the general seminar and for the first time, there were more applicants than could be accepted. Table 9 contrasts percentage attendance figures for major health professional disciplines at general seminars prior to June 1974 and after June 1974.

Table 9. Percentage of Selected Health Care Disciplines Attending HPDAEP General Seminar (Accumulative)

Health Professional Discipline	Pre-6/74	Post-6/74
Physician	3.4	5.1
Pharmacist	3.7	7.7
Registered Nurse	14.6	31.4
Director of Nursing	.7	5.1
Other Hospital Staff	2.4	5.7
Social Worker	7.1	12.6
Alcohol/Drug Counselor	17.7	5.9

The primary disadvantage to this recruitment approach was economic. It was expensive for two people to travel throughout the five-state area spending from one to two weeks recruiting for each workshop.

Hospital Inservice (Fall 1974)

The final model used for recruitment was identical to that just described, with the exception that the HPDAEP staff member conducting the meeting was not accompanied by an ex-addict. Again, the process was this:

1. Mail packets of posters, flyers and brochures to every hospital

in the program target area (10-12 weeks prior to workshop).

2. Mail public service announcements to target area media (6-8 weeks prior to workshop).
3. Telephone target hospital Inservice Education Directors to arrange in-hospital meetings with staff (7-8 weeks prior to workshop).
4. Hold hospital inservice staff meetings (5-6 weeks prior to workshop).
5. Follow-up with target hospital Inservice Education Directors (3-4 weeks prior to workshop).

There were two advantages to eliminating the ex-addict component of the hospital inservice programs: (1) expense was reduced since travel expenses were incurred by only one person and no outside person had to be paid a speaker's fee; and (2) the inservice meetings became shorter since there was less discussion about "what it's like to be a 'dope fiend.'" There was no apparent loss of effectiveness in recruiting appropriate workshop participants, and this became the model utilized for the remainder of the project.

RECRUITMENT AND CHANGE

Luther Gerlach and Virginia Hine have identified five factors which they feel are present in all successful social movements.[4] HPDAEP's efforts to effect change among health practitioners in a five-state area were in some ways parallel to these five concepts of social change. This chapter will be summarized by identifying each of those five factors and its application to recruitment during HPDAEP's final year.

A segmented, usually polycephalous, cellular organization composed of units reticulated by various personal, structural and ideological ties. (In addressing a target group for participation in the general seminar, HPDAEP took advantage of such pre-existing cellular organizations — the individual health care disciplines.)

Face-to-face recruitment by committed individuals using their own pre-existing, significant social relationships. (The face-to-face recruitment process was begun with visits by a HPDAEP staff member to health care institutions, but it could not have succeeded if the people at in-hospital meetings had not in turn used their pre-existing social and professional relationships to continue the recruitment process by locating and getting commitment from other interested health professionals.)

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[4] Gerlach, Luther P. and Virginia H. Hine, *People, Power, Change: Movements of Social Transformation*, 1970, New York: Bobbs-Merrill, p. xvii.

Personal commitment generated by an act or an experience which separates a convert in some significant way from the established order (or his previous place in it), identifies him with a new set of values, and commits him to changed patterns of behavior. (HPDAEP concentrated on locating individuals who were frustrated with the status quo – in family, institution or community – relative to drug use and abuse problems and who were seeking alternative methods and resources to apply in those areas.)

An ideology which codifies values and goals, provides a conceptual framework by which all experiences or events relative to these goals may be interpreted, motivates and provides rationale for envisioned changes, defines the opposition, and forms the basis for conceptual unification of a segmented network of groups. (HPDAEP offered the structural framework within which general seminar participants could begin to assess their own attitudes toward drug use and abuse and what effect those attitudes had upon health care delivery. The seminar assisted in clarifying the significant issues surrounding drug use and abuse and helped participants discover new methods for dealing with frustrating problems.)

Real or perceived opposition from the society at large or from that segment of the established order within which the movement has risen. (For many of the health care disciplines, the perceived opposition generated from the physician, i.e., "I can't do anything that the physician [or institutional administration] won't let me do; I'm powerless." For the physician the perceived opposition arose from drug users and abusers themselves, since the physician felt that group was attempting to use him/her to obtain drugs.)

To quote Gerlach and Hine in conclusion:

> It has been impossible to discuss any of the five key factors significant in the spread of a movement without repeated reference to other factors and to their interrelatedness. Opposition provides the risk necessary for genuine commitment. The commitment of the true believer invariable offends and calls forth opposition from members of the established order. Personal commitment is one of the causes of organizational segmentation, while organizational diversity provides charismatic elbowroom for further commitment. Commitment increases the ability to recruit, and recruitment initiates the process by which commitment occurs.[5]

[5] Ibid., p. 196.

Chapter 5
Evaluation

This chapter outlines the basic evaluation model developed for HPDAEP. It describes the development of the evaluation instruments and their uses, includes a demographic description of the participant population, and explains the process used in gathering follow-up data. The last section summarizes outcomes resulting from the project's efforts.

BASIC MODEL

The purpose of HPDAEP's evaluation system was twofold: to determine the extent to which the project achieved its goals and to provide intermediate process feedback to facilitate accomplishment of end goals. The first objective required evaluation data to assess outcomes (this meant follow-up of program participants to determine changes in the individuals' lives and communities that might be related to their participation in the seminar). The second objective required evaluation data on the program processes in order to determine the effective areas of programming and those not so strong. Hence, the evaluation model was based primarily on a Stake model[1] which gathered pre-conference and post-conference data from each participant and then followed up a random sample of persons six months subsequent to conference participation.

The evaluation system is based on the belief that evaluation of educational processes and accomplishments should facilitate goal achievement for learners and staff. It has to be integrated into the system; it

[1] Stake, Robert E., "The Countenance of Educational Evaluation," *Teachers College Record,* Vol. 68 (1967) 523-540.

cannot take an undue amount of time away from the learning process; it should help focus on objectives; it should be in a format that allows statements to be made about objective achievement; it should facilitate process assessment to allow changes in current programming; and it should provide timely feedback to staff.

The original evaluation model was changed somewhat as the program itself evolved and the goals and objectives were shifted in emphasis and priority. The first stage of the model included (1) defining the initial assumptions, problems, and populations; (2) defining the end goals of the project, the specific objectives that would lead to goal achievement, and the variables that would indicate achievement of these objectives and goals; and (3) setting forth the processes through which the population would move from initial setting to specific objective and goal achievement. The second stage involved determining the extent to which the components of the first stage were achieved. The third stage involved gathering data, tabulation, providing feedback to appropriate staff, and analysis for indications of adjustments needed in the program. The fourth stage included observations by the evaluators about the achievement of objectives and goals.

EVALUATION DESIGN

The project's purpose was to achieve certain outcomes by influencing the affective and cognitive domains of the participants, as well as by introducing specific psycho-social skills. The affective domain was an effort to influence the person's attitudes, that is, at least to make the person aware of his/her attitudes and the effect these attitudes have on the patient or client receiving health care relating to drug abuse. The cognitive area included furnishing participants with specific knowledge of drugs, drug abuse, legal considerations involved in treatment of drug-related problems, information sources, referral sources, strategies for community involvement, and other areas within the cognitive domain. The skill finally emphasized was diagnostic interviewing to determine the extent of a drug problem in a client/patient.

The main process which evolved in the project was the two-and-a-half-day general seminar. Thus, the evaluation design focused on the process of the workshops and their effect on the affective and cognitive domains of the participants. (No objective or external process evaluation instrumentation was developed for this aspect of the program. However, the close contact between small group leaders and participants in role play practice sessions allowed staff observation of skills developed, and subjective feedback from participants about their experiences in the diagnostic interviewing sessions allowed some judgments to be made.) The major tools developed for process evaluation included a measure of affective change, cognitive change, and personal perception changes, as

well as participant comments about the program including its strong and weak points.

Affective and Cognitive Instruments

The first instruments developed were designed for measuring cognitive and affective changes and for use in a pre- and post-conference format.[2]

The final pre-post cognitive test evolved through several stages. Each component of the two-and-a-half-day seminar was examined for its cognitive elements. Questions were developed from these elements and cross-referenced with the specific behavioral objectives of the project to determine if each cognitive element related to specific behavioral objectives and if each behavioral objective with cognitive elements was covered in the question set and hence in the workshop itself. A set of questions was administered to several workshop populations, analyzed for item validity and reliability, and revised. Because of the diversity of participant populations and the varying emphases of different workshops, the cognitive test had to be a compromise if held as a constant exam. Consequently, item analysis of the cognitive test by individual conference indicated a higher or lesser degree of appropriateness of particular questions for particular populations. However, it was felt that the final test gave a relatively stable baseline to measure cognitive changes. (Overall pre-post realibility gave and $r = .871$ across 706 participants.) This test was used pre-post for each conference and analyzed subsequent to each conference. Feedback provided to staff the week after the workshop (see data report, Appendix 5) contained overall and specific cognitive changes which indicated particular strengths and weaknesses of the program.

An attitudinal scale was necessary to measure the affective elements of the program. The scale was designed to reflect a person's attitude set toward certain types of life styles, toward drug use and abuse, and toward the abuse potential of drugs. It was felt that these three dimensions of a person's attitude were likely to be strongly interrelated and that it would be necessary to look at all three categories working together to get some idea of the person's attitude set. The purpose of the attitude scale was to measure the degree of helping attitudes a participant possessed toward drug users and abusers. A summary of the development of the attitude questionnaire is discussed in Appendix 6. After testing and retesting, a 19-item questionnaire was developed and utilized in all subsequent workshops.

Participant Response Questionnaire

A third source of data was the participants' own perceptions about

[2] The initial assumption of the project was that these instruments would be used both in short three-hour workshops and the longer two-and-a-half-day seminar.

their knowledge, about their participation in community activities, and about some of the underlying assumptions of the project. An instrument was developed to get participant response to thirteen items which reflected one or more of the specific behavioral objectives of the project. Several of these items were also included on the follow-up questionnaire to record perceptual changes which occurred over time. Each item was seen to be of a monotonic function with a linear relationship from one end of a scale to the other. For computation purposes, a single score was developed for the instrument. The thirteen items were treated as separate entities; the overall score indicated (1) if there were participant response changes and, if so, in what direction, and (2) if there were certain elements in the workshop or certain workshops that contributed more to participant response change.

Post-conference Evaluation Forms

A fourth instrument was developed to evaluate the process of each conference. This instrument (see Appendix 7) focused on each objective of the workshop, asking if each was adequately covered and if each was helpful. The instrument provided information which led to program revisions and refinement of program objectives. Once the program became stabilized, this initial format was deleted, and the focus was redirected to specific areas of concern and open-ended responses (see Appendix 8).

The post-conference evaluation form gave participants the opportunity to assess how well their small groups operated and how helpful their group facilitator was. Participants were asked how they felt their attitudes changed as a result of the conference toward social, prescription and illicit drugs and to state what in the conference they felt was most and least helpful. They were also asked to state how they were recruited and how their day-to-day behavior might change as a result of their participation. Participants noted how they would attempt to use the information gleaned in their community and/or work setting and how the workshop could have been changed to make it better. Participants indicated their general feelings about the conference by means of a "Happy Face" index. This information was reviewed quarterly by the program staff to determine how well the small groups were functioning, to consider the suggestions for change and to determine what, if any, impact the workshop had on participants.

Another area of early process evaluation was observation at each workshop. The Project Evaluator observed each component of the workshop in relation to content and process. The content was then compared to the objective for that particular component, i.e., were the objectives for that component of the workshop covered at the level necessary to achieve the objective? The time spent on each segment of the program was a part of the observation. The evaluator also discussed with participants their feelings and concerns throughout the earlier workshops.

Program staff received these observational data subsequent to each workshop, re-examined workshop components, and made revisions. These early process evaluation efforts were discontinued once the program stabilized.

Use of Process Data: Feedback to Staff and Facilitators

The process data, that is, information from the pre- and post-conference instruments, were coded after each conference for computerization. Each participant's data were punched into eight cards including: Card 01—biographical data, Card 02—pre-attitude responses, Card 03—pre-participant responses, Card 04—post-attitude responses, Card 05—post-participant responses, Card 06—evaluation form responses, Card 07—pre-cognitive responses, Card 08— post-cognitive responses. A codebook was developed to provide for accuracy and consistency of coding. The cards were then processed, utilizing the Statistical Package for the Social Sciences (SPSS).

The data output listed each participant by I.D. number, reporting the pre, post, and change scores on each instrument and the small group which the participant attended. The print-out also listed: a frequency distribution of responses for each question on each test, including both pre- and post-conference instruments; a frequency distribution of the range in scores for that conference; a frequency distribution of change scores for each instrument; a frequency distribution of the evaluation form responses, including questions 1, 2, 13, 5A, 5B, and 5C; cross-tabulations of small group number by change in attitude, participant response and cognitive scores. Student's dependent t-test was then run on the means of each question of the pre- and post-attitude and participant response, and a t-test was also computed for the overall pre- and post-conference means of each instrument, including cognitive.

The Data Report and the Facilitator Feedback Report were developed to condense this information to a usable format (see Appendices 5 and 9). The Data Report, including participant's comments about most and least helpful components of the workshop and suggestions for change, provided a mechanism of feedback to the program staff for review immediately after each conference. The Data Reports from all conferences completed during a given quarter, along with the raw data from each conference, were reviewed quarterly. Any program changes for the next quarter's seminars were finalized at that time.

The Facilitator Feedback Report was designed to report to small group leaders how comfortable their group members felt with the group, how helpful members felt the leader to be, and how happy each participant was with the conference as a whole. Each facilitator kept a session-by-session diary during the conference to assist them in checking their pre-existing impressions with actual outcomes data. The Facilitator Feedback Report was mailed to each facilitator for review prior to the

facilitators meeting nine days after each conference.

Ongoing feedback to program staff is an integral part of an evaluation system. The information provided in the Data Report and the Facilitator Feedback report afforded the staff directly involved with a given workshop the opportunity to review and discuss what changes could be made and to offer constructive criticism to fellow staff members regarding method of presentation, content or group facilitation techniques.

Development of the Follow-up Questionnaire

The final evaluation instrument developed was the follow-up questionnaire. Implementation of a follow-up program six months after a workshop involved three considerations. The primary question was what specific behavioral observations, actions or comments would indicate achievement of outcomes. Secondly, how could subsequent achievements or statements be related to the project as part of its accomplishments as opposed to some other independent variables? Third, what length of time would be adequate to realize outcomes, and what resources were available to operationalize a follow-up program?

The follow-up questionnaire was developed in three stages. The initial questions tested for follow-up early in 1974 were brief and related primarily to the process of the two-and-a-half-day workshop. The questionnaire was designed for in-person interviews and was used solely for that purpose, since the total follow-up process had not yet been developed. This questionnaire led to development of a more formalized questionnaire, the developmental model (see Appendix 10).

The developmental model of the follow-up questionnaire was designed in June 1974. The questionnaire format was conducive to mailing, as well as to use in telephone and in-person interviews. It included questions relating to the specific learning objectives of the project developed in January 1974. The design required participants to check the most appropriate response, and space was provided for elaborative comments. This follow-up questionnaire was used through February 1975 and provided the basis for the final follow-up questionnaire.

In December 1974, at the quarterly data review session, the project staff decided to expand the follow-up questionnaire. It was determined that the questions asked did not provide adequate information to assess achievement of the specific program objectives. Consequently, ten of the 21 questions on the developmental follow-up questionnaire were modified to speak more appropriately to the program goals and specific objectives, and another 26 questions were added. The additional questions solicited more information on how participants' attendance at the conference might have affected their day-to-day behavior either personally or professionally and provided more appropriate information to ascertain achieve-

ment of the program's specific objectives (see Appendix 11). An example may help explain how this finalized follow-up questionnaire provided more appropriate information. Several participants mentioned at follow-up that they had re-examined and changed their own drug-taking behavior because of conference participation. However, the question (question 18, developmental model) was not specific enough to provide adequate information about this outcome. The final follow-up questionnaire addressed this issue more specifically (questions 32A, 32B, 32C), and 25% of the participants reported significant changes in their drug-taking behavior six months later, with 80% documenting the change.

The Follow-up Process

To emphasize the importance of the project's evaluation efforts, participants were informed at the conference that they would be contacted for follow-up by mail and might be asked to participate in a telephone or in-person interview as well. To improve the possibility of locating participants for the six month follow-up, they were asked for both residence and busines addresses and phone numbers. Participants were assured of confidentiality, i.e., that neither their names, nor the names of their employers would be used in reporting outcome data without their specific consent. At the time of follow-up, participants were again assured that all information they offered would be reported anonymously, and their most candid responses were requested. All participants who registered at a given conference received a copy of the follow-up questionnaire by mail, including a cover letter (see Appendix 12) explaining the purpose of the follow-up and a stamped, addressed return envelope.

In addition to the mailed questionnaire, telephone and in-person interviews were conducted with a randomly selected group of participants. A twenty percent random sample was drawn from the total population for phone interviews, and another twenty percent were randomly selected for in-person interviews. The personal contact provided the opportunity to solicit elaborations from participants and to collect anecdotal information. The personal contact, especially the in-person interview, also afforded the interviewer an opportunity to validate information gleaned from another interview. When, for example, an individual reported having increased referrals to a particular agency since attendance at the conference, the interviewer could validate the report by contacting the agency mentioned.

Telephone interviews with participants from a particular conference were completed at least one week before the in-person interviews were conducted. This provided the in-person interviewer with information about specific agencies, institutions or the community as a whole. In-person interviews were initially conducted on an impromptu basis. Participants were not expecting the interviewer, and the interviewer was not sure if

the participant still worked or resided at the same address. After two conferences were followed up in this manner and many persons were unlocatable, a system of pre-arranged appointments was employed.

All telephone interviews in 1975 were conducted by one of three group facilitators. These three persons were chosen on the basis of their familiarity with the HPDAEP program and their interviewing skills. The three facilitators attended an orientation session during which the follow-up questionnaire was reviewed, basic telephone interviewing techniques were discussed, and the project's commitment to participant confidentiality was defined. The outcome scores from interviews conducted by telephone did not vary significantly among interviewers, nor were they significantly different from the in-person or mailed follow-up questionnaire scores. The Evaluator or the Evaluation Specialist completed all in-person interviews.

DESCRIPTION OF PARTICIPANT POPULATION, INSTRUMENTS AND FOLLOW-UP

Since January 1974, eighteen two-and-a-half-day general seminars were conducted, inlcuding 706 participants. Complete demographic data are not available for the 248 participants who attended general seminars prior to 1974, because the data collection forms and the pre-post conference evaluation instruments (cognitive, attitude, participant response) were in flux as was the developing program. All but two of the conferences since January 1974 were held for practicing health professionals. Of the other two, one was a community program and the other was for health science students and faculty from the University of Minnesota. Reports on these conferences may be found in Chapter 6, "Special Programs." Nine of the remaining sixteen conferences were held in Minnesota, four were held in Iowa, and one each was held in Wisconsin, North Dakota and South Dakota. These sixteen seminars had 610 participants.

Demographics

Participants were asked to complete a biographical data form attached to the pre-conference instruments (see Appendix 13). The mean age of the 610 participants was 35 with an age range from 16 to 69. Two-thirds of the participants were female, one-third male; 61% of the participants were married, 24% were single and 10% were divorced. One of the primary objectives of the project was to promote interdisciplinary education. Table 10 reports the distribution of professions represented by the 610 participants.

Additional information asked of participants included their reason for attending the conference, their expectations of the conference, whether

they perceived themselves as working in a drug-related job, and whether they had recently started a new job. Tables 11-14 report the frequency and percentage of responses for each of these questions.

Table 10. Distribution of Professions Represented at General Seminars since January 1974

Profession	No.	%
Unknown	6	1.0
M.D.	31	5.1
R.N.	175	28.7
L.P.N.	14	2.3
School Nurse	13	2.1
Nurse Director	28	4.6
Public Health Nurse	13	2.1
Psychiatric Technician	8	1.3
Nursing Assistant	6	1.0
Other Hospital Staff	31	5.1
Pharmacist	44	7.2
Clergy	10	1.6
Social Worker	70	11.5
Alcohol and Other Drug Counselor	38	6.2
Educator	32	5.2
Psychologist	11	1.8
Health Science Student	14	2.3
Youth Worker	6	1.0
Court Services and Probation	7	1.2
Drug Educators	8	1.3
Other	45	7.4

Table 11. Participant Reasons for Attending the General Seminar

Reason for Attending	No.	%
Unknown	1	0.2
Uncodable*	53	8.7
Job-related interest	392	64.3
Community interest	40	6.6
Personal interest	86	14.1
Required by employer	10	1.6
To become more familiar with HPDAEP	9	1.5
Curiosity	5	0.8
Other	14	2.3

*These persons checked two or more responses and thus their reasons for attending were not categorically codable.

Table 12. Participant Expectations of the General Seminar

Expectations of the Conference*	No.	%
Unknown	38	6.2
Don't know	3	0.5
To learn	75	12.3
To learn about chemical dependency	260	42.6
To learn about the chemically dependent person	79	13.0
To learn about drugs	67	11.0
To learn treatment alternatives	179	29.3
To discuss attitudes	74	12.1
To learn about referrals	44	7.2
Other	141	23.1

*Up to two expectations were coded for each participant

Table 13. Percentage of Participants Working in Drug-related Jobs

Perceived or Described Self as Working in a Drug-related Job	No.	%
Unknown	28	4.6
Yes	201	32.9
No	381	62.5

Table 14. Percentage of Participants Who Had Started New Jobs

Recently Started New Job	No.	%
Unknown	7	1.1
Yes	153	25.1
No	450	73.8

Instruments

Immediately before the conference and immediately after, participants were asked to complete the cognitive, attitude and participant response questionnaires (see Appendix 14). These questionnaires were altered and added to as the two-and-a-half day workshop program developed. Just as

the program was solidified by January 1974, so too were the pre- and post-conference instruments. The only exception was the cognitive test which went through changes into 1974. Thus, cognitive scores from the first two conferences are not comparable to scores from the latter fourteen conferences.

Attitude Inventory. The attitude inventory is a nineteen-item questionnaire with an optimal possible score of 76.00. Figure 3 graphically represents the pre- and post-conference mean scores by conference.

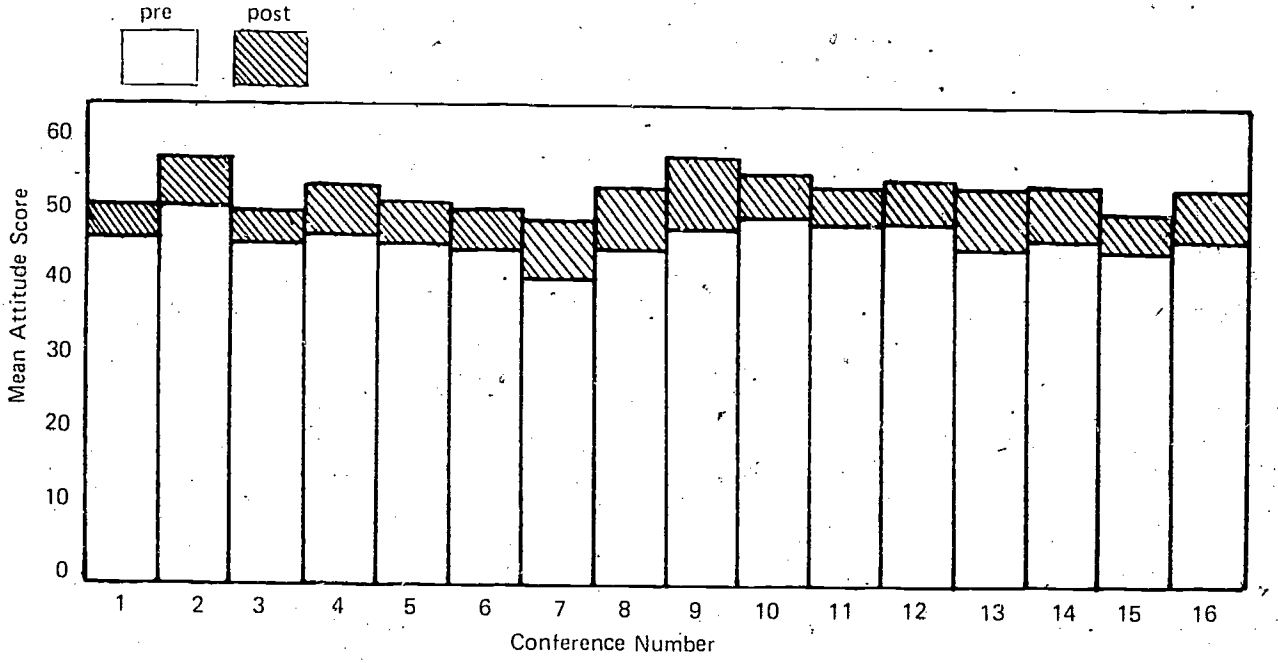

Figure 3: Mean Attitude Scores: Pre- and Post-Conference

Cognitive Instrument. As mentioned earlier, the cognitive test went through a number of developmental phases. The instrument used for Conferences 1 and 2 is not comparable to that used for later conferences. For Conferences 3, 4, and 5 the cognitive instrument had an optimal possible score of 24.00; for conferences 6, 7, and 8 the optimal score was 35.00; for the remaining conferences the optimal possible score was 37.00. Due to this descrepancy, the pre- and post-conference scores will be represented in Figure 4 by mean percentage of correct responses for each conference.

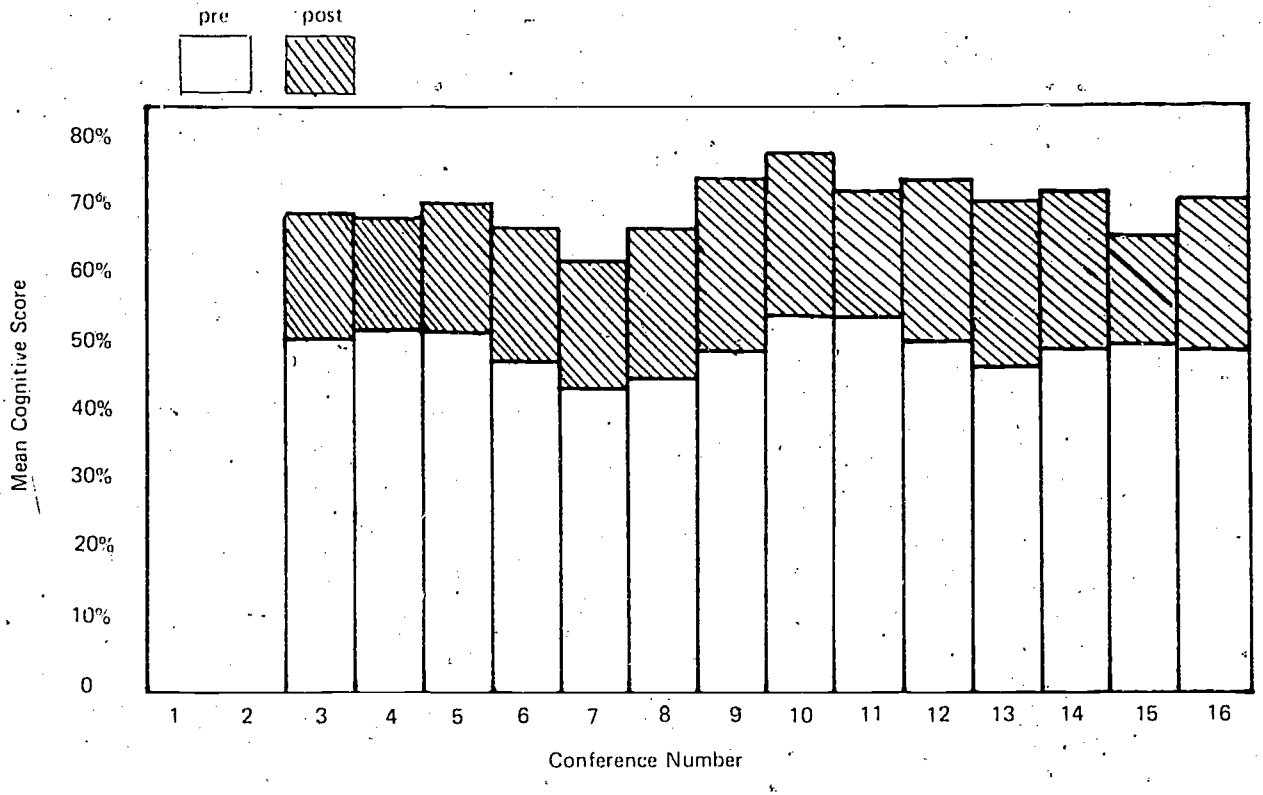

Figure 4: Mean Cognitive Scores: Pre- and Post-Conference

Participant Response Instrument. The participant response questionnaire includes thirteen questions relating to participants' confidence levels and skills. The optimal possible score is 78.00. Figure 5 reports the pre- and post-conference mean scores. Conference 15 is excluded because the participant response instrument included on its pre- and post-tests was inadvertently that for a community program and not pertinent to the health professionals who attended the conference.

Post-conference Evaluation Forms

Immediately following the last session of the HPDAEP general seminar, participants were asked to complete the post-conference attitude, cognitive and participant response instruments. Attached to this set of instruments was the post-conference evaluation form (see Appendix 8). The following

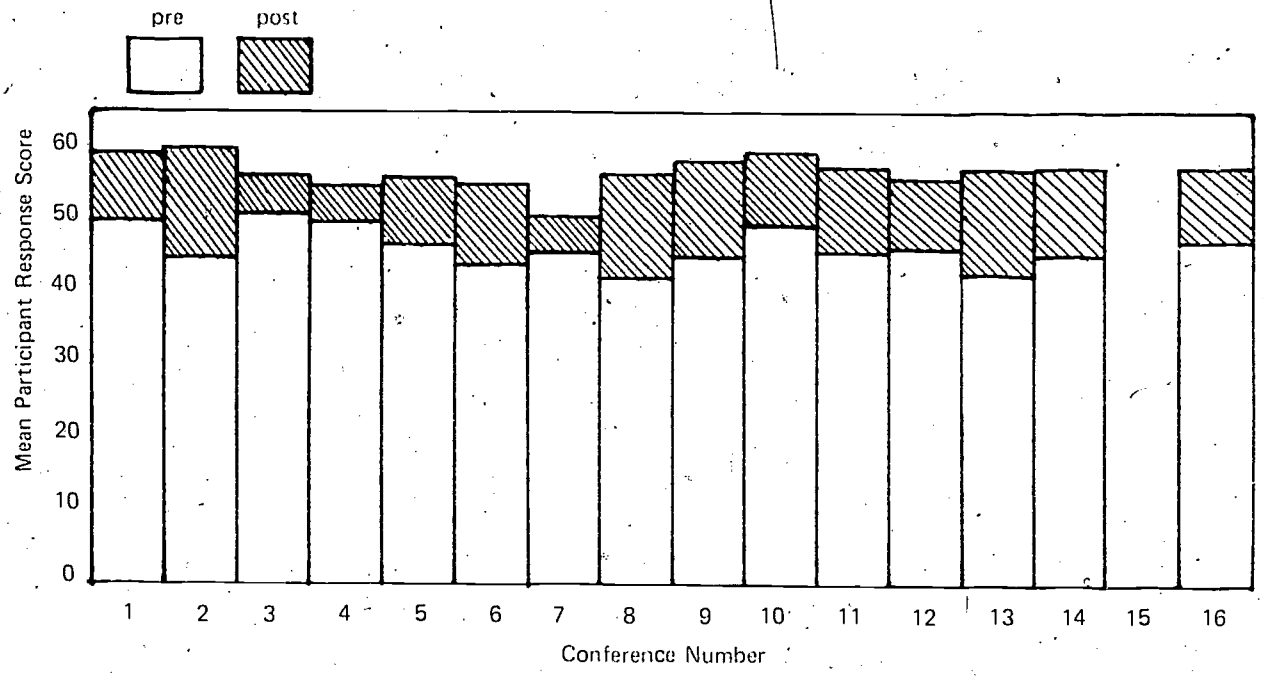

Figure 5: Mean Participant Response Scores: Pre- and Post Conference

will discuss questions 1-2 regarding small group activity, questions 5A-5C, and the report on the "Happy Face" or participants' overall feelings about the conference.

Small Group Feedback. Each participant was asked how comfortable he/she felt in the small group and how helpful their group facilitator was. This information, along with participants' overall feelings about the conference (Happy Face), was reported to the small group facilitators after each conference by means of the Facilitators Feedback Report.

The first question regarding small groups was "How comfortable did you feel in your small group." The response categories ranged from very uncomfortable (0) to very comfortable (4). The second question asked how helpful they felt their small group facilitator to be. The response categories were again 0-4, or unhelpful to helpful, respectively. Facilitators were also given an indication of how the persons in their respective groups rated the conference as a whole by means of the Happy Face question.

The response categories ranged from unhappy with the conference (0) to happy with the conference (4). Table 15 reports the mean responses to these questions by conference.

Table 15. Feedback to Group Facilitators

Comfort Level with Small Group
(Response Categories: 0 to 4, Uncomfortable to Comfortable)

Conference	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Mean	3.42	3.74	3.45	3.31	3.29	3.43	3.23	3.38	3.52	3.17	3.66	3.44	3.42	3.59	3.55	3.07	3.34

Helpfulness of Facilitator
(Response Categories: 0 to 4, Unhelpful to Helpful)

Conference	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Mean	3.14	3.37	3.45	3.49	3.24	3.40	3.11	3.44	3.46	3.17	3.41	3.44	3.12	3.49	3.24	3.13	3.44

"Happy Face" Indication of Overall Feelings About the Conference
(Response Categories: 0 to 4, Unhappy to Happy

Conference	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Mean	3.42	3.84	3.60	3.61	3.34	3.75	3.23	3.52	3.80	3.67	3.63	3.75	3.40	3.81	3.65	3.24	3.61

Change in Attitudes Resulting from Participation in the Workshop. Participants were asked to rate to what extent they felt their attitudes changed toward the use and abuse of (1) social drugs, (2) illicit drugs and (3) prescription drugs. Table 16 reports the mean responses, by conference, to questions 1 through 3.*

Most and Least Helpful Aspects of Seminar. On the evaluation forms completed at the end of the general seminar (see Appendix 8), participants were asked to state what in the workshop was most helpful to them, what was least helpful, and what suggestions they would offer for changes in the seminar. All these questions invited open ended

Table 16. Change in Attitudes Toward Social, Prescription and Illicit Drugs

Change in Attitude toward Social Drugs
(Response Categories: 0 to 4, No Extent to A Great Extent)

Conference	6	7	8	9	10	11	12	13	14	15	16	17
Mean	2.52	2.21	2.38	2.56	1.89	2.00	2.26	2.17	2.53	2.42	1.74	2.08

Change in Attitudes toward Illicit Drugs
(Response Categories. 0 to 4, No Extent to A Great Extent)

Conference	6	7	8	9	10	11	12	13	14	15	16	17
Mean	2.52	2.39	2.64	3.09	2.23	2.28	2.57	2.28	2.60	2.85	2.30	2.11

Change in Attitudes toward Prescription Drugs
(Response Categories: 0 to 4, No Extent to A Great Extent)

Conference	6	7	8	9	10	11	12	13	14	15	16	17
Mean	2.35	2.05	2.18	2.40	2.04	1.61	2.14	1.78	2.21	2.33	1.67	1.80

*Questions 5a, 5B, and 5C were not included on the evaluation form for conferences 1 through 5, thus will not be included in the table.

responses from participants and were later collapsed into categories. Some participants cited more than one item, and some cited none. This was especially true for the questions regarding least helpful aspects and suggestions for change.

The section of the workshop most frequently indicated as most helpful was the session on diagnostic interviewing techniques, cited by 214 of the 706 participants, or 30.3%. This included the lecture on interviewing techniques, as well as the two hour lab session where participants interviewed a person with a chemical problem and the person's spouse (both parts were role played by group facilitators). The second most frequently cited part of the program was the lectures dealing with attitudes and values clarification. Out of 706 participants, 120 (17.0%) indicated these to be the most helpful part of the workshop.

The area most frequently cited as least helpful was the section on the law and legal ramifications, which was noted by 73 (10.3%) of the participants. The second most frequently cited part of the program was the small groups, indicated by 63 (8.9%) participants. Both of these areas represent a small proportion of the total 706 participants, and a number of participants noted that everything in the workshop was helpful.

Suggestions for Changes in the Seminar. It was important to the HPDAEP program staff to solicit suggestions for changes in the seminar to make it more beneficial for health professionals. These suggestions were collapsed into categories for the purpose of reporting back to staff. Interestingly, most often no suggestions were offered. Many participants stated that the seminar was adequate as presented. However, the comment made most frequently was the request for more free time available during the 2½ days. This was cited by 64 (9.1%) of the 706 participants. One of the reasons for requesting more time was that with so much material presented, time for periodic assimilation would have been helpful to avoid stimulus overload. Some participants would have appreciated more time to meet and share ideas with other participants. The second most frequently offered suggestion was spending less time in small groups, which was cited by 33 (4.7%) participants. The elaborative comments were similar to those suggesting more free time, i.e., that the intensity of absorbing material from the lectures and immediately breaking into small groups for discussion allowed little time to digest the material presented.

SUMMARY OF OUTCOMES

To determine the outcome effects of the project, it is necessary to look at the changes made by participants. The questions included on the follow-up questionnaire were grouped into the fourteen outcome goals of the project. The percentage of responses for each question category are reported in Appendix 15. The fourteen outcome goals were then divided into three different categories: (1) those which related to professional practice or management of drug-related problems with clients, (2) those which involved personal action within community or institutional settings, and (3) those which related to personal and family activities. The follow-up responses were then averaged for each of these categories. The averages were calculated for: (1) those persons indicating the question was not applicable to them, (2) those indicating a level of response in the desired category, (3) those indicating that this activity had changed since their workshop participation and was related to their participation, and (4) those indicating that their current activities were not in the desired categories. The table in Appendix 16 shows the percent of response by category of goal and the means of these responses.

Twenty-four percent of the participants indicated that the first category, goals applying to a client relationship, was not applicable to them. Of the remianing 76%, 31.2% reported a change in their activities and attributed some or all of this to conference participation. Thus, of total conference participants, about 23.8% reported changes attributable to the conferences. This does not mean that only 24% of the participants were practicing the desired activities but that 24% had changed these activities subsequent to the conference and attributed that change to conference participation.

The largest achievement of outcome goals was in the category relating to personal activities. These goals averaged 82.5% success, with participants reporting that the workshop was helpful to them in working with family members and friends, in making them more aware of their own drug-taking behavior, and in better understanding the effects of their attitudes towards drugs, drug users and drug abusers. Twenty-one percent of the participants reported a decrease in their social drug usage, another 3% a decrease in illicit drug use and 5% in prescription drug use. Affecting personal drug use was not included in the original goals of the project. However, in early follow-up interviewing, several participants reported significant changes in their own drug usage because of their participation in the workshop. Subsequently, the questions were added to the follow-up instruments, and virtually 25% of the participants reported a decrease in their own use of social, prescription or illicit drugs. Eighty-two percent of these cases were documented with specific details or explanations of the change.

The third category of goals, those involving community and institutional change and personal activity in the community, involved the least change of the three broad categories. An average of 21.9% of participants attributed changes in this category to the conference. The least goal achievement in this category related to participants increasing their involvement with community drug agencies; on this goal only 12.3% of the participants reported a change attributable to the conference. Twenty-five percent reported that they attempted or effected change regarding drug-related problems in their community, and 28.5% reported that they sought further information and/or training regarding drug use and/or abuse since the workshop.

Overall, participants reported the biggest changes as a result of their participation in the workshop in their personal lives, the secondary changes in their work lives, and the least change in their community activities. Between twenty and twenty-five percent of the participants did not find the work-related goals of the workshop applicable to their job situations; 43% found two other goals inappropriate to their job situations: (1) making more appropriate prescriptions, recommendations, or utilization of psychoactive prescription drugs and (2) making more appropriate and

an increased number of referrals for drug-related problems. Roughly one-fourth of the participants felt that the conference's major objectives were not applicable to them; another fourth changed in the direction stated as desirable in the original goals of the workshop; about 31% already exhibited the desired behaviors prior to the workshop; and the remaining fifth were people for whom the goals were applicable but apparently not achieved as a result of the workshop.

In regard to the goals relating to work activities, about 56% of the total respondents at follow-up indicated achieving the desired outcomes. From this group roughly 25% attributed that change to the conference, and those remaining indicated no change from before the conference. Data on the community activities category showed that 27.5% of the population were exhibiting the desired activities at the time of follow-up. Eighty percent of this group attributed their current activities to their workshop participation.

Analysis

Analysis involves looking at relationships within the project in order to analyze what changes are taking place at the conferences. Such information should allow better targeting of future projects and more appropriate use of techniques. Two principal tools were utilized in analyzing the relationships: multiple step regression and factor analysis. The responses for each question were regressed against participants' pre-conference scores on attitude, cognitive and participant response instruments and on post-conference scores in the same three areas. The responses were also regressed against the change scores in these three areas, as well as other items including conference attended, age, profession, drug-related jobs, new jobs, and against responses to evaluation questions 1, 2, 13 and 5A, 5B, and 5C (see Appendix 8).

An overall outcome score was developed. This score was based on the extent of change attributable to the conference by participants for each question under a goal. A participant who recorded an item as not applicable was given the mean score of all participants on that question. This mean value did not change the mean of the group, but neither was the participant treated as having zero score on the question. This approach sets up the analysis on the basis of change relating to participation as opposed to an absolute level of activity. Likewise, the score favors participants who had the items of highest applicability. One would expect participants whose work involves prescribing and/or administering drugs or direct counseling and referral to score higher on the summative score. Thus, it was no surprise to find that the highest r^2 value contributing to the outcome score was drug-related job. This variable accounted for 10% of the outcome score. However, this relationship should be viewed as a construct of the outcome score and the outcome instrument rather than a

significant process factor. It does indicate, however, that to have a high group score, one needs an appropriate audience with jobs related to the goals desired.

In addition to the relationship of the drug-related job to total outcomes score, two other areas are of related significance. One is the response to the evaluation questions, particularly the expression of a change in attitude towards social drug use and abuse (evaluation question 5A) and prescription drug use (evaluation question 5C), along with the happiness index of evaluation question 13 and the small group comfort level index of evaluation question 1. These questions taken together accounted for 25% of the change in the outcome scores. They had a combined r^2 value of 25.97 (cases = 78) with evaluation 5A being the highest, followed closely by evaluation question 1 and evaluation question 13. The other important relationship to total outcome score was that of the change score factors on cognitive change, participant response change and attitude change. An earlier analysis of the data looked at total participant response on absolute levels of activity in relationship to conference as the basis of the outcome score, and hence, it is not surprising to see that this related to the change in cognitive score, participant response score and attitude score. The combined r^2 of these change variables accounted for 13.7% of the variance in outcomes. The change in these three scores as a group had the highest correlations with outcome score; they had correlations of .3577, .2427, and .2532, respectively. Pre-conference cognitive score of -.3681 was the only other factor higher than these. Interestingly, the correlation with post-conference cognitive score is -.0707. Thus, although change in cognitive score is important in outcome scores, the high cognitive scores are not responsible for the outcome change. (This supports the speculation that those with high cognitive scores are already carrying out the desired activities and experience little change.) These relationships become more clear when looking at the factor analysis of the data.

The structure matrix of an oblique rotated factor analysis indicated some clear relationships among the data. Six factors clearly emerge from the rotation. Tnese six factors, along with their principal and secondary factor loadings, are contained in Table 17.

From these six factors one can begin to see some of the dynamics of change taking place at the conferences. The main influence on outcome behavior was related to the amount of change a participant achieved from pre- to post-conference on the cognitive instrument. Participants with low pre-conference cognitive scores had an opportunity for change during the conference; thus, the relationship between the low pre-conference cognitive score and the change score is logical. It appears that the first factor in the

Table 17. Factors

	Factor Load
Factor: Perceived Change in Attitude of Participants	
Evaluation 5A	.8668
Evaluation 5B	.6078
Evaluation 5C	.6523
Age	−.3137
Post-conference Attitude Score	.2980
Change in Attitude	.2565
Change in Cognitive	.2113
Evaluation 13	.2844
Factor: Conference Enjoyment and Comfort	
Evaluation 1	.5831
Evaluation 2	.6862
Evaluation 13	.6306
Post-conference Participant Response Score	.2296
Factor: Outcomes	
Outcome Score	−.7414
Pre-conference Cognitive Score	.6136
Change in Cognitive Score	−.5664
Conference	.2408
Evaluation 1	−.2464
Evaluation 5C	−.2204
Profession	−.2127
Factor: Job Related	
Drug-related Job	.6129
New Job	.5453
Conference	−.4190
Change in Cognitive Score	.2302
Evaluation 1	−.3407
Factor: Attitude Change	
Change in Attitude Score	.8617
Post-conference Attitude Score	.5808
Outcome Score	.2300
Factor: Participant Response Change	
Change in Participant Response	.9258
Pre-conference Participant Response Score	−.6842
Change in Cognitive Score	.2572
Post-conference Participant Response Score	.2057
Pre-conference Attitude Score	−.1965
Outcome Score	.1964

participant's change in behavior was a change in his/her knowledge or reference base about drugs. In the earlier analysis, cognitive change appeared to be virtually unimportant in relation to levels of activity. Here, when comparing the correlation between post-conference score and outcome score, the relationship is almost zero. Since there is a strong correlation between pre and post cognitive scores (r = .733) and between change in cognitive score and post cognitive score (r = .528), but virtually no correlation between post cognitive score and outcome score (r = .07), one sees the effect of the outcome score being based on changes taking place as opposed to assessing achievement at a certain level. Thus, participants coming into the conference with high activity tended also to have high pre- and post-conference activities and thus would have a fairly low outcome score. However, another group of participants with low outcome scores did not have high pre-conference activity associated with them. These persons tended also to have lower pre-conference cognitive, attitude and participant response scores. Thus, this group had the best opportunity to exhibit change on outcome scores, cognitive scores, and attitude scores.

The second factor influencing outcome scores was the attitude factor. This factor had the second highest loading on outcome scores, with a high change in attitude score of .86 followed by post-conference attitude loading of .58. The third heaviest loading of outcome scores was on the change in participant response factor. Hence, change in outcome activity brought about by conference participation appears to be due first to change in cognitive knowledge, secondly, to a shift in attitude, and third, to the participant response perceived. However, participant response loads with the enjoyment and comfort level factor and the change in attitude factor. Post-conference attitude loads high with the participant's perceived change in attitude toward drugs, as well as with age and with the happiness index. Thus, participants appear to be aware at a cognitive level of changes taking place in both knowledge and attitude. This supports the concept that the cognitive information would bring about an attitude shift and that the two working together would bring about an outcome change. If participants not already practicing desired activities became aware of what they should be doing through cognitive gain and, through such information, changed their view on drugs and realized that their attitudes were shifting, one would expect to find the kind of loading one finds on the perceived change in attitude factor. Since this was a major emphasis of the conference, it is not surprising to find the happiness index also loading on this factor.

However, age also loads on this factor, and this is virtually the only factor in which it loads significantly. There is a correlation of -.07 between age and outcome score. Age correlates most highly with pre-conference attitutde score at -.310 and next highest with post-conference

attitude score at -.265. However, its correlation with change in attitude is .003. Thus, younger persons tended to score higher on the pre-conference attitude instrument, but the change in attitude score was unrelated to age and the post-conference attitude score correlates somewhat lower with age. Therefore, age appears not to be a significant factor on any issue except the evaluation questions 5A, 5B, and 5C, where its correlations are -.299, -.162, and -.146, respectively. The correlation with evaluation question 13 is -.244. Hence, there is some relationship between age and happiness with conference and between age and perceived change. Conference attended has some light loadings with other factors, but its main loading is with the job-related factor, as are profession, drug-related job and new job. Since conference attended loads so heavily with drug-related job and new job, and given that the outcome instruments were skewed toward drug-related jobs, it would be difficult to find any other relationships between conference attended and scores or changes in any of the attitudinal, cognitive, and participant response areas that would not have major interaction effects with drug-related job.

The major question that remains is: why was it that about half of the participants who felt the questions applicable to them scored significant cognitive, attitudinal, and participant response changes and, concomitant with that, outcome changes, and the other half did not? There is nothing in the factor tables or in the step regression of outcome scores that gives a clue to this question. There are several isolated clues in the individual regressions of outcome questions.

One item that stands out in analyzing the individual questions and changes related to the conference deals with involvement in voluntary activities. Persons who subsequent to participation in the conference became involved in volunteer activities in the community had a very high enjoyment index or happy face relating to the conference. The correlation between those marking a high happiness index and beginning to participate in volunteer activities subsequent to the workshop equals .707 with an r^2 of .468. Hence, virtually half of the variance of those persons involved in voluntary activity subsequent to the workshop was accounted for by the person's happiness with the workshop. Whether they attributed the changes in outcome question 14 to the conference related highly with the degree of comfort in the small group, that is, evaluation question 1. Evaluation question 1 in the multiple regression had an r^2 of .319 in relationship to the dependent variable of question 14 on the change attributed to the conference.

The most important conference variable relating to change in subsequent activities was the change in cognitive knowledge; change in attitude was a secondary influence. Age, profession, sex, and marital status were not important change variables. However, working in a drug-related

job provided the opportunity to score higher on outcome activities. Also associated with subsequent change were the comfort and happiness levels expressed by the participant and the extent of perceived attitude change reported by the participant at the close of the workshop. The data at this time do not answer the question of why half the potential change group changed in cognitive knowledge and in relation to the desired outcome and why the other half did not. The substance of this question is a research project in and of itself.

Chapter 6
Special Programs

During the last year of HPDAEP the staff tried new adaptations of the general seminar content. This chapter reports on three adaptations to special audiences. The first section discusses offering the general seminar as a community organization and education device. The second section discusses offering the program to health science students and faculty. Finally, offering the content in shorter term inservice programs is discussed.

EXPANDING THE GENERAL SEMINAR TO COMMUNITY-WIDE PARTICIPATION

Earlier chapters of this report explain the attempt to use health professionals as community change agents. Chapter 3 describes how early program emphasis on community organization changed to a more realistic expectation that the health professionals would accomplish personal, professional and institutional changes.

In October 1974 the HPDAEP program director decided to pursue an attempt to effect community change. Shelly Kranz, health educator working for the Region D Area Health Education Consortium, was involved with a group of community members in Brainerd, Minnesota, who wanted to design drug education for that community. Two members of the community group had attended a November 1973 HPDAEP seminar. Ms. Kranz contacted HPDAEP, and meetings with the group began on November 7, 1974.

Utilizing concepts of community and social change,[1] HPDAEP staff

[1] Detailed in two books by Luther Gerlach and Virginia Hine, *People, Power, Change* and *Lifeway Leap – The Dynamics of Change in America.*

provided organization, education and evaluation expertise to help the group attempt change in the community. The group eventually became known as the Crow Wing County Drug Council and was responsible for identifying and recruiting key community members to participate in a modified HPDAEP general seminar. Monies for the seminar were generated by $25 participant registration fees and funds provided by HPDAEP and the Area Health Education Consortium.

Using a face-to-face recruitment method, the council members gained commitments to attend the conference from key law enforcement officers, school principals and counselors, health professionals, health care administrators, social service personnel, county and city officials, parents and civic leaders. To ensure appropriate programming, HPDAEP staff members interviewed nearly three-fourths of the individuals prior to the workshop.

The conference took place March 6-8, 1975, at a retreat center sixty miles from Brainerd. Didactic presentations and interdisciplinary small group discussions were employed throughout the conference. Since the conference focus was on gaps in community services for alcohol/drug problems, a variety of special workshops were offered during the two and a half days. These workshops were conducted by practitioners skilled in:

—utilization of a "Community Needs Assessment Monitor"

—crisis intervention and overdose first aid

—development of youth programs

—methods for implementing innovative treatment modalities

—residential treatment options

—programs for business and industry

—alternative programs for the criminal justice system

—alternative programs for the school system

Evaluation

Participants were asked to complete pre- and post-conference attitude, cognitive and participant response questionnaires. With the exception of the participant response questionnaire, which was modified to pertain to a community workshop, the questionnaires were the same as those used for all other HPDAEP seminars (see Appendix 14). These instruments provided the program staff with information regarding change from pre- to post-conference.

The optimal possible score as well as the mean pre- and post-conference scores are reported in Table 18. Calculation of the dependent

t-test indicates the change for each instrument to be significant of the .001 level.

Table 18. Brainerd Community Workshop: Pre- and Post-conference Test Scores

Instrument	Optimal Score	Mean Pre-conference	Mean Post-conference
Cognitive	37.00	16.29	22.40
Attitude	76.00	44.31	49.42
Participant Response	78.00	53.96	59.56

One month prior to the workshop, a telephone survey (see Appendix 17) was conducted with 92 persons whose names were selected from a 1974 Crow Wing County Directory. The most serious health problems in the county were reported to be alcohol misuse and heart disease. Seventy-one percent of the respondents thought there was a drug problem in Crow Wing County, and most persons reported that the problem was too many young people on drugs. When asked what was being done to alleviate the problem, 38% reported that they didn't know and another 22% felt that nothing was being done in the county. When asked about treatment centers available for dealing with chemical dependency problems, 45% reported that they knew of none in the county and 26% reported knowledge of Brainerd State Hospital. Sixty-three percent of the persons interviewed felt there was a need for additional facilities in their area.

Five months after the conference the telephone survey was conducted again, reaching only 80 of the original 92 persons contacted pre-conference. A few questions were added to the interview form to determine if residents of the county were aware of the Crow Wing County Drug Council. At this time 76% of the respondents thought there was a drug problem in Crow Wing County, and most of these reported the problem to be use of illicit drugs. Thirty-one percent reported that they didn't know what was being done to alleviate the problem, and 25% reported that law enforcement officials were working to alleviate the problem.

A shift occurred from pre- to post-conference survey when respondents were asked to which facility they would refer someone with a chemical dependency problem. Before the conference, 26% reported they didn't know, 17% reported they would refer someone to Brainerd State Hospital, and another 17% said they would refer someone to their physician. After the conference, 20% reported they didn't know, while 40% reported they would refer someone to their physician.

Fifty-one percent of the persons interviewed the second time reported they had heard of or had some contact with the Crow Wing

County Drug Council, but only 39% of these reported that contact to be something other than the pre-conference telephone interview. The most frequent suggestions for the Crow Wing County Drug Council were (1) get rid of drugs, and (2) get rid of drug pushers.

Five months after completion of the workshop, 50% of the participants (n = 24) were randomly selected for an in-person follow-up interview (see Appendix 18). At the time of the interview, 80% of those interviewed reported that they had attempted to distribute drug information to friends and/or colleagues since the workshop, and 70% reported having encouraged others to visit and/or help drug agencies since the workshop.

Fifty percent of the respondents reported that since the workshop they attempted to or did effect procedure or policy changes within their institutions regarding drug-related problems. Examples: one of Brainerd's hospitals is exploring the possibility of opening a chemical dependency treatment unit, and law enforcement officers in the area are referring more persons for chemical dependency counseling as an alternative to immediate arrest.

Sixty percent of the past participants reported that the workshop was helpful or very helpful in handling situations with family or friends concerning drug-related problems. Changes within the community since the workshop include the participation of 168 members of the community in a Parents Are Responsible Program (PAR) in April 1975. The PAR program was introduced to the community at the March seminar conducted by HPDAEP. Participants at that workshop were also told about the Communication Skills Seminar offered by Metro Drug Awareness, Minneapolis Health Department. After the workshop, two members of the Drug Council invited Metro Drug Awareness to present their seminar. It was conducted in the summer of 1975 and was attended primarily by Brainerd area school personnel.

Five members of the community (three of whom attended the March seminar conducted by HPDAEP) attended a training program at the Office of Education, Regional Training Center in Chicago, funds for which were provided by a grant from the Minnesota Department of Education. A Drug Education Consultant reported that the State Department of Education plans to continue working with school personnel in the Brainerd area as a result of the community's interest in additional educational and prevention information for dealing with chemically-related problems in the schools.

Recommendations

1. According to evaluation findings, this program achieved more community change than HPDAEP programs that dealt only with health professionals. Precise geographical targeting and education of key com-

munity members appear to be the key ingredients in programs of this type.

2. The desire of this community to implement prevention programs is encouraging. It is recommended that federal and state funding sources consider implementation of community organization and education programs as catalysts for community-based prevention programs based on this model used in Crow Wing County. This model moves beyond the Regional Training Center concepts. Instead of training community teams in groups of 5 to 7, this model of training 45 to 50 key community members deserves further investigation.

3. Future projects of this type should consider the need for extensive post-conference technical assistance. Statewide technical assistance capabilities should be assured if projects of this type are funded in the future.

4. Existing community groups could be used as the community force to recruit and mobilize key people. Four more community groups expressed a desire to sponsor similar community education programs in their areas, but HPDAEP was unable to fill the requests due to lack of funds.

A paper which presents additional information on this community conference can be obtained from:

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GENERAL SEMINAR FOR FACULTY AND STUDENTS, UNIVERSITY OF MINNESOTA HEALTH SCIENCES

During the summer of 1974 plans were formulated to sponsor a HPDAEP general seminar for faculty and students. Directors of the University of Minnesota Drug Information and Education Program (since renamed Office of Alcohol and Other Drug Abuse Programming) requested that the HPDAEP staff develop and implement plans for recruiting an appropriate interdisciplinary audience of students and faculty. The directors suggested that the same program developed by HPDAEP for practicing health professionals be offered for the students and faculty.

Five schools were selected to participate in the conference. Meetings were held with deans and interested faculty from the Schools of Pharmacy, Nursing, Social Work, Public Health and Medicine. Recruitment and

publicity procedures varied within each school, depending on the suggestions of each administrative contact. Active recruiting began in late September, and by early December, 99 students and thirteen faculty had submitted registrations for attendance. Table 19 notes the distribution of these registrations.

Table 19. Seminar for Health Sciences Faculty and Students: Distribution of Registrations

School	Number of Faculty	Number of Students
Pharmacy	3	19
Medicine	3	16
Nursing	4	16
Public Health	2	20*
Social Work	0	18
Other	1	10

*15 of these 20 were public health nursing students

The Drug Information and Education Program (DIEP) provided $2,000 to be used for programming and evaluation. A maximum of 55 participants could be accepted, and the staff decided to accept registrations on an equal basis from each of the five schools. Two faculty and nine students (who had some level of clinical experience) were accepted from each school. Priority was given to early registrations. The HPDAEP office received more than twenty calls from rejected registrants to ask if another program could be offered in the future. Fifteen letters were received in December from students who did not submit registrations but requested that another program be offered in the future.

The conference was held December 12-14, 1974, at Camp Courage near Maple Lake, Minnesota (50 miles from Twin Cities), providing a residential environment similar to those for other seminars. Agenda and objectives for this program were exactly the same as for other conferences offered under General Seminar Format #5 (see Chapter 3).

Small group assignments were made with the primary goal of providing an interdisciplinary mix. Staff facilitators noted during and after the conference that much of the small group discussion centered on professional roles, stereotyping and interdisciplinary cooperation. One facilitator said of his group, "I started having some concerns by the fourth session because there was so much discussion on interdisciplinary issues. I felt that they might not deal adequately with attitudes and issues about drug use — the major focus of the seminar." Another facilitator reported, "The first two sessions were amazing. One of the students looked at one of the other participants and said, 'I've never met a pharmacy student before; what is it that you people do?'" Similar reports by other facilitators were viewed

by program staff as resulting from the best interdisciplinary representation ever attained for a HPDAEP general seminar.

After the conference, the DIEP office reported that they were "flooded" with student requests for similar programs, but due to lack of program money, no further workshops of this type could be made available. HPDAEP staff suggested that outcome results be collected and analyzed for use in making decisions about offering similar programs in the future.

Evaluation

To determine short-term change as a result of the conference, participants were asked to complete both pre- and post-conference attitude, cognitive and participant response questionnaires. The optimal score possible as well as the pre- and post-conference mean scores are reported in Table 20. Student's t-test was calculated indicating the change for each instrument to be significant at the .001 level.

Table 20. Seminar for Health Sciences Faculty and Students: Pre- and Post-conference Test Scores

Instrument	Optimal Score	Pre-conference Mean	Post-conference Mean
Attitude	76.00	50.46	55.40
Cognitive	37.00	20.35	28.90
Participant Response	78.00	46.02	58.81

Since conference participants represented both health science students and faculty, the mean scores were also separated by faculty and students and are reported in Table 21. A total of 53 persons participated in the workshop; however, three persons did not complete their pre- and post-conference questionnaires.

Table 21. Seminar for Health Sciences Faculty and Students: Faculty Scores and Student Scores

Instrument	Faculty N=10		Students N=40	
	Pre-conference Mean	Post-conference Mean	Pre-conference Mean	Post-conference Mean
Attitude	49.10	52.00	51.20	56.10
Cognitive	19.00	25.50	19.12	26.92
Participant Response	47.20	54.80	46.08	59.60

Six months after the workshop, all participants were mailed a follow-up questionnaire. Sixty-eight percent of the participants returned the questionnaire completed. In addition to the 100% mailing, 20% of the participants were randomly selected for a telephone interview, and another 20% were randomly selected for an in-person follow-up interview. All of the telephone interviews were completed. The in-person interviews began after May 1975, and many of the students were unlocatable; consequently only 11% of the random sample completed the in-person interviews.

Because the follow-up questionnaire was designed for practicing health professionals, slightly more than 54% of the participants reported that the questions regarding screening, effectiveness and referrals did not apply to them. With regard to attempting or effecting procedure or policy changes within their institutions, two participants (4%) reported that definite changes had occurred since the workshop, and four persons (8%) reported that small changes had occurred.

Two persons (4%) reported that through their efforts since the conference, small changes had apparently occurred within their communities regarding drug-related problems. All other respondents reported that no attempts had been made to effect change since the workshop.

When asked if the workshop was helpful in handling drug-related situations with family and/or friends, of the 43 persons who responded, ten persons (23%) reported "very helpful," 54% reported "helpful," and 23% reported that the workshop provided no help that they were aware of. With regard to use of social drugs, 19% reported a decrease in use since the workshop, 2% reported an increase and 79% reported no change or that they didn't use any social drugs.

Regarding use of illicit drugs, two respondents noted an increase in their use since the workshop, two reported a decrease, and the remaining 39 respondents reported no change or that they didn't use any illicit drugs. None of the respondents indicated an increase or decrease in use of psychoactive prescription drugs at the time of follow-up.

Fifty-one percent of the respondents indicated they had obtained further information regarding drug use and abuse since the workshop, and three persons (7%) reported having attended other drug training programs since their participation in the HPDAEP general seminar.

Recommendations

1. Since the follow-up instrument is biased towards the practicing health professional, it would be helpful to re-survey the student population after they have graduated. Suggest a longitudinal study of the 45 student participants and compare data with a

longitudinal study of the 44 students who submitted registrations but were rejected due to fiscal and program constraints.

2. Chemical dependency and drug misuse is an excellent topic for interdisciplinary education. Based on the communication patterns among participants at the conference observed by staff, health science schools should be encouraged to design a cooperative program in this area and be discouraged from implementing single discipline curriculum in drug use and misuse.
3. Faculty within the health science schools should be involved in any future programs of this type. Comparing pre- and post-conference test scores suggests that faculty may need as much attention as the student population. Faculty post-conference test scores as a group are lower than those achieved by practicing health professionals who participated in the HPDAEP general seminar.
4. Any future programs of this sort should be accompanied by clinical experience (internship) offerings. Trained faculty should be used to help students integrate material through participation in interdisciplinary medication review teams, chemical assessment teams, etc.

TAILORING GENERAL SEMINAR CONTENT TO INSERVICE EDUCATION

HPDAEP received a request in late summer 1974 to sponsor some inservice programs for a group of 40 to 50 public health nurses from Ramsey County (St. Paul, Minnesota). Two of the nurses from this agency had been general seminar participants, and the agency's assistant director requested that the rest of the staff be exposed to similar content.

Objectives and format were established in cooperation with the Ramsey County Nursing Service staff. Eight hours of inservice programs were allotted and presented in three sessions (2 to 3 hours each).

The programs were held on November 18 and December 16, 1974, and March 17, 1975. Seven months after the first seminar, a telephone follow-up interview was completed by an experienced interviewer employed by HPDAEP.

Forty participants completed the pre-workshop forms and a 50% random sample (N = 20) was drawn for follow-up. During the course of the presentations, participants were informed that they might be contacted in the future for a follow-up interview. Participants were assured of confidentiality and were informed that at the time of follow-up they could refuse to participate in the interview.

Table 22. Format of Inservice Programs Adapted from HPDAEP General Seminar

Time in Hours	Activity
.5	Completion of pre-workshop evaluation forms.
1.0	"Attitudes Towards the Use/Abuse of Social, Prescription and Illicit Drugs." An attempt to help clarify some confused societal attitudes toward the use of various psychoactive drugs.
.5	Chemical Break (coffee, tea, cigarettes, etc.)
1.0	"Critical Issues in Trying to Understand the Development of Drug Problems." A presentation to provide some working models for evaluating a person's possible drug problems. Different theories concerning chemical dependency are compared in an attempt to find some commonality.
1.5	"Just What Is Treatment?" "What Kinds of Alternatives Should There Be?" An overview of the variety of treatment modalities that can be utilized in attempting to treat a variety of drug problems. Methods for evaluating treatment agencies for possible referral are presented.
.75	"Diagnostic Interviewing — How to Get the Necessary Information." A presentation designed to provide the content of and the rationale for routine screening of all clients for drug problems.
.5	Demonstration of the use of the diagnostic interview. Simulation of the techniques and questions employed in this type of assessment interviewing. Time is allotted for participants to ask questions about various parts of the interview.
1.75	"Laboratory experience — practice and feedback." Participants are given an opportunity to interview a role player to assess the possibilities of a drug problem. One role player was assigned per nine participants. Critiquing and feedback were done by program staff.
.5	Completion of post-workshop evaluation forms.
8.0	

Evaluation

The interviews were completed by telephone utilizing the same follow-up questionnaire used with general seminar participants (Appendix 10). At the time of follow-up, participants were asked how many of the three inservice programs they attended. Sixty percent (N = 12) attended all three sessions, 35% (N = 7) attended two sessions, and one person (5%) attended only one of the sessions.

Seven months after the initial program, over half of the PHNs always do routine screening for chemical dependency with their clients. Problems are always being documented in charts by 75% of the PHNs sampled. Three-fourths of all referrals are being followed up. Sixty percent of the nurses feel that the agency is offering more services to clients with drug-related problems than before the inservice programs. More than a third have sought further information or education. Finally, two-thirds of all respondents noted that the seminar material was helpful in dealing with drug concerns in their families and social circles.

Recommendations

1. Outcome results of this set of inservice programs have low generalizability to other agencies. This series was tailored to an agency whose staff already realized their chemical dependency services were lacking. Individuals who would like to use HPDAEP materials as inservice programs with "rigid" audiences or agencies will need to spend additional time in attitudinal areas and small group discussion.

2. To better determine base line functioning, parts of the follow-up instrument should be completed by participants before the seminar as well as six months after. Changes in objectives to better meet the needs of a particular agency could easily be incorporated into the testing instruments.

3. Agencies unable to schedule live speakers could utilize video or audio types of program material. Having tapes available to staff during free time and scheduling small group discussions over lunch are two of many ways material could be used. Program consultants are available through CREATE, Inc. to train or supply role players, group facilitators and trainers.

Further information on objectives, content and evaluation of this program is contained in a detailed report available from:

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Appendices
Social, Prescription and Illicit Drugs: Topics in Interdisciplinary Health Education

A Final Report of the

Health Professionals Drug Abuse Education Project

July 1972 — September 1975

William J. Hodapp, Project Director
Robert M. Muscala, Program Director

NIDA Training Grant # 1T15-MH13254
6T15-DA00077

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TABLE OF CONTENTS, APPENDIX

Appendix 1

Learning Objectives and Agenda for General Seminar

(Format #6, Final Model)

GENERAL SEMINAR LEARNING OBJECTIVES

I. *General Objective: To help participants become aware of how their own attitudes toward drugs, drug users and drug abusers affect the health care they provide to clients with drug-related problems.*

Specific Objectives

Participants will be able to . . .

1. discuss their attitudes towards drugs, drug users and drug abusers and how these attitudes affect the health care they provide.
2. describe how they feel their own drug use affects their attitudes toward other drug users.
3. identify two public attitudes which are reflected in the Uniform Controlled Substance Act of 1970.
4. identify at least one prevalent attitude which is likely a result of existing legislation rather than pharmacological effects of the drug.
5. state to what extent, if any, their attitudes have changed toward social, prescription and illicit drugs.
6. state that they are more aware of their attitudes towards drugs, drug users and drug abusers.
7. state that their attitudes greatly affect the health care they

provide to clients with drug-related problems, both negatively and positively.

8. state that the most important factor in assessing the success of any chemical dependency treatment program is determining the therapeutic goals of the program.
9. recognize at least two commonly held attitudes towards treatment of chemical dependency that may prevent clients with drug-related problems from receiving appropriate treatment.

II. *General Objective: To assist participants in developing an understanding of the chemically dependent person.*

Specific Objectives

Participants will be able to . . .

1. recognize at least three characteristics of the state of intoxication that define it as an altered state of consciousness.
2. state that drug abuse is not limited to any life style, age, creed, race, or profession.
3. write an appropriate definition of chemical dependency that at least includes the concept of drug use interfering with life function.
4. recognize two positive and two negative effects of regarding chemical dependency as a chronic problem.
5. recognize an appropriate definition of "enabling."
6. recognize two significant aspects of the Jellinek study of chemical dependency.
7. recognize two significant aspects of a "Public Health Model" of chemical dependency.
8. recognize that at the present time there is no known certain cause of chemical dependency.
9. recognize three common reasons for poly-drug use.

III. *General Objective: To help participants become aware of how they as health professionals can better provide care for clients with drug-related problems.*

Specific Objectives

Participants will be able to . . .

1. recognize three aspects of the health care delivery system that may prevent drug abusers from entering the system.
2. list one way in which they feel their day-to-day behavior may change as a result of the seminar.
3. state that they better understand laws and legal procedures pertaining to their work with clients with drug-related problems.

4. recognize the definitions of two services that should be available in any community for drug problems.
5. recognize an appropriate definition of an interdisciplinary approach to health care.
6. describe one way in which they will attempt to use the information gained at the conference to achieve change in their own community and/or work setting.
7. state the purpose of intervention as getting the client to acknowledge that drug use is having harmful consequences in his/her life.
8. list three coercive intervention strategies as group confrontation, commitment and separation.
9. list at least four noncoercive intervention strategies from the following list:

   Lead own life
   Don't nag
   Reduce enabling (allow negative consequences)
   Seek ongoing supportive help
   Reinforce appropriate behavior

10. simulate the use of intervention strategies with a family member in a role play situation.

IV. *General Objective: To assist participants in discovering methods of obtaining information about their client's drug taking behavior that will have a direct effect on treatment referral options.*

Specific Objectives

Participants will be able to . . .

1. recognize that past attempts to get help are an important consideration in evaluation for possible referral.
2. recognize at least three common mistakes which health professionals may make when making a referral and which likely prevent successful treatment follow-through.
3. recognize two important kinds of information about the place of referral which should be communicated to their clients when making a referral.
4. recognize a proper sequence of events in obtaining information and making a referral.
5. recognize at least three important areas of behavior that should be evaluated in the diagnostic interview for chemical dependency.
6. recognize treatment modalities that could be classified as low, moderate and high structure.
7. demonstrate use of the diagnostic interview in obtaining a thorough drug-taking history in a simulated situation.

V. *General Objective: To assist participants in understanding some of the information and training resources available to them beyond the general seminar.*

Specific Objectives

Participants will be able to . . .

1. state that they better understand the resources available to them for further information and training.
2. list at least one resource available to them for further information and one resource for further training.

AGENDA

General Seminar for Twin Cities Metropolitan Area Health Professionals, Dunrovin Retreat Center, Stillwater, Minnesota, January 16-18, 1975.

Thursday	
3:00 – 5:00	Registration
5:00 – 5:30	Completion of Pre-conference Evaluation Forms
5:30 – 6:30	Dinner and Free Time
6:30 – 7:00	"Glad to Have You With Us." An introduction to the project and the program. Doug Morgan, Assistant Director, Health Professionals Drug Abuse Education Project.
7:00 – 7:30	"One of the Health Professional's Roles—Change Agent in the Community." Doug Morgan discusses some of his feelings about how health professionals can have an impact on chemical dependency problems in their communities.
7:30 – 7:45	Chemical Break
7:45 – 8:45	Introduction to Small Group Discussion/Sharing Expectations
8:45 – 9:00	Chemical Break
9:00 – 10:00	"Attitudes Toward the Use and Abuse of Social, Prescription and Illicit Drugs." A presentation to help clarify some confused societal attitudes toward the use of various psychoactive drugs. Bob Muscala, Program Director, Health Professionals Drug Abuse Education Project.
10:00 – 10:15	Chemical Break
10:15 – 11:15	Small Group Discussion
Friday	
8:00 – 8:45	Breakfast and Free Time

8:45 – 9:00	Living Scale on "Getting High"
9:00 – 9:45	"Attitudes Towards Intoxication: A Model for Understanding Drug Taking Behavior." A presentation by Dr. John Brantner, Department of Clinical Psychology, University of Minnesota Hospitals.
9:45 – 10:00	Chemical Break
10:00 – 11:00	Small Group Discussion
11:00 – 11:15	Chemical Break
11:15 – 12:00	"Critical Issues in Trying to Understand the Development of Drug Problems." A presentation of some working models for attempting to evaluate a person's possible drug problems. Some of the different theories concerning chemical dependency will be compared in an attempt to find some commonality. Bob Muscala.
12:00 – 1:45	Lunch and Free Time
1:45 – 3:00	"The Role of the Law–What It Is . . . What It Should Be . . ." A presentation by Marc Kurzman, pharmacist, lawyer and director of the office of Alcohol and other Drug Programming, University of Minnesota.
3:00 – 3:15	Chemical Break
3:15 – 4:05	Small Group Discussion
4:05 – 4:15	Chemical Break
4:15 – 5:30	"Just What Is Treatment? What Kinds of Alternatives Should There Be?" An overview of the variety of treatment modalities that can be utilized in attempting to treat a variety of drug problems. Methods for evaluating treatment agencies for possible referral will also be presented. Gary Schoener, psychologist and director of the Walk-In Counseling Center, Minneapolis.
5:30 – 7:00	Supper and Free Time
7:00 – 8:15	Specialty Workshops (to be announced)
8:15 – 8:30	Chemical Break
8:30 – 9:30	Small Group Discussion

Saturday

8:00 – 8:45	Breakfast and Free Time
8:45 – 9:30	"The Diagnostic Interview–How to Get the Necessary Information." A presentation by Jon Weinberg, Ph.D., Director of Training and Education, Hennepin County Alcohol and Drug Program; Clinical Assistant Professor of Psychiatry, University of Minnesota.
9:30 – 9:45	Chemical Break

9:45 – 10:15	Demonstration of the Use of the Diagnostic Interview. Jon Weinberg and Bob Muscala.
10:15 – 12:00	Laboratory Experience In Using the Diagnostic Interview for Chemical Dependency: Practice and Feedback. Doug Morgan, Jon Weinberg, Bob Muscala and Staff.
12:00 – 1:00	Lunch and Free Time
1:00 – 3:45	Beyond Diagnosis—Intervention Alternatives. Jon Weinberg and Staff.
3:45 – 4:00	Chemical Break
4:00 – 4:45	Small Group Discussion. Contracting for change strategies in families, work setting and community.
4:45 – 5:15	Completion of Post-conference Evaluation

Appendix 2

Material from Pre-workshop Packet

BACKGROUND INFORMATION

Health Professionals Drug Abuse Education Project General Seminar "Critical Issues for the Health Professional: The Abuse Of Social, Prescription and Illicit Drugs"*

Chemical dependency is presently the largest untreated problem in our society. It is estimated that 10 to 25% of all hospital inpatients have some type of drug-related problem. "I never see drug problems in my practice" is a statement that reflects the health professional's inability to recognize and diagnose and *not* the absence of drug problems.

The general seminar involves approximately 40 participants, as well as 10 to 15 staff and resource people. The seminar is usually held at a camp or retreat center to allow minimal distraction from TV, newspapers, and usual social demands. Our past experience has shown us that these facilities allow us to provide seminars at a reasonable cost, facilitate interaction between participants and staff, and maximize the learning experience.

The seminar utilizes large group lectures and discussions, as well as small group meetings. Small groups of 7 to 10 persons are scheduled throughout the seminar to encourage persons to reflect on their own attitudes and feelings about drugs, durg users and drug abusers.

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* Social Drugs: alcohol, nicotine, caffeine, etc.
Prescription Drugs: minor tranquilizers, barbiturates, etc.
Illicit (illegal): narcotics, hallucinogens, etc.

Since the first general seminar of March 1973, over 900 health professionals have attended the workshop. The project is committed to evaluating its efforts on a continuing basis. Evaluation materials are completed by all participants immediately before and immediately after the seminar. Participants are also followed up six months after their participation in the general seminar. Anticipated benefits include:

- —Using appropriate drug history taking techniques
- —Making appropriate referrals
- —Recognition of drug problems in clients
- —Involvement with community drug agencies
- —Communicating information to other health professionals
- —Seeking further information and training about drug use/abuse
- —Changing procedures and policies in organizations, respective communities, and own families
- —Increased comfort and effectiveness in handling drug-related problems
- —More appropriate prescribing of psychoactive drugs
- —Increased awareness and utlization of the interdisciplinary approach to health care
- — Awareness of how one's own drug taking behavior affects oneself and others
- —Better understanding of attitudes towards drugs, drug users and drug abusers

This workshop is not designed to train participants to be chemical dependency counselors. Rather, we are interested in improving the diagnostic and referral skills of physicians, nurses, pharmacists, mental health professionals, social workers and other health professionals.

Appendix 3

Specialty Workshop Agendas

AGENDA

School Nurses Organization Of Minnesota
Fall Conference, October 19, 1973

7:30 a.m.	Registration and Coffee
8:30 a.m.	Greetings Mary Lou Christensen, School Nurses Organization of Minnesota
8:45 a.m.	"Attitudinal Rap" Bob Muscala, Assistant Coordinator, Health Professionals Drug Abuse Education Project, University of Minnesota
9:00 a.m.	"Street Pharmacology" John Washburn, Coordinator, Chemical Dependency Unit, Minnesota Department of Health
9:30 a.m.	"School Nurse: Legal Responsibility to Student, Parent and Self" Marc Kurzman, Assistant Director, University Drug Information and Education Program, University of Minnesota
10:15 a.m.	Break
10:30 a.m.	"School Nurse: Role in Relating to School Administration and Policy" Jim Evans, Metro Drug Awareness, Minneapolis Health Department
11:15 a.m.	"Emergency Treatment of Drug Reactions" Jim Rothenberger, Coordinator, Health Professionals Drug Abuse Education Project, University of Minnesota
12 noon	Luncheon

1:00 p.m.	" 'Dealing' with Kids and Parents" Len Colson, Drug Abuse Coordinator, Robbinsdale School District 281
2:45 p.m.	Break
3:00 p.m.	"Attitude Awareness" A multimedia presentation. Staff, Health Professionals Drug Abuse Education Project.
3:30 p.m.	"Values Clarification" Terri Kurzman, Metro Drug Awareness, Minneapolis Health Department
4:00 p.m.	"Alternatives" John Washburn, Coordinator, Chemical Dependency Unit, Minnesota Department of Health
4:30 p.m.	Wrap-up

OBJECTIVES AND AGENDA

Detoxification Training Program, Hennepin County Receiving Center
(July 2, 9, 16, 1973)

8:00 – 8:30	Introduction 1. Participants will be aware of staff expectations for this training session. 2. Staff and participants will feel more comfortable with each other. 3. Allow participants and resource people to meet and develop a first-name relationship with each other. 4. Participants will be able to share some of their expectations for the session with group. 5. Participants will be aware of the importance of the training session for detoxification staff.
8:30 – 9:15	Attitude Awareness and Values Clarification 1. Participants will be made aware of the concept that drug abusers are determined largely by the attitudes they hold toward drug use and drug abuse. 2. Participants will be made aware of some of their individual values and how these values influence the type of care they provide in a detoxification setting.
9:15 – 9:20	Introduction of Multimedia Presentation 1. Participants will be made aware of the purposes of the multimedia presentation.
9:20 – 9:45	Multimedia Presentation 1. Participants will be made aware that drugs have been around a long time and are not a new phenomenon.

2. Participants will be made aware that alcohol, caffeine and nicotine are possible drugs of abuse.
3. Participants will be made aware that drug use exists in all age groups and social groups.
4. Participants will be made aware of the theory that most people probably use and abuse various drugs for similar reasons.
5. Participants will be made aware of the idea that the attitudes we hold toward drug use and abuse influence the way we treat people who abuse drugs.

9:45 – 10:00 — Discussion of Multimedia Presentation

1. Participants will begin to feel comfortable with the small groups they have been assigned to.
2. Participants will feel they have had an opportunity to share their feelings about the multimedia presentation with the group.

10:00 – 11:00 — Drug Emergency First Aid

Film (Skip Gay's) and a five-minute explanation afterwards

1. Participants will be able to describe the proper treatment techniques for various drug emergencies.
2. Participants will be made aware of ways in which the emergencies can be dealt with in their detox settings.

Videotape: Paul Kurtz and Staff of St. Cloud Detoxification and Treatment Unit

1. Participants will be made aware of ways in which the emergencies can be dealt with in their detox settings. (There is even more emphasis on that objective in this videotape.)
2. Participants will be able to define their specific roles with regard to detoxification of individuals who have other than alcohol problems.

11:45 – 1:30 — Role Playing First Aid

1. Participants will be able to recognize common drug emergencies and describe proper treatment techniques.
2. Participants will be able to describe their own feelings in handling drug emergencies

1:30 – 2:15 — Identification and Detoxification

1. Participants will be made aware of their abilities to propose a diagnosis using a case study format.
2. Participants will be made aware of how their receiving center presently deals with the problems presented and how it could better deal with these problems.
3. Each participant will be made aware of how he/she individually acts in

a group decision-making situation.

2:15 – 2:45 Drug-Taking History

1. Participants will be made aware of a specific framework with which to obtain a thorough drug-taking history from their clients.
2. Participants will be able to demonstrate their use of this framework in role playing intervention and counseling techniques.
3. Participants will be able to identify how a drug-taking hsitory method as presented by John Siverson is valuable in making proper diagnoses of the client's chemical problems.
4. Participants will be able to describe how the proper diagnosis is a necessary tool for making proper referrals.

3:00 – 4:45 Intervention and Counseling Techniques

1. Participants will be able to describe and demonstrate various techniques of intervention and counseling.
2. Participants will feel more comfortable in handling intervention and counseling situations.

Appendix 4

Program Materials and Bibliography

PROGRAM MATERIALS

Materials developed and utilized by HPDAEP are available from the Office of Alcohol and Other Drug Abuse Programming (AODAP), N616 Elliott Hall, University of Minnesota, Minneapolis, Minnesota, 55455. Video tapes, reprints, manuals and other items can be purchased for cost of duplication and mailing. Requests for materials should be specific with the requestor's complete mailing address and phone number. Some materials are available only in limited quantity.

Readings Book

A compilation of reprinted articles distributed to health professionals at HPDAEP seminars. Fifty-four different articles in five chapters.

Agenda Book

Additional reprints and outlines of lectures from HPDAEP seminars. Other agencies have used copies of this book as a training manual in combination with the Readings Book.

Selected Articles

This appendix includes complete bibliographical references used in composition of HPDAEP educational material. Individuals are encouraged to seek these articles on their own. However, specific copies can be requested from the AODAP office and will be sent if available.

Audiotapes

Audio-casette tapes of presentations made during the general seminar.

—"Attitudes Towards the Use of Social, Prescription and Illicit Drugs," Bob Muscala, R.N.

—"Just What is Treatment—What Kind of Options Should There Be?" Gary Schoener, Psychologist

—"Critical Issues in Prevention and Development of Drug Problems," Bob Muscala, R.N.

—"The Role of the Law—What It Is, What It Could Be," Marc Kurzman, R.Ph., J.D.

—"Diagnostic Interview—How To Get the Necessary Information," Jon Weinberg, Ph.D.

—"Intervention Alternatives—Beyond Diagnosis," Jon Weinberg, Ph.D.

Film and Workbook

16mm color film of Dr. John Brantner's lecture "Psychology of Intoxication—a Model for Understanding Alcohol and Other Drug Use." Forty-five minute presentation. Workbook developed by Kaye Wildasin, Deborah Dean, Bill Cullen and Suzanne Hallenberg contains exercises, discussion questions and articles related to drug and non-drug altered states of consciousness.

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Appendix 5

Sample Data Report

DATA REPORT (9-27-74)

Castaways' Club, Detroit Lakes, Minnesota, September 19-21, 1974
(58 participants)

I. Attitude, Cognitive and Participant Response Analysis

1. Attitude Score: Pre-conference = 45.12; Post-conference = 51.74. Calculation of the dependent t-test indicates the change is highly significant at the .001 level.
2. Cognitive Score: Pre-conference = 16.41; Post-conference = 23.19. Calculation of the dependent t-test indicates the change is highly significant at the .001 level.
3. Participant Response Score: Pre-conference = 45.07; Post-conference = 56.05. Calculation of the dependent t-test indicates the change is highly significant at the .001 level.
4. Attitude statements most and least contributory to change:

Most Contributory to Change		Least Contributory to Change	
Question	t Value	Question	t Value
5	3.85	2	1.58
6	3.77	9	1.16
7	4.95	10	.85
8	8.71	11	.20
14	6.93	13	.28
15	3.72	18	1.42
16	5.80		

5. **Cognitive Change** by number of correct responses.
Range: -10 to +27. N = 58 *least change **most change
#correct/total response

Ques.	BCog	Chg	Ques.	BCog	Chg	Ques.	BCog	Chg	Ques.	Bcog	Chg
1.**	10/53	+22	10.	35/52	+18	19.	34/56	+14	28.	49/55	+9
2.*	48/53	+3	11.	7/41	+8	20.	46/57	-10	29.	18/56	+10
3.	15/58	+7	12.**	12/53	+25	21.*	38/55	0	30.**	16/57	+23
4.	34/55	+8	13.	44/55	+5	22.	30/56	+13	31.	24/57	+12
5.	31/56	+13	14.**	11/54	+27	23.	30/56	+13	32.**	20/56	+27
6.*	18/57	+4	15.	28/55	+12	24.	34/55	+13	33.	7/48	+11
7.	24/57	+18	16.	7/52	+16	25.*	55/56	+1	34.	31/52	+9
8.	11/56	+8	17.	44/57	+8	26.	42/55	+10			
9.	50/56	+7	18.	26/54	+8	27.**	23/54	+21			

6. **Participant Response Change** by difference of the means form before and after instruments for each statement.
Limits: 0-6, N = 58 *least change **most change

Question	Before Mean	After Mean	Difference
1.	3.356	4.596	+1.060
2.*	4.125	4.456	+0.331
3.**	2.804	4.018	+1.214
4.*	4.727	5.158	+0.431
5.	3.571	4.123	+0.552
6.*	4.964	5.351	+0.387
7.**	2.321	3.509	+1.188
8.	2.946	3.860	+0.914
9.	4.333	5.193	+0.860
10.	2.870	3.526	+0.656
11.	2.964	4.125	+1.161
12.	2.870	3.857	+0.987
13.**	3.357	4.643	+1.286

II. Evaluation

1. The mean happiness score (N=58) is 3.754. The response limits are 0-4 with one person (1.72%) responding "2," 12 persons (20.69%) responding "3," and 44 persons (75.86%) responding "4." One person (1.72%) did not respond at all.

2. **Small Group Comparisons.** For each area covered, an indication is made of the small group number (SGN), the number of participants per group (N), the mean score for the group, the mean score

of all other participants not including the participants of the small group, and the difference of the means to compare the small group response relative to the participants in all other small groups.

A. Comfort Level (N = 58)

Limits: 0-4 (very uncomfortable — very comfortable)

SGN	N	Mean Response of Group	Mean Response of Other Participants	Difference	Below-Above Median
1.	7	3.57	3.41	+.16	2 4/5 — 4 1/5
2.	9	3.67	3.39	+.28	3 1/5 — 5 4/5
3.	9	3.11	3.49	-.38	4 4/5 — 5 1/5
4.	8	3.75	3.38	+.37	3 — 5
5.	8	3.25	3.46	-.21	5 1/2 — 2 1/2
6.	9	3.56	3.41	+.15	4 — 5
7.	8	3.13	3.48	-.35	5 1/2 — 2 1/2

B. Happy Face (N = 57)

Limits: 0-4 (sad face — happy face)

SGN	N	Mean Response of Group	Mean Response of Other Participants	Difference	Below-Above Median
1.	7	3.71	3.76	-.05	2 3/10 — 4 7/10
2.	9	3.78	3.75	+.03	1 1/2 — 7 1/2
3.	9	3.67	3.77	-.10	3 2/5 — 5 3/5
4.	8	3.75	3.76	-.01	2 2/5 — 5 3/5
5.	8	3.88	3.74	+.14	1 1/2 — 6 1/2
6.	9	3.78	3.75	+.03	2 1/2 — 6 1/2
7.	7	3.71	3.76	-.05	2 3/10 — 4 7/10

C. Helpfulness of Facilitator (N = 58)

Limits: 0-4 (unhelpful — helpful)

SGN	N	Mean Response of Group	Mean Response of Other Participants	Difference	Below-Above Median
1.	7	3.29	3.41	-.12	4 1/5 — 2 4/5
2.	9	3.22	3.43	-.21	5 3/10 — 3 7/10
3.	9	3.22	3.43	-.21	4 3/10 — 4 7/10
4.	8	3.38	3.40	-.02	5 1/5 — 2 1/5
5.	8	3.50	3.38	+.12	3 3/10 — 4 7/10
6.	9	3.44	3.39	+.05	4 3/10 — 4 7/10
7.	8	3.75	3.34	+.41	2 2/5 — 5 3/5

D. **Attitude Change** (N= 58)

Range: - 11 to +22

SGN	N	Pre-conference Mean	Mean Change for Group	Mean Change for Other Participants	Differences	Below-Above Median
1.	7	50.00	2.28	7.22	- 4.94	6 – 1
2.	9	46.44	3.22	7.24	- 4.02	6 1/2 – 2 1/2
3.	9	39.22	10.89	5.84	+5.05	0 – 9
4.	8	44.62	5.62	6.78	- 1.16	4 1/2 – 3 1/2
5.	8	44.25	8.00	6.40	+1.60	3 1/2 – 4 1/2
6.	9	45.11	9.33	6.12	+3.21	3 – 6
7.	8	47.38	6.00	6.68	- .68	5 1/2 – 2 1/2

E. **Cognitive Gain** (N = 58)

Range: - 1 to +16

SGN	N	Pre-Conference Mean	Mean Gain for Group	Mean Gain for Other Participants	Differences	Below-Above Median
1.	7	17.14	6.00	6.80	- .80	4 – 3
2.	9	18.33	6.67	6.71	- .04	4 – 5
3.	9	14.33	7.22	6.61	+.61	3 – 6
4.	8	14.25	7.38	6.60	+.78	5 – 3
5.	8	17.38	7.13	6.64	+.49	2 – 6
6.	9	15.33	5.56	6.92	- 1.36	7 – 2
7.	8	18.38	7.00	6.66	+.34	4 – 4

F. **Participant Response Change** (N = 58)

Range: -3 to +36

SGN	N	Pre-Conference Mean	Mean Gain for Group	Mean Gain for Other Participants	Differences	Below-Above Median
1.	7	45.86	14.57	10.49	+ 4.08	3 – 4
2.	9	46.00	10.22	11.12	- .90	4 – 5
3.	9	39.67	10.44	11.08	- .64	4 – 5
4.	8	50.50	5.00	11.94	- 6.94	8 – 0
5.	8	4.38	11.75	10.86	- .89	4 – 4
6.	9	47.22	12.44	10.71	+ 1.73	3 – 6
7.	8	45.25	12.88	10.68	+ 2.20	3 – 5

Appendix 6

Development of the Attitudinal Questionnaire

Construction of the attitude scale began with the generation of a number of statements thought to reflect social attitude set or drug attitude set. This list of approximately eighty statements was edited for factual statements. Any statements which could be checked for rightness or wrongness against a recognized authoritative source of information were discarded as cognitive-based rather than affectively-based.

The next step involved having five staff members, along with others working closely with the project in its early phases, indicate which response on an agreement scale they thought reflected a positive position about each statement. Any item for which either end of the scale was seen both as a positive position or a negative position was discarded as not being monotonic. After these two initial screening processes, there were fifty-two items felt both to be in the affective domain and to have monotonic value characteristics. These fifty-two items were examined by an expert panel composed of nine drug abuse counselors who were from different kinds of agencies in three states served by the project and who were judged by a minimum of three separate sources as being effective drug counselors. The expert panel responsed to each statement by indicating their personal agreement or disagreement. Those items on which the panel had consensus (at least in the direction from neutral to one end of the scale or the other) were left in. Any items on which the experts' attitudes were divided between agreement and disagreement responses were dropped from the scale. Hence, if all nine panel members were not at least between "strongly agree" and "neutral" or between "neutral" and "strongly disagree" on a particular item, it was dropped. The scale was then given to a larger population of conference participants. Independent

of the attitude scale response, the participants were interviewed or ranked by project staff as having very negative or positive attitudes toward drug users and abusers. Using the value scoring developed from the panel's responses, the participants' attitude instruments were scored. This conference participant population numbered 100. Any items on which there was total participant response agreement and expert agreement were dropped. (Two of these items were later put back into the test as a measure for internal reliability of the respondents.) Those items were dropped as being non-informative about the particular attitude set which was being examined; if no variance existed between the responses of those felt to have the most positive attitude set and those the least positive, then that item could not contribute any helpful information in scoring changes. The remaining items were then compared for the number of responses positively keyed as "strongly agree" as opposed to the number keyed "strongly disagree." To increase reliability of the instrument, the items keyed "strongly agree" and those keyed "strongly disagree" were matched in number as closely as possible, giving a final set of ten items indicating strong disagreement and nine items indicating strong agreement as the positive score on the atitude scale. From this nineteen-question set, all prior instruments were rescored and examined. Examination of the scores and other biographical and ranking data available on the participants showed a distinct scaling effect taking place; those active in drug counseling programs fell at one end of the scale, and at the other end of the scale were those persons having very negative attitudes about even the concept of therapeutic programs for drug abuse, and particularly programs for street drug abuse or illicit drug abuse. Without exception those who had previously been rated as positive, that is, as effective drug counselors, scored above sixty on the scale; those who had previously been identified as ineffective in working with drug-related problems scored below fifty on the scale; and those rated most negative scored below forty on the scale. Persons who scored above sixty, but whose biographical data showed no particular relationship with drug counseling, were interviewed. It was discovered that among this population one of two things existed: either the person had a vocation not directly related to drug programs and counseling problems but gave volunteer time with counseling programs (and the volunteer work did not show up in the biographical data), or the person had personally gone through treatment for drug abuse problems. Those in the population who scored very low on the test were also interviewed to determine some of their broader attitude responses and background. By this time it was felt that the attitude scale did to some extent measure positive attitudes that might be useful in working with drug abuse problems and that it could be a useful scale in measuring attitude changes pre- and post-conference.

Appendix 7

Post-conference Evaluation Form (1973)

EVALUATION

The following statements reflect some of the objectives for the retreat. Would you please indicate how well these were covered and how helpful you feel these were to you. Please use the following scales for responding.

How Adequate:
- 0 = not covered at all
- 1 = not adequately covered
- 2 = barely adequate
- 3 = adequate (ok)
- 4 = very adequate

How Helpful
- 0 = not helpful to me
- 1 = likely of little help to me
- 2 = it may be of help to me in future
- 3 = it was helpful for me
- 4 = it was very helpful for me

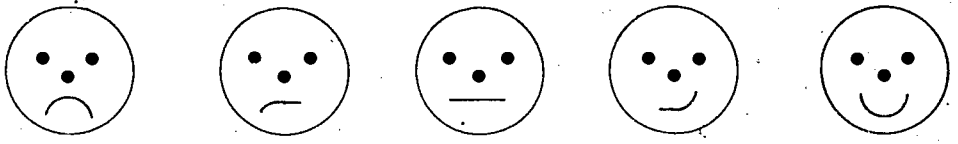
	How Adequate	How Helpful
Aware that drugs have been around.	0 1 2 3 4	0 1 2 3 4
Aware that alcohol, nicotine, and caffeine are possible drugs of abuse.	0 1 2 3 4	0 1 2 3 4
Aware that drug use exists in all age and social groups.	0 1 2 3 4	0 1 2 3 4
Aware that it is possible that most people use and abuse various drugs for similar reasons.	0 1 2 3 4	0 1 2 3 4
Aware that how we treat people who use drugs likely is influenced by our attitudes on drug use and abuse.	0 1 2 3 4	0 1 2 3 4

	How Adequate	How Helpful
Aware of a systems approach to explaining the progression of chemically dependent or dysfunctional people.	0 1 2 3 4	0 1 2 3 4
Aware of the various ways that individuals presently enter the health care system.	0 1 2 3 4	0 1 2 3 4
Aware of some methods to provide more adequate health care services in crisis situations.	0 1 2 3 4	0 1 2 3 4
Aware of studies that indicate a number of chemical-related problems of persons entering the health system.	0 1 2 3 4	0 1 2 3 4
Aware of differences between short-term and long-term management.	0 1 2 3 4	0 1 2 3 4
Aware of specific patterns of drug use in your community.	0 1 2 3 4	0 1 2 3 4
Aware of types of drug use among various age groups.	0 1 2 3 4	0 1 2 3 4
Aware of new trends of drug use.	0 1 2 3 4	0 1 2 3 4
Aware of where people are going for help with drug problems.	0 1 2 3 4	0 1 2 3 4
Aware of how people in your community view drug usage.	0 1 2 3 4	0 1 2 3 4
Aware of the various treatment modalities and referral services available in your community.	0 1 2 3 4	0 1 2 3 4
Aware of the definition and explanation of some drug-related terms.	0 1 2 3 4	0 1 2 3 4
Able to recognize and describe proper treatment techniques of common drug emergencies.	0 1 2 3 4	0 1 2 3 4
Aware of a specific framework that deals with how to determine needs in your community.	0 1 2 3 4	0 1 2 3 4
Aware of how a community power structure operates and how to function with this to achieve change.	0 1 2 3 4	0 1 2 3 4
Able to express (in general) the vario laws pertaining to possession and sale of controlled substances in your state.	0 1 2 3 4	0 1 2 3 4
Aware of the legal aspects of emergency treatment, crisis intervention and counseling in drug abuse.	0 1 2 3 4	0 1 2 3 4

	How Adequate	How Helpful
Aware of new trends in the law and social policy.	0 1 2 3 4	0 1 2 3 4
Aware of various reasons for not working on an interdisciplinary health team and counter-arguments for such reasons.	0 1 2 3 4	0 1 2 3 4
Able to study case histories and present problem determination, diagnosis and referral possibilities.	0 1 2 3 4	0 1 2 3 4
Aware of a specific framework with which to obtain a thorough drug-taking history.	0 1 2 3 4	0 1 2 3 4
Aware of the number of treatment options available.	0 1 2 3 4	0 1 2 3 4
Aware that different types of persons may respond to different kinds of therapy.	0 1 2 3 4	0 1 2 3 4
Aware of ways to implement the alternatives concept in working with clients.	0 1 2 3 4	0 1 2 3 4

OVERALL CONFERENCE RESPONSE

Check what face best describes your feelings about being at this conference.



1.	How comfortable did you feel with your small group?	Very Uncomfortable Very Comfortable 0 1 2 3 4
2.	Did you feel you were able to share your feelings *about the program* with your group?	Not At All Very Much 0 1 2 3 4
3.	How comfortable did you feel with your community group?	Very Uncomfortable Very Comfortable 0 1 2 3 4
4.	Did you feel you were able to share your ideas for the community with your group?	Not At All Very Much 0 1 2 3 4

What in the conference was most helpful to you?

What was least helpful to you?

What suggestions would you make for changes in this conference or for your future training needs?

Appendix 8

Post-conference Evaluation Form (1974-75)

EVALUATION

Small Groups

1. How comfortable did you feel with your small group?
   Very Uncomfortable 0 1 2 3 4 Very Comfortable

2. How would you rank your small group leader?
   Not Helpful 0 1 2 3 4 Helpful

3. Describe what happened in your small group and discuss whether or not it was appropriate to your needs and expectations of the group.

   _____

   _____

   _____

4. List two things that your small group leader could have done to make your experience more worthwhile.

   (1)
   (2)

5. As a result of the seminar, to what extent do you think your attitudes have changed toward the use and abuse of:

	No Extent				Great Extent
Social Drugs	0	1	2	3	4
Illicit Drugs	0	1	2	3	4
Prescription Drugs	0	1	2	3	4

Please explain:

_____

6. Describe how your own drug use (or lack thereof) affects the attitudes you hold toward drug users.

7. What in the seminar was most helpful to you?

8. What was least helpful?

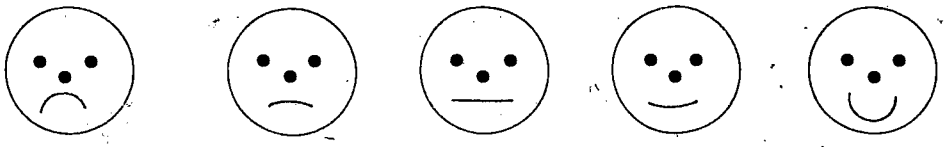
9. In what ways do you feel your day-to-day behavior may change as a result of this seminar?

10. Describe one way that you will attempt to use the information gained at this seminar to achieve change in your own community and/or work setting.

11. What suggestions would you make for changes in this seminar?

12. How did you hear about this conference?

13. Check which face best describes your feelings about this conference.



14. Please circle your small group number.

1 2 3 4 5 6 7 8

Appendix 9

Sample Facilitator Feedback Report

FACILITATOR FEEDBACK REPORT

Detroit Lakes, Mn	9/19-21/74	58 (total of 61; 3 missing)
Conference	Date	number of participants

Cognitive Questionnaire: Pre-conference mean 16.41; Post-conference mean 23.19. (limits: 0-40)

Attitude Questionnaire: Pre-conference mean 45.12; Post-conference mean 51.74. (limits: 0-76)

Participant Response: Pre-conference mean 45.07; Post-conference mean 56.05. (limits: 0-78)

Small Group Data

1. Comfort Level with Group
   N = 58
   Limits: 0 – 4 (very uncomfortable – very comfortable)
   Overall mean for comfort = 3.43

	SGN	N	Distribution 0	1	2	3	4	Mean	Participants Below – Above Median
Gordon	1	7			1	1	5	3.57	2 4/5 – 4 1/5
Kodrich	2	9			1	1	7	3.67	3 1/5 – 5 4/5
Paul	3	9	1	0	1	2	5	3.11	4 4/5 – 4 1/5
Norlander	4	8				2	6	3.75	3 – 5
Cullen	5	8			1	4	3	3.25	5 1/2 – 2 1/2
Steiner	6	9			1	2	6	3.56	4 – 5
Hallenberg	7	8			2	3	3	3.13	5 1/2 – 2 1/2

2. Happiness Index

N = 57

Limits: 0 — 4 (unhappy — happy)

Overall mean for happiness = 3.75

SGN	N	Distribution					Mean	Participants Below — Above Median
		0	1	2	3	4		
1	7				2	5	3.71	2 3/10 — 4 7/10
2	9			1	0	8	3.78	1 1/2 — 7 1/2
3	9				3	6	3.67	3 2/5 — 5 3/5
4	8				2	6	3.75	2 2/5 — 5 3/5
5	8				1	7	3.88	1 1/2 — 6 1/2
6	9				2	7	3.78	2 1/2 — 6 1/2
7	7				2	5	3.71	2 3/10 — 4 7/10
8								
9								
10								

3. Helpfulness of Facilitator

N = 58

Limits: 0 — 4 (unhelpful — helpful

Overall mean for helpfulness = 3.40

SGN	N	Distribution					Mean	Participants Below — Above Median
		0	1	2	3	4		
1	7			1	3	3	3.29	4 1/5 — 2 4/5
2	9		1	0	4	4	3.22	5 3/10 — 3 7/10
3	9		1	1	2	5	3.22	4 3/10 — 4 7/10
4	8				5	3	3.38	5 1/5 — 2 4/5
5	8			1	2	5	3.50	3 3/10 — 4 7/10
6	9			1	3	5	3.44	4 3/10 — 4 7/10
7	8				2	6	3.75	2 2/5 — 5 3/5
8								
9								
10								

4. Change in Attitude
N = 58
Limits: -11 — +22

SGN	N	Distribution																								Mean
		-11	-7	-4	-2	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	22					
1	7	1				1	2			1	1					1										2.28
2	9		1		1	1	1		1	1		1		1	1											3.22
3	9												3		1	2		1	1	1						10.89
4	8				1	1	1				1	1	1		1			1								5.62
5	8							1			1	3	1				1		1							8.00
6	9			1					1		1		1	1		1		1		1	1					9.33
7	8						2	2	1			1					1									6.00
8																										
9																										
10																										

MEAN ATTITUDE SCORES

SGN	Pre-Conference	Post-Conference	Participants Below — Above Median
1	50.00	52.28	6 — 1
2	46.44	49.66	6 1/2 — 2 1/2
3	39.22	50.11	0 — 9
4	44.62	50.24	4 1/2 — 3 1/2
5	44.25	52.25	3 1/2 — 4 1/2
6	45.11	54.44	3 — 6
7	47.38	53.38	5 1/2 — 2 1/2

5. Change in Participant Response
N = 58
Limits: -3 to + 36

SGN	N	Distribution																									Mean
		-3	-2	-1	0	2	3	4	5	6	7	8	9	10	11	12	14	15	16	17	20	21	23	24	26	28	36	
1	7	1					1					1						2								1	1	14.57
2	9						1			1		1	1	2			1		2									10.22
3	9		1	1					1				1		1				2	1			1					10.44
4	8		1			1				3	2	1																5.00
5	8				1				1	1		1					1			1	1			1				11.75
6	9				1	1			1						1	1		1			1	1			1			12.44
7	8					1		1				1			1		3										1	12.88

SGN	MEAN PARTICIPANT RESPONSE SCORES Pre-Conference	Post-Conference	Participants Below — Above Median
1	45.86	60.43	3 — 5
2	46.00	56.22	4 — 5
3	39.67	50.11	4 — 5
4	50.50	55.50	8 — 0
5	41.38	53.13	4 — 4
6	47.22	59.66	3 — 6
7	45.25	58.13	3 — 5

6. Change in Cognitive

N = 58

Limits -1 to +16

SGN	N	Distribution -1	1	2	3	4	5	6	7	8	9	10	11	12	13	15	16	Mean
1	7			1	1	1		1	1		1		1					6.00
2	9		1		1	1		1	1	1	1		2					6.67
3	9			1	1	1				2	2	1		1				7.22
4	8					1	4		1						1	1		7.38
5	8		1		1				3		1		1	1				7.13
6	9	1	1	1			3	1					1				1	5.56
7	8		1	1	1	1						2	1			1		7.00
8																		
9																		
10																		

SGN	MEAN COGNITIVE SCORES Pre-Conference	Post-Conference	Participants Below — Above Median
1	17.14	23.14	4 — 3
2	18.33	25.00	4 — 5
3	14.33	21.55	3 — 6
4	14.25	21.63	5 — 3
5	17.38	24.51	2 — 6
6	15.33	20.89	7 — 2
7	18.38	25.38	4 — 4

Appendix 10

Follow-up Questionnaire (Developmental Model)

1. How comfortable do you feel working with clients with drug-related problems?

   Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

   1. Very comfortable _____
   2. Comfortable _____
   3. Somewhat comfortable _____
   4. Somewhat uncomfortable _____
   5. Uncomfortable _____
   6. Very uncomfortable _____
   7. Does not apply _____

2. How effective do you feel you are in working with clients with drug-related problems?

   Please indicate one or more specific examples, incidents, or reasons to illustrate vour response.

   1. Very effective _____
   2. Effective _____
   3. Somewhat effective _____
   4. Somewhat ineffective _____
   5. Ineffective _____
   6. Very ineffective _____
   7. Does not apply _____

3. Have you noticed any changes in the way you dispense or recommend prescription of psychoactive drugs since the workshop?

   Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

   1. Great increase of prescriptions _____
   2. Somewhat increased _____
   3. No change _____

4. Somewhat decreased _____
5. Great decrease _____
6. Does not apply _____

4. Have you noticed any changes in the way other health professionals dispense or recommend prescription of psychoactive drugs?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Great increase of prescriptions _____
2. Somewhat increased _____
3. No change _____
4. Somewhat decreased _____
5. Great decrease _____
6. Does not apply _____

5. Have you noticed a change in your ability to recognize and diagnose drug abuse problems in your clients since the workshop?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Great increase of recognition _____
2. Somewhat increased _____
3. No change _____
4. Some decrease _____
5. Great decrease _____
6. Does not apply _____

6a. Since the workshop, have you noticed a change in the *number* of referrals you have made?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Great increase in number _____
2. Somewhat increased _____
3. No change _____
4. Somewhat decreased _____
5. Definitely decreased _____
6. Does not apply _____

6b. Since the workshop, have you noticed a change in the referral agencies you are utilizing?

Please indicate names of specific agencies utilized.

1. Using new agencies as well as those used before _____
2. Using new agencies instead of the ones used before _____
3. No change _____

4. Use fewer agencies than I used before _____
5. Does not apply _____

7. Since the workshop, have you noticed a change in the type of drug-related problems you've dealt with?

Please specify the type(s) of drug problems you are now working with (e.g. alcohol, amphetamines, barbiturates, etc.)

1. Definite change in type _____
2. Some change in type _____
3. No noticeable change _____
4. Does not apply _____

8. Since the workshop, have you been responsible for, or attempted to effect procedure and/or policy changes with regard to drug problems in your institution?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Definite changes have occurred _____
2. Small changes have apparently occurred _____
3. Changes are now being considered _____
4. I've tried, but to no avail _____
5. No attempts have been made. _____
6. Does not apply _____

9. Since the workshop, have you been responsible for or attempted to distribute drug information to health professionals?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Yes, to a great extent _____
2. Yes, some _____
3. Not at all _____

10. Since the workshop, have you been responsible for or attempted to effect procedures and/or policy changes with regard to drug problems in your community (outside of work related activities)?

Please indicate one or more specific examples, incidents, or reasons to illustrate your responses.

1. Definite changes have occurred _____
2. Small changes have apparently occurred _____
3. Changes are now being considered _____
4. I've tried, but to no avail _____
5. No attempts have been made _____

11. Was the workshop helpful to you in handling personal situations with family and/or friends, concerning drug-related problems?

Please indicate one or more specific examples, incidents, or reasons to illustrate your responses.

1. Very helpful _____
2. Helpful _____
3. Somewhat helpful _____
4. No help that I'm aware of _____
5. Somewhat unhelpful _____
6. Unhelpful _____
7. Very unhelpful _____

12. Do you now have a different job (either within the same institution or at another insitution) since the workshop?

1. ____ yes. If yes, have you become:
   1. Definitely more directly involved with drug-related problems _____
   2. Somewhat more involved _____
   3. Somewhat less involved _____
   4. Not involved at all _____
2. ____ no. If no, have you become:

Please indicate one or more specific examples, incidents, or reasons to illustrate your responses.

1. Definitely more directly involved with drug-related problems _____
2. Somewhat more involved _____
3. Somewhat less involved _____
4. Not involved at all _____

13. Since the workshop, has your involvement with an interdisciplinary (team) approach to health care changed?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Definitely more involvement with other team members _____
2. Somewhat more involved _____
3. No change _____
4. Somewhat less involved _____
5. Definitely less involved _____
6. Does not apply _____

14. With regard to your attitudes and values about drugs, drug users, and drug abusers, since the workshop do you feel you understand your values and attitudes:

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Much better _____
2. Better _____
3. Somewhat better _____
4. No change _____
5. Somewhat more confused _____
6. Definitely more confused _____

15. To what extent do you feel your own personal attitudes about a person affect the type of health (helping) care you provide to that person?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Not at all _____
2. Probably, but I'm not aware of it _____
3. I don't know _____
4. Somewhat _____
5. To a great extent _____
6. Does not apply _____

16. To what extent do you feel you are able to obtain relevant information regarding drug-taking behavior from clients?

Please indicate one or more specific examples, incidents, or reasons to illustrate your response.

1. Not at all _____
2. Very little _____
3. To some extent _____
4. To a fair extent _____
5. To a great extent _____
6. Does not apply _____

17. To what extent do you feel you understand your own drug-taking behavior?

Please explain.

1. Much better _____
2. Somewhat better _____
3. Better _____
4. No change _____
5. Somewhat more confused _____
6. Definitely more confused _____

18. Do you feel you have changed your own drug usage behavior since the conference?

Please offer any comments or explanations you might have.

1. Yes _____
2. No _____

19. In what ways was the retreat most helpful to you?

20. Are there any other incidents or examples of how individuals and the community at large have benefited, directly or indirectly, from the activities of the Health Professionals Drug Abuse Education Project?

21. Have you attended any other drug training programs since the workshop?

22. Do you have any suggestions on how the workshop could have been more helpful to you?

Appendix 11

Follow-up Questionnaire

1. Approximately what percentage of your clients have drug-related problems themselves or in their families?

   1. _____%
   2. Don't know
   3. Does not apply

2. Approximately how often do you do routine screening for chemical dependency problems with clients or client families?

   1. Always
   2. Frequently
   3. Sometimes
   4. Not too often
   5. Never
   6. Does not apply

3. Approximately how often do you use an external validation source to verify a client report regarding possible drug problems?

   Please elaborate.

   1. Always
   2. Frequently
   3. Sometimes
   4. Not too often
   5. Never
   6. Does not apply

4. Approximately how often do you document chemical dependency problems in

charts or other client records?

1. Always _____
2. Frequently _____
3. Sometimes _____
4. Not too often _____
5. Never _____
6. Does not apply _____

5. How effective do you feel you are in working with clients with drug-related problems?

1. Very effective _____
2. Effective _____
3. Don't know _____
4. Ineffective _____
5. Very ineffective _____
6. Does not apply _____

6. To what extent do you feel you are able to obtain relevant information from clients regarding drug-taking behavior?

1. To a great extent _____
2. To a fair extent _____
3. To some extent _____
4. Very little _____
5. Not at all _____
6. Does not apply _____

7. What is the average number of referrals for drug-related problems you make per month?

1. _____
2. Does not apply _____

8. What is the approximate number of agencies (persons) to which you now refer clients with drug-related problems?

1. _____
2. Does not apply _____

9. What types of agencies (persons) do you routinely utilize when making referrals for drug-related problems?

1. Individual counselor _____
2. Drug Information Centers _____
3. Outpatient counseling _____
4. Self-help Groups _____
5. Residential treatment _____
6. Therapeutic communities _____

7. Family counseling _____
8. Other _____
9. Does not apply _____

10. Do you routinely do follow-up on clients you have referred?
    1. Yes _____
    2. No _____
    3. Does not apply _____

11. How often do your referrals actually go to the agency to which they were referred?
    1. Always _____
    2. Frequently _____
    3. Sometimes _____
    4. Not too often _____
    5. Never _____
    6. Don't know _____
    7. Does not apply _____

12. How often do you visit drug treatment agencies?

13. How often do you visit drug information centers?

14. Are you currently helping drug treatment agencies with:
    A. Medical/health input? 1. Yes _____
    2. No _____
    3. Does not apply _____
    B. Volunteer activity? 1. Yes _____
    2. No _____
    C. Psychological support services 1. Yes _____
    2. No _____
    3. Does not apply _____
    D. Other _____

15. Have you attempted to distribute drug information to other health professionals?
    1. To a great extent _____
    2. Some _____
    3. Not at all _____
    4. Does not apply _____

16. Have you disseminated information to other health professionals about referral

sources available?

1. To a great extent _____
2. Some _____
3. Not at all _____
4. Does not apply _____

17. Have you encouraged any colleagues to visit and/or help drug agencies?

1. To a great extent _____
2. Some _____
3. Not at all _____
4. Does not apply _____

18. To what extent are you involved with an interdisciplinary (team) approach to health care?

Please eleborate.

1. To a great extent _____
2. Somewhat _____
3. Not at all _____

19A. How do you feel about persons who use/abuse social drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

19B. How do you feel about persons who use/abuse illicit drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

19C. How do you feel about persons who use/abuse prescription drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

20. To what extent to you feel your own attitudes about a person affect the type of health (helping) care you provide to that person?

1. Not at all _____
2. Probably, but I'm not aware of it _____

3. I don't know _____
4. Somewhat _____
5. To a great extent _____
6. Does not apply _____

21. Have you been responsible for or attempted to effect any procedure or policy changes with regard to drug problems in your institution?
1. Definite changes have occurred _____
2. Small changes have apparently occurred _____
3. Changes are now being considered _____
4. I've tried but to no avail _____
5. No attempts have been made _____
6. Does not apply _____

22. Is your agency currently offering more services for clients with drug-related problems than it was six months ago?
If yes, please specify:
1. Yes _____
2. No _____
3. Does not apply _____

23. Was the workshop helpful to you in handling personal situations with family and/or friends, concerning drug-related problems?
Please elaborate.
1. Very helpful _____
2. Helpful _____
3. No help that I'm aware of _____
4. Unhelpful _____
5. Very unhelpful _____

24. Have you discussed the similarities/differences of social, illicit, and prescription drug use with your family and/or friends?
Please elaborate.
1. Yes, a great deal _____
2. Yes, some _____
3. Not at all _____

25. Have you attempted or been responsible for procedure and/or policy changes within your community with regard to drug-related problems?
Please elaborate.
1. Definite changes have occurred _____

2. Small changes have a apparently occurred _____
3. Changes are now being considered _____
4. I've tried, but to no avail _____
5. No attempts have been made _____

26A. Have you read *Mystification and Drug Misuse?*

1. Yes _____
2. No _____

26B. If yes, at what level of agreement are your views with those of the authors?

Please elaborate.

1. Strongly agree _____
2. Agree _____
3. Neutral _____
4. Disagree _____
5. Strongly disagree _____

27. Since the workshop, have you noticed any changes in the way you dispense, utilize or recommend prescription or psychoactive drugs?

Please elaborate.

1. Great increase _____
2. Somewhat increased _____
3. No change _____
4. Somewhat decreased _____
5. Great decrease _____
6. Does not apply _____

28. Since the workshop have you utilized or recommended utilization of treatments other than psychoactive drug therapy for the clients you see?

If yes, what?

1. To a great extent _____
2. Somewhat _____
3. Not at all _____
4. Does not apply _____

29. Since the workshop, have you noticed any changes in the way other health professionals dispense, utilize or recommend prescription of psychoactive drugs?

Please elaborate.

1. Great increase _____
2. Somewhat increased _____
3. No change _____
4. Somewhat decreased _____
5. Great decrease _____
6. Does not apply _____

30. Since the workshop, how comfortable do you feel with your own drug use, or lack thereof?

1. Very comfortable _____
2. Comfortable _____
3. Not sure _____
4. Uncomfortable _____
5. Very uncomfortable _____

31. Since the workshop, to what extent do you feel you understand your own drug-taking behavior, or lack thereof?

1. Much better _____
2. Somewhat better _____
3. No change _____
4. Somewhat more confused _____
5. Not at all _____

32A. Since the workshop, have you increased/decreased your use of social drugs?

Explain:

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any _____

32B. Since the workshop, have you increased/decreased your use of illicit drugs?

Explain:

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any _____

32C. Since the workshop, have you increased/decreased your use of psychoactive prescription drugs?

Explain:

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any _____

33. What in the workshop was most helpful to you?

34. Have you attended any other drug training programs since the workshop?

If yes, where?

1. Yes _____
2. No _____

35. Have you written for or in any other way obtained further information on drugs and/or drug use since the workshop?

If yes, where?

1. Yes _____
2. No _____

36. Do you have any suggestions on how the Health Professionals Drug Abuse Education Project workshop could have been more helpful to you?

Appendix 12

Follow-up Letter of Introduction

About six months ago you participated in a two and one-half day workshop conducted by the Health Professionals Drug Abuse Education Project. The project is now conducting a follow-up of persons attending that workshop. The project is continually trying to evaluate its effectiveness, and one of the best ways to accomplish this is to find out what has been happening with past participants.

Your activities and experiences following the workshop, your feelings about its usefulness or lack thereof for you, and any effects or lack of effects in your community, are all quite helpful information. It will be most appreciated if you would complete the enclosed questionnaire and return it to us within the next week.

The information, of course, is confidential and identification of participants and even communities will be prevented. However, it is hoped that we will be able to share with you information on overall outcomes of the project and give ideas on how communities, institutions, and individuals have utilized the workshop experience.

Thank you for your time and consideration of this effort.

Very truly yours,

Donna Audette
Evaluation Specialist

Appendix 13

Biographical Data Sheet

Today's Date Month _____ Day _____ Year _____

Age _____ Number of Children _____

F ____ M ____

Marital Status (circle one)

1. Single
2. Married
3. Divorced
4. Other

Profession or major activity: Please be specific. (Example: Emergency Room Nurse in county hospital)

Are you now involved with or working for a drug-related agency? If so, what kind? Please be specific. (Example: Chemical Dependency Program in private hospital)

Have you recently taken on a new job or involvement in drug-related programs or activities?

Yes____

No_____

What is your *main* reason for attending this program? (Circle one)

1) Job-related interest
2) Community interest
3) Personal interest
4) Required by employer
5) Personal contact with project staff
6) Curiosity
7) Other _____

What are your primary expectations from this program?

Appendix 14

Pre- and Post-conference Instruments

COGNITIVE INSTRUMENT

For the following, circle the one best answer.

1. The most appropriate definition of "enabling" as used in the study of chemical dependency is:
   1. Helping another person achieve self-awareness through the use of drugs.
   2. Encouraging another person to continue the use of illicit drugs.
   3. Allowing another person to use drugs for pleasure or recreation.
   4. Helping another person through the stages of recovery from chemical dependency.
   5. Shielding a person from experiencing the negative consequences of his/her drug abuse.

2. A drug abuser can often be identified by looking at the person's:
   1. Age, sex, profession and type of drug used
   2. Age, sex, life style and type of drug used
   3. Age, life style, socio-economic status and type of drug used
   4. Age, education, occupation and type of drug used
   5. None of the above

3. The underlying causes of chemical dependency must be clear to both the counselor and the client if the client is to get any better.
   1. True
   2. False

4. Which of the following statements is false:

   1. Alcohol is a potentially addictive drug.
   2. Many people tend to equate addiction with iliegality.
   3. Alcoholism is different from other forms of drug addiction.
   4. Alcoholics usually present far more physical damage than do heroin addicts.
   5. 1 and 4 above

5. Multiple drug use (poly-drug use) can be a result of which of the following?

   1. Wide availability of various drugs.
   2. Heightened effect when some drugs are taken together.
   3. Unavailability of drug of choice.
   4. All of the above
   5. 1 and 2 above

6. The referral of choice for alcoholics is Alcoholics Anonymous.

   1. True
   2. False

7. At the present time, chemical dependency is known to be caused by:

   1. Personality disorder
   2. Genetic predisposition
   3. Biochemical imbalance
   4. More than one of the above
   5. None of the above

8. In assessing the success of any chemical dependency treatment program, it is most important to determine:

   1. What are the established therapeutic goals of treatment?
   2. What percentage of graduates remain abstinent?
   3. What type of counseling is utilized?
   4. 1 and 2 above
   5. 2 and 3 above

9. The use of marijuana often leads to violent behavior.

   1. True
   2. False

10. The diagnosis of chemical dependency on alcohol should be determined by:

    1. How much and how often a person drinks.
    2. Whether or not a person goes into withdrawal.
    3. The problems a person has as a result of drinking.
    4. The reasons why a person drinks.
    5. If a person has a drink in the morning to relieve a hangover.

11. Which of the following are characteristic of the theory of chemical dependency proposed by Jellinek?

    1. Opposed the disease theory of chemical dependency.
    2. A result of sampling a highly selective population.
    3. Defined chemical dependency as a disease.
    4. 2 and 3 above
    4. 1 and 2 above

12. Which of the following is *not* a characteristic of the state of intoxication?

    1. Accompanied by changes in sensory perception.
    2. Can be induced only by using drugs.
    3. It is usually a pleasurable feeling.
    4. Accompanied by changes in time perception.
    5. Has been experienced by everyone.

13. The abuse of alcohol usually results in more physiological damage than the abuse of heroin.

    1. True
    2. False

14. Which of the following alternatives includes the *most* appropriate diagnostic considerations in evaluating a drug problem for possible referral.

    1. Evaluating amount of drug use, frequency of drug use, reasons for using drugs.
    2. Evaluating amount of drug use, frequency of drug use, and the person's strengths.
    3. Evaluating the person's strengths, effects of drug usage on total life function, and past attempts to get help.
    4. Evaluating past attempts to get help, reasons why a person uses drugs, the type of drugs used.
    5. Evaluating effects of drug usage on total life function, reasons for using drugs, amount and frequency of drug use.

15. With regard to intervention in the development of drug problems, if you wait until the presenting complaint is a serious medical problem, (e.g. cirrhosis of the liver):

    1. The number of treatment options available for referral greatly increases.
    2. The person probably will have less resources available (job, family, etc.)
    3. The seriousness of the problem will motivate the person to be more attentive in a treatment program.
    4. The person has almost no chance of getting better.

5. The person will probably stop denying that he/she has a drug problem.

16. Which of the following include examples of only *moderate* structure treatment modalities:

    1. Drug education, outpatient counseling, third-community approaches.
    2. Residential treatment, halfway house, information-referral centers.
    3. Daycare-partial hospitalization, business-industry programs, halfway houses.
    4. Outpatient counseling, therapeutic communities, halfway houses.
    5. Business-industry programs, outpatient counseling, residential treatment.

17. Methadone maintenance programs are based on the belief that chemical dependency is a problem of physical addiction.

    1. True
    2. False

18. Which of the following is a context variable to be aware of when using the diagnostic interview for chemical dependency?

    1. If the client will be seeing you again.
    2. If the client drinks in the morning.
    3. If the client misses work regularly.
    4. If the client's spouse is using drugs.
    5. 2 and 3 above

19. Which of the following information should be communicated to a client when you are making a referral for drug problems?

    1. Name of contact person at referral agency.
    2. What type of intake procedure will be used.
    3. Success rate of the agency.
    4. 1 and 2 above
    5. None of the above is pertinent information for the client.

20. A common mistake of making a referral for clients with drug problems is:

    1. Failure to evaluate past attempts to get help.
    2. Catalog shopping for referral agency.
    3. Failure to get family involved.
    4. All of the above are common mistakes.
    5. 1 and 2 above.

21. This service is usually aimed at keeping people from entering the treatment system for drug abuse problems:

    1. Casefinding — Early Detection Services
    2. Law Enforcement Services
    3. Prevention — Education Services

4. Aftercare — Rehabilitation Services
5. None of the above

For the following four questions 22-25

An unconscious person (etiology unknown) is brought to your facility. In which order should these procedures be carried out.

A. If necessary, administer appropriate drugs.
B. Assess circulation by checking pulses and skin color.
C. Check and clean airway, repositioning tongue if necessary.
D. Ease breathing by extending the neck and inserting an airway if needed.

22. The *first* procedure should be:
    1. A above
    2. B above
    3. C above
    4. D above

23. The *second* procedure should be:
    1. A above
    2. B above
    3. C above
    4. D above

24. The *third* procedure should be:
    1. A above
    2. B above
    3. C above
    4. D above

25. The *fourth* procedure should be:
    1. A above
    2. B above
    3. C above
    4. D above

26. An interdisciplinary approach to health care is best described or exemplified by:
    1. Physicians delegating more responsibility to other health professionals for patient care.
    2. Realizing and utilizing the potential of each health professional to provide team-oriented health care for the patient.
    3. Medical staffs from different hospitals meeting to decide how to avoid duplication of services.
    4. Representatives from each discipline attending weekly meetings to discuss better health care for patients.
    5. None of the above

27. Which of the following is *not* an appropriate alternative to traditional drug treatment programs:

    1. Mixing several treatment efforts to create more structure.
    2. Environmental referral: Suggest change in life situation (job, neighborhood, etc.).
    3. Provide help for someone else (example: involving spouse of the chemically dependent person in group therapy).
    4. Go into living circumstances and organize a therapeutic effort around the client.
    5. All of the above are appropriate.

28. From a medical-social-legal point of view, which of the following drugs probably creates the largest number of problems in our society?

    1. Narcotics
    2. Amphetamines
    3. Marijuana
    4. Alcohol
    5. Barbiturates

29. This service includes a variety of methods aimed at stopping or reducing a person's harmful use of drugs.

    1. Treatment Services
    2. Emergency Services
    3. Detoxification Services
    4. Prevention-Education Services
    5. None of the above

30. Which of the following is a correct sequence of events in obtaining information and making appropriate referrals:

    1. Developing trust ⟶ explain purpose of interview ⟶ suggesting referral possibilities ⟶ determining whether treatment is necessary.
    2. Explain purpose of interview ⟶ determining whether treatment is necessary ⟶ suggesting referral possibilities ⟶ validating information.
    3. Contracting with client as to choice of action ⟶ explain purpose of interview ⟶ suggest referral possibilities ⟶ developing trust.
    4. Developing trust ⟶ using appropriate questions ⟶ contract with client as to choice of action ⟶ validating information.
    5. Explain purpose of interview ⟶ using appropriate questions ⟶ validating information ⟶ determining whether treatment is necessary.

31. Which of the following is a shortcoming of the health care delivery system that may prevent drug abusers from entering the system.

    1. Lack of routine screening of all patients for chemical dependency.
    2. Inability of many health professionals to recognize and diagnose drug problems.
    3. Moralistic and judgmental attitudes of some health professionals towards individuals who use and/or abuse drugs.
    4. 2 and 3 above
    5. All of the above

32. Which of the following is the *most* appropriate technique to use for the diagnostic interview for chemical dependency?

    1. Looking for personality changes associated with intoxication.
    2. Evaluating the number of drinks that a person has per day.
    3. Determining the reasons why the person uses drugs.
    4. Looking for signs of a lack of will power.
    5. Evaluating the number of times the person is intoxicated per week.

For questions 33, consider the following attidudes:

    A. You can deal effectively with drug abuse behavior by imposing criminal penalties.
    B. Alcohol is a potentially dangerous drug.
    C. The most effective way to deal with second-time drug offenders is to impose harsh penalties coupled with minimum mandatory sentencing.
    D. Alcohol is not a potentially dangerous drug.
    E. Medical and/or scientific knowledge are the sole determinants of the relative harmfulness of drugs.

33. Which of these attitudes are reflected in the Uniform Controlled Substance Act of 1970.

    1. B and C above
    2. A and D above
    3. A and E above
    4. B and E above
    5. C and D above

34. Which of the following attitudes is a result of existing legislation and not a result of the pharmacological nature of the durg.

    1. Any controlled substance has greater potential for abuse than alcohol.
    2. Heroin is more dangerous than alcohol.
    3. Use of narcotics may lead to violent crime.
    4. 2 and 3 above
    5. All of the above

35. In the space below please write your own definition of chemical dependency.

Chemical dependency is _____

_____

_____

36. In this state, a minor cannot give effective consent for chemical dependency treatment without the approval of his/her parent.

1. True
2. False

37. Which of these individuals, acting on their own behalf, are given privileged communication status under the laws of this state which prevents them from disclosing information regarding drug-taking behavior without their client's consent.

1. Physicians and Nurses
2. Pharmacists and Nurses
3. Social Workers
4. Physicians and Psychologists
5. Clergy and Physicians
6. Educators and Clergy

ATTITUDE INVENTORY

Instructions: Please make a determination or selection which most closely defines your opinion. Circle your choice from label SA for strongly agree, A for agree, N for neutral, D for disagree, and SD for strongly disagree.

1.	For total amount of damage done to our society, alcohol is more dangerous than any other drug.	SA	A	N	D	SD
2.	A major part of the drug problem in the U.S. is the over-manufacture of drugs by the drug industry.	SA	A	N	D	SD
3.	I would expect that all drug use leads to substantial physical damage to the user.	SA	A	N	D	SD
4.	Strong law enforcement will decrease drug abuse.	SA	A	N	D	SD
5.	Street professionals have very limited value in health centers for drug crisis intervention.	SA	A	N	D	SD
6.	I consider alcohol and nicotine as drugs.	SA	A	N	D	SD
7.	Sexual deviation is highly correlated with drug use.	SA	A	N	D	SD

8.	The pleasurable use of drugs is justified.	SA	A	N	D	SD
9.	All health-related problems have a chemically related solution.	SA	A	N	D	SD
10.	An important motive for drug use is dissatisfaction or disillusionment with the prevailing social system.	SA	A	N	D	SD
11.	Health professionals contribute to more drug dependency than they cure.	SA	A	N	D	SD
12.	Drug use can be helpful in coping with one's environment.	SA	A	N	D	SD
13.	The most frequent cause of drug dependency among teenagers is the "pusher."	SA	A	N	D	SD
14.	The greatest danger of marijuana is arrest.	SA	A	N	D	SD
15.	Any nonprescription use of a drug is abuse.	SA	A	N	D	SD
16.	Use of drugs for pleasure has a place in our society.	SA	A	N	D	SD
17.	You can generally tell a drug user by physical appearance.	SA	A	N	D	SD
18.	People who use drugs are trying to cope with stress.	SA	A	N	D	SD
19.	With regard to work, I would expect drug users to be less dependable.	SA	A	N	D	SD

PARTICIPANT RESPONSE QUESTIONNAIRE

Please respond to the following statement to the degree to which you feel it is applicable. The scale is 0 to 6, where 0 is equal to no extent whatsoever and 6 is equal to a very great extent.

		Please circle one of the following						
1.	To what extent do you feel you understand your own values and attitudes about drug usage?	0	1	2	3	4	5	6
2.	To what extent do you feel your attitudes towards a person affect the type of health (helping) care you provide to that person?	0	1	2	3	4	5	6
3.	To what extent do you feel you understand chemical dependency?	0	1	2	3	4	5	6
4.	To what extent do you feel that drug abuse is *not* limited to any lifestyle, age, sex, creed or profession?	0	1	2	3	4	5	6
5.	To what extent do you feel you can effectively use your own professional skills in caring for a client with drug problems?	0	1	2	3	4	5	6

6.	To what extent do you feel an interdisciplinary approach to health care is important in managing drug abuse problems?	0	1	2	3	4	5	6
7.	To what extent do you feel you understand laws and legal procedures that relate to your work with drug abusers?	0	1	2	3	4	5	6
8.	To what extent do you feel drug abusers are prevented from receiving access to the health care delivery system?	0	1	2	3	4	5	6
9.	To what extent do you feel health professionals have a role as change agents in their communities?	0	1	2	3	4	5	6
10.	To what extent do you feel you are able to obtain relevant information regarding drug-taking behavior from clients?	0	1	2	3	4	5	6
11.	To what extent do you feel you are aware of various treatment modalities available for referral of clients with drug problems?	0	1	2	3	4	5	6
12.	To what extent do you feel you are able to effectively use information gained from a client to make an appropriate referral for the specific problem involved?	0	1	2	3	4	5	6
13.	To what extent do you feel you know where to obtain information and training regarding drug use and abuse?	0	1	2	3	4	5	6

Appendix 15

Description of Outcomes

Description of Outcomes

The fourteen anticipated behavioral outcomes of participants are reported by questions from the six month follow-up questionnaire which relate to the objectives. The percentage of responses is discussed by profession for those participants to whom the question was applicable, and the distribution of responses is discussed by profession for those participants who responded that the question did not apply. Where appropriate, anecdotal information will be reported to support participants' checked responses.

A total of 267 follow-up questionnaires were completed by past participants. Not all the percentages reported will equal 100% because some persons did not respond to every question and some responses were uncodable.

GOAL 1: Participants report that they are using appropriate drug history taking techniques.

Outcome Question 3: Approximately how often do you use an external validation source to verify client reports regarding possible drug problems?

On the follow-up questionnaires, 32% of the respondents indicated that this question was not applicable to them; the remaining categories

were indicated by the following percentage of participants:

Category	Percentage
1. Always	9%
2. Frequently	14%
3. Sometimes	21%
4. Not too often	13%
5. Never	10%

When a sample (N=78) of these respondents were asked if this represented an increase, decrease or no change compared to their activities prior to the workshop, 22% reported that it was an increase, 77% indicated no change, and 1% reported a decrease. The explanation offered by the participant who decreased the use of external validation sources was that after the conference, the participant did not feel comfortable contacting the police for verification and thus decreased verification efforts. All participants who indicated a change (23%) reported that the change was somewhat or totally due to their participation in the workshop.

Outcome Question 4: Approximately how often do you document chemical dependency problems in charts or other client records?

For this question 27% of the participants responded "does not apply." The remaining categories were checked by the following percentage of participants:

Category	Percentage
1. Always	31
2. Frequently	11
3. Sometimes	12
4. Not too often	10
5. Never	8

A sample of these respondents (N=78) were asked whether or not this was increased, decreased or the same as before the workshop. Thirty-three percent reported an increase and 67% reported no change. Of those who reported an increase, 100% indicated that the cahnge was totally or somewhat related to their participation in the workshop.

Outcome Question 6: To what extent do you feel you are able to obtain relevant information from clients regarding drug-taking behavior?

In response to this question, 16% of the 267 respondents reported that it did not apply. Of the remaining participants, the percentage breakdown of responses is as follows:

Category	Percentage
1. To a great extent	14
2. To a fair extent	40
3. To some extent	21
4. Very little	8
5. Not at all	0

One person (1%) did not respond at all.

The 14% "to a great extent" response was more than double the pre-conference response of 6.1% and appeared to be a growth even over the post-conference response of 7.8%. A significant shift occurred during the conference regarding the extent to which participants felt they were able to obtain relevant information. Before the conference 36.6% indicated an extent of confidence in the upper 43% of the scale. This moved to 66% on the post-conference test. At follow-up 54% indicated confidence in the upper 40% of the scale. This move was even more significant from the lower 43% of the scale. On the pre-conference test 31.6% indicated a low level of confidence, whereas on the post-conference test only 10.2% indicated an extent in the lower 43% of the scale. At follow-up only 8% were in the lower 40% of the scale. Hence, there was a long-term increase in the confidence participants felt in their ability to obtain relevant information six months after the conference. (Forty percent of the follow-up sample indicated an increase in history taking that they attributed directly to their conference participation.)

GOAL 2: Participants will make more appropriate and an increased number of referrals for drug-related problems.

Outcome Question 7: What is the average number of referrals for drug-related problems you make per month?

Forty-nine percent of the respondents reported that this question did not apply. The remaining categories were checked by the percentage of respondents reported below:

Category	Percentage
21 or more per month	2
16 to 20 per month	2
11 to 15 per month	1
6 to 10 per month	4
1 to 5 per month	35
0 per month	4

From the sample of 78 persons who were asked whether this was an increase, decrease or the same as before the workshop, 24% reported an increase, 3% reproted a decrease and 73% reported no change. The 3%

(N=2) reporting a decrease stated, in one case, that it was due to a reduced number of clients seen since the workshop and, in the other case, that the decrease was due to a change in job. Both participants reported that this decrease in number of referrals was not related to their paraticipation in the workshop. Of the 24% who did report an increase in referrals, 89% reported that the increase was due to their participation in the workshop.

Outcome Question 8: What is the approximate number of agencies to which you now refer clients with drug-related problems?

Of the 267 respondents, 42% reported that the question was not applicable. The remaining persons responded as follows:

Category	Percentage
9 or more	3
7 or 8	2
5 or 6	10
3 or 4	20
1 or 2	17
0	3

Twenty-one percent of the persons sampled (N=78) reported that this was an increase, 1% reported a decrease and 78% reported no change. The 1% reporting a decrease (N=1) indicated that the decrease was due to a new job situation and was not realted to workshop attendance. Of the 21% reporting an increase, 100% related the change to their participation in the workshop.

Outcome Question 10: Do you routinely do follow-up on clients you have referred?

This question was not applicable to 39% of the 267 respondents. The distribution of the other responses was:

Yes = 31% No = 29%

When a sample (N=78) of the respondents were asked whether or not this was an increase, decrease or the same as before the workshop, 12% indicated an increase, and 100% of these reported that the increase was related to their participation in the workshop. No one reported a decrease in routine follow-up of clients since the workshop, and 88% reported no change.

GOAL 3: Participants will report doing routine assessment for drug-related problems with clients.

Outcome Question 2: Approximately how often do you do routine screening for chemical dependency problems with clients or client families?

Twenty-seven percent of the 267 respondents reported that the question was not applicable to them. The percentage breakdown of participants

responding to the remaining categories is as follows:

Category	Percentage
1. Always	18
2. Frequently	14
3. Sometimes	17
4. Not too often	13
5. Never	11

When these same persons (N=78) were asked if this represented a change, 40% reported that this was an increase since the workshop. Of these, 97% related the increase to their participation in the workshop. Sixty percent of the respondents reported no change.

GOAL 4: Participants will increase their involvement with community drug agencies.

Outcome Question 12: How often do you visit drug treatment agencies?

For this question, 1.5% of the respondents reported that it did not apply, and one person (0.4%) reported not knowing how often. Of the 267 respondents, 6% left the question blank, and the other categories were checked as follows:

Category	Percentage
Frequently	16
Sometimes	13
Seldom	25
Never	38

When the sample of 78 were asked whether or not this was an increase, decrease or the same number of visits as before the workshop, 14% reported an increase, 1% a decrease and 85% reported no change. The one person reporting a decrease noted that it was because of fewer problems, a change apparently due to the decrease in college enrollments. This decrease in visits to treatment centers was not related to the workshop, according to the participant. Of the 14% who reported an increase in the number of times they visit drug treatment agencies, 82% reported that the increase was related to their participation in the workshop.

Outcome Question 13: How often do you visit drug information centers?

Three of the 267 respondents (1%) reported that this question did not apply to them. Another 6% did not respond at all, and the remaining responses are as follows:

Category	Percentage
Frequently	13
Sometimes	10

Seldom	22
Never	48

When a sample of 78 of the total population were asked whether this was an increase, decrease or the same as before their attendance at the workshop, 10% reported an increase and 90% reported no change. Of those who reported an increase in the frequency of visits to drug information centers, 100% reported that the increase was related to their participation in the workshop.

Outcome Question 14: Are you currently helping drug treatment agencies with: A medical/health input; B. volunteer activity; C. psychological support services; D. other?

With regard to medical/health input, 23% reported that they were providing these services for a drug treatment agency and 72% reported that they were not. Five percent of the 267 respondents did not answer the question.

Regarding volunteer activities, 14% responded affirmatively, 78% negatively and 8% did not respond at all.

For psychological support services, 20% reported that they were offering services to drug treatment agencies, while 73% were not. Seven percent did not respond.

With regard to the "other" category, two persons (6%) reported that they were offering services to Alcoholics Anonymous groups. The remaining 94% of the respondents did not respond affirmatively to this question.

Of the 78 person sample who were asked whether this was increased, decreased or the same activity as before the workshop, 13% reported an increase and the remaining 87% reported no change. Of those who did report an increase, 90% related that increase to their participation in the workshop.

GOAL 5: Participants will disseminate seminar material to other health professionals.

Outcome Question 15: Since the workshop, have you attempted to distribute drug information to other health professionals?

Of the 267 participants followed-up, 5% reported that this question was not applicable to them and 1% did not respond at all. The percentage breakdown of remaining responses is as follows:

Category	Percentage
1. To a great extent	24
2. Some	58
3. Not at all	12

Some examples of how participants disseminated drug information to other

health professionals, as reported by the participants, include one person who presented information regarding attitudes, treatment methods and detoxification to student nurses, registered nurses and other staff within the institution. In another case, the participant reported working conjointly with the hospital social service department in presenting two inservice programs for the Intensive Care Unit of the hospital. Another participant discussed with the hospital pharmacist the need for record keeping of medicines distributed. A pharmacist reported having done a presentation on the material gleaned from the workshop to the county pharmaceutical agency.

Several participants reported that they disseminated workshop material by means of informal discussions with colleagues. However, several other persons reported having taken part in formal inservice presentations for their agencies after the workshop, either by themselves or in conjunction with other staff who also attended the workshop. Most participants also reported that they had made all literature received at the workshop available to their colleagues.

Outcome Question 16: Since the workshop have you disseminated information to other health professionals about referral sources available?

Nine percent of the 267 participants reported that this question was not applicable to them and the remaining responses were as follows:

Category	Percentage
1. To a great extent	12
2. Some	52
3. Not at all	26

Anecdotal information supplied by respondents regarding how they disseminated information about referral sources included two persons from two different institutions who invited a representative from one of their local drug treatment agencies to do an inservice for staff. Information regarding what kind of clients each agency worked with best was included in both instances. Another participant invited the regional chemical dependency coordinator to the agency to provide staff with information regarding all referral agencies available for that area.

As with question 15, most people reported that their dissemination of information about referral sources available was done informally through discussions with other health professionals.

Outcome Question 17: Since the workshop have you encouraged any colleagues to visit and/or help drug agencies?

Of the 267 persons followed up, 9% reported that this question was

not applicable to them. The remaining respondents checked the following categories:

Category	Percentage
1. To a great extent	11
2. Some	45
3. Not at all	35

Participant descriptions of these efforts included encouraging the hospital social service department to visit all agencies to which they referred clients with drug-related problems in order to determine which clients could best be treated where. One participant reported informally encouraging colleagues to visit other agencies, and as a result two persons did visit an agency. Another participant reported encouraging those within the agency who do visit drug treatment agencies to bring back information regarding the agencies to other staff who cannot go, and this has been operationalized.

GOAL 6: Participants will seek further information and training regarding drug use and/or abuse.

Outcome Question 34: Since the workshop have you attended any other drug training programs?

Category	Percentage
Yes	15
No	85

Examples cited by participants who did seek further training included: a visit to the National Drug Abuse Center, application to the Chemical Dependency Counseling Program at the University of Minnesota, attendance at a district chemical dependency workshop through the Minnesota Nurses Association including treatment techniques, and application for a traineeship with HPDAEP.

Outcome Question 35: Have you written for or in any other way obtained further information on drugs and/or drug use since the workshop?

Category	Percentage
Yes	42
No	57

Some examples of material sent for and agencies to which requests were made by participants include: *Licit and Illicit Drugs*, State Health Department, "Do It Now" Foundation, American Cancer Society, local drug libraries, and the Parents Are Responsible program from Metro Drug Awareness.

GOAL 7: Participants will attempt to effect procedure and policy changes

within their institutions regarding drug-related problems.

Outcome Question 21: Since the workshop have you been responsible for or attempted to effect any procedure or policy changes with regard to drug problems in your institution?

Four percent of the population (N=267) did not respond to this question, and 16% reported that it did not apply to them. The response distribution for the remaining categories is as follows:

Category	Percentage
1. Definite changes have occurred	14
2. Small changes have apparently occurred	21
3. Changes are now being considered	12
4. I've tried but to no avail	8
5. No attempts have been made	25

Anecdotal information provided by respondents for this question was extensive. Examples of supportive information offered by participants are reported for each of the first four response categories.

1. Definite changes have occurred.

   —Questions regarding alcohol and nicotine use have been included on the intake form.

   —A past participant helped set up a referral service within the institution for employees and employee families regarding mental health and drug-related problems. An employee's job security is not threatened by utilization of the service.

   —A participant reported that 13 members of the hospital staff, including R.N.'s, social workers, staff educators and residents attended various HPDAEP seminars. The 13 past participants now make up a Chemical Assessment Team which is recognized throughout the hospital, supported by the medical staff, and called upon to do diagnostic interviewing of patients for whom a possible drug problem is suspected.

   —A physician has implemented a prescription review procedure within his family practice clinic and with family practice residents whom he supervises. The prescription pad is numbered consecutively and written in duplicate. A monthly computer print-out will be reviewed to discuss prescribing habits of physicians and can be interfaced with an already operative monthly review of the diagnosis made for each client.

2. Small changes have apparently occurred.

   —After the workshop a participant prepared a chart about appropriate treatment of acute drug overdose; the chart is posted in the emergency room.

—A participant reported that attitudinal changes are apparent among colleagues. A team approach has been implemented to educate physicians to look more seriously at chemical problems.

—Judgmental attitudes of an emergency room staff have changed since the workshop. Intoxicated persons are now treated as opposed to being ignored by the staff.

—Some changes have been effected among staff by encouraging them to look at how their own drug use may affect the kind of care they provide to clients with drug-related problems.

3. Changes are now being considered.

—An assistant chief pharmacist is working conjointly with the hospital's chief pharmacist to provide drug education for the medical staff on an ongoing basis. Plans to utilize the John Brantner film entitled "The Psychology of Intoxication—A Model for Understanding Drug Taking Behavior" are part of the education process.

—Plans to set up a drug education and counseling program within a senior high school are being considered. The program would involve training peer counselors to work with students whose drug use is or may be interfering with academic achievement. Support for the program has been requested from the Midwest Regional Training Center.

—Since the workshop, a hospital pharmacist has received medical staff approval to include pharmacists as part of the health team. Planning is underway to employ the hospital pharmacists to do all drug history interviews on clients admitted to the hospital.

—A past participant and three other staff members have proposed establishing a drug treatment center in their area as an alternative to incarceration.

4. I've tried but to no avail.

—A participant has suggested utilizing treatments other than chemotherapy for depression, but physicians have not been receptive.

—A participant reports trying to implement new diagnostic interviewing techniques learned at the workshop, but efforts were not well-received by other staff.

—An attempt was made to implement a chemical assessment team for the hospital, but general staff opinion was that an assessment team was not needed.

Outcome Question 22: Is your agency currently offering more services for clients with drug-related problems than it was six months ago?

Of the 267 persons followed-up, 2% did not respond to the question, and 20% indicated that the question was not applicable to them. The remaining categories were checked as follows:

Category	Percentage
Yes	30
No	48

Anecdotal information provided by the respondents does not indicate whether the new services are in any way related to a staff member's attendance at the workshop. However, responses to question 21 regarding changes within participants' institutions suggest that services such as a chemical assessment team and a referral service for employees with drug-related problems are new services not available before the workshop.

GOAL 8: Participants will be able to utilize workshop material in helpful ways with family members and friends.

Outcome Question 23: Was the workshop helpful to you in handling personal situations with family and/or friends, concerning drug-related problems?

Five percent of the 267 participants followed-up did not respond to the question. One person (.7%) reported that the question did not apply at the time of follow-up because no drug-related problems were perceived to be apparent in the respondent's family or friends. For analysis of the responses, item 4, "Unhelpful," and item 5, "Very Unhelpful," were merged, and the remaining categories were checked as follows:

Category	Percentage
1. Very helpful	27
2. Helpful	47
3. No help that I'm aware of	19
4. Unhelpful or very unhelpful	0.4

The following anecdotal information was offered by respondents to clarify why they felt the workshop was either very helpful or helpful.

1. Very helpful
   - —One participant reported that the workshop provided the rationale and courage to confront a close friend about the friend's apparent drug problem. The friend entered treatment as a result of the confrontation, and the participant reported feeling very good about that happening.
   - —A relative of a participant died just prior to the workshop and the death was related to the relative's use of alcohol. The workshop was helpful to the participant for sorting out feelings about the death and for talking with the rest of the family.

—One participant reported that the workshop was stimulating and helpful in understanding a spouse's alcoholism.

—The workshop was especially helpful to one participant in terms of attitudes toward the participant's own teenage children.

2. Helpful

—One participant reported that the workshop provided the tools to help people make their own decisions about drugs.

—At the time of follow-up, a participant reported being better able to be supportive of a friend whose father was an alcoholic.

—The workshop was helpful to a participant who reported that her husband was an alcoholic and is in and out of treatment periodically.

—One participant responded with the statement: "My changes in attitude and understanding will be helpful to my own family's development."

Outcome Question 24: Have you discussed the similarities and/or differences of social, illicit and prescription drug use with your family and/or friends since the workshop?

Six percent of the 267 participants did not respond to this question. One person reported that it was not applicable since none of the participant's family or friends used drugs. The remaining categories were checked as follows:

Category	Percentage
1. Yes, a great deal	40
2. Yes, some	53
3. Not at all	7

GOAL 9: Participants will attempt to or effect changes regarding drug-related problems in their community.

Outcome Question 25: Have you attempted or been responsible for procedure and/or policy changes within your community with regard to drug-related problems?

One person responded that this question did not apply but offered no explanation, and 2% did not respond at all. The remaining categories were checked as follows:

Category	Percentage
1. Definite changes have occurred.	4
2. Small changes have apparently occurred.	10
3. Changes are now being considered.	8
4. I've tried but to no avail.	3
5. No attempts have been made.	73

One anecdotal statement will be reported for each of the first four response categories.

1. Definite changes have occurred.

   A participant initiated a Parents Are Responsible program for the community.

2. Small changes have apparently occurred.

   One participant reported doing lectures to church groups regarding attitudes abouts drugs and drug users based on the workshop format.

3. Changes are now being considered.

   A participant reported talking with elementary school officials to encourage good drug education at an early age.

4. I've tried but to no avail.

   One participant reported trying to talk with school officials about drug programs for the schools but got nowhere.

GOAL 10: Participants will report increased effectiveness in working with clients with drug-related problems.

Outcome Question 5: How effective do you feel you are in working with clients with drug-related problems?

This question was not applicable to 15% of the 267 respondents. The remaining categories were checked as follows:

Category	Percentage
1. Very effective	7
2. Effective	37
3. Don't know	30
4. Ineffective	7
5. Very ineffective	2

Response to this question indicates little change from the pre-conference rating of very effective. However, there was a decrease in those feeling relatively ineffective. On the pre-conference test, 52.3% indicated effectiveness in the upper 43 percent of the scale, whereas 20.6% indicated effectiveness in the lower 43 percent of the scale. This moved to 70.2% and 8.6%, respectively, on the post-conference test. However, as indicated, 44% indicated effectiveness in the upper 40% of the scale, whereas 9% responded in the lower 40% of the scale. Thus, although fewer are indicating ineffectiveness, more are saying they don't know. As might be expected, those working in a drug-related job indicated the higher feeling of effectiveness ($r^2 = .0982$).

GOAL 11: Participants will report appropriate prescribing, recommending and utilization of psychoactive prescription drugs.

Outcome Question 27: Since the workshop have you noticed any changes in the way you dispense, utilize or recommend prescription of psychoactive drugs?

This question was not applicable to 38% of the 267 respondents. The remaining categories were checked as follows:

Category	Percentage
1. Great increase	3
2. Somewhat increased	3
3. No change	25
4. Somewhat decreased	24
5. Great decrease	5

Participants who explained their decrease in prescription or utilization of psychoactive drugs noted for the most part that the workshop caused them to be more aware of drugs prescribed, either by themselves or others, and also helped them become more cautious about the distribution of psychoactive drugs.

Outcome Question 28: Since the workshop have you utilized or recommended utilization of treatments other than psychoactive drug therapy for the clients you see?

Forty-eight percent of the participants reported at the time of follow-up that this question was not applicable to them. The remaining categories were checked as follows:

Category	Percentage
1. To a great extent	9
2. Somewhat	28
3. Not at all	14

Some of the suggested treatment alternatives include: drug information centers, group therapy, increased individual counseling, occupational therapy, relaxation therapy, and self-help groups. An I.C.U. allowed longer visiting hours for patient families (from 10 to 30 minutes per visit) and found that patients required less sedative-type medication.

Outcome Questions 26A and 26B: Prior to the workshop, participants were sent a copy of the book *Mystification and Drug Misuse* by Henry L. Lennard and associates. At the time of follow-up, participants were asked whether they read the book and, if so, to what extent they agreed with the views of the authors.

Eighty-nine percent of the participants reported that they did read the book, and of these, eighty-six percent reported their level of agreement

as follows:

Category	Percentage
1. Strongly agree	20
2. Agree	60
3. Neutral	17
4. Disagree	3
5. Strongly disagree	0

GOAL 12: Participants will report greater awareness and utilization of interdisciplinary approach to health care.

Outcome Question 18: Since the workshop, has your involvement with an interdisciplinary (team) approach to health care changed?

A sample of 78 participants (29%) were asked whether or not their involvement with an interdisciplinary team had changed and whether they attributed all, some or none of the change to their participation in the workshop.

The percentage breakdown of responses is:

Category	Percentage
1. Definitely more involved with team	24
2. Somewhat more involved	33
3. No change	31
4. Somewhat less involved	0
5. Definitely less involved	0
6. Does not apply	12

For those who stated that they were either definitely more involved or somewhat more involved with a team approach to health care, 98%, related this increase to their participation in the workshop.

GOAL 13: Participants will report comfort with and a better understanding of their own drug taking behavior.

Outcome Question 30: Since the workshop, how comfortable do you feel with your own drug use or lack thereof?

The percentage breakdown of responses to this question is as follows:

Category	Percentage
1. Very comfortable	45
2. Comfortable	47
3. Not sure	3
4. Uncomfortable	4
5. Very uncomfortable	0

One of the participants in the "not sure" category commented that since the workshop he is more aware of own drug uses and thus not sure of his level of comfort. For those who responded that they are very comfortable or comfortable, typical comments included:

I don't use any drugs.
I am now more aware of my own drug use.

For those who responded that they are uncomfortable, comments included:

I am now more aware of my own smoking habits, as I never considered nicotine a drug before the workshop.

I am less comfortable with my own drug use since the workshop because of greater awareness of my drug use.

Outcome Questions 32A, B, C: Since the workshop, have you increased/ decreased your use of A. social drugs, B. illict drugs, C. psychoactive prescription drugs?

The percentage breakdown of responses for each of these questions is as follows:

A. Social Drugs

Category	Percentage
1. Great increase	0
2. Increased	1
3. No change	72
4. Decreased	18
5. Great decrease	3
6. I don't use any	6

B. Illicit Drugs

Category	Percentage
1. Great increase	0
2. Increased	3
3. No change	34
4. Decreased	3
5. Great decrease	0
6. I don't use any	61

C. Psychoactive prescription drugs

Category	Percentage
1. Great increase	1
2. Increased	0
3. No change	27
4. Decreased	4
5. Great decrease	1
6. I don't use any	67

GOAL 14: Participants will understand the effect of their attitudes toward drugs, drug users and drug abusers.

Outcome Question 20: To what extent do you feel your attitudes about a person affect the type of health (helping) care you provide to that person?

Three percent of the participants reported that the question was not applicable to them. The remaining categories were checked as follows:

Category	Percentage
1. Not at all	8
2. Probably, but I'm not aware of it	8
3. I don't know	4
4. Somewhat	26
5. To a great extent	49

This response by the follow-up sample indicated a continued change from the conference. On the same question prior to the conference, 31 percent indicated "to a great extent." The post-conference response was 39 percent marking "to a great extent." Hence, the follow-up response indicated a possible growing awareness of attitudes and their effect on health care as persons returned to work experiences subsequent to the workshop emphasis on attitudes. This concept is further supported by the fact that the main correlation factor for indicating "to a great extent" on the follow-up interview was post-conference attitude score (a Pearson r correlation of .439 with an $r^2 = .193$).

Appendix 16

Table 1.

Job-related Change, Personal Change, Community Change

Goal Category: Job-related Change

Goal	Question	% Responding Does Not Apply	Mean % For Goal	% of Desired Response	% Of Undesired Response	% Relating Change To Workshop	Mean % of Goal
1	3	32%	25%	44%	23%	22%	27.5%
	4	27%		54%	18%	33%	
	6	16%		54%	29%	-----	
2	7	49%	43%	9%	39%	24%	19%
	8	42%		35%	20%	21%	
	10	39%		31%	29%	12%	
3	2	27%	27%	49%	24%	40%	40%
5	15	5%	7.7%	82%	12%	24%	15.7%
	16	9%		64%	26%	12%	
	17	9%		56%	35%	11%	
7	21	16%	18%	55%	25%	55%	42.5%
	22	20%		30%	48%	30%	
10	5	15%	15%	44%	39%	-----	-----
11	27	38%	43%	29%	31%	29%	33%
	28	48%		37%	14%	37%	
12	18	12%	12%	57%	31%	57%	57%

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Goal Category: Personal Change

Goal	Question	% Responding Does Not Apply	Mean % For Goal	% of Desired Response	% Of Undesired Response	% Relating Change To Workshop	Mean % of Goal
8	23	5%	5.5%	74%	19%	74%	83.5%
	24	6%		93%	7%	93%	
13	30	0	---	92%	7%	92%	81.5%
	31	0		71%	28%	71%	
14	20	3%	3%	75%	21%	---	

Goal Category: Community Change

Goal	Question	% Responding Does Not Apply	Mean % For Goal	% of Desired Response	% Of Undesired Response	% Relating Change To Workshop	Mean % of Goal
4	12	1.5%		29%	63%	14%	12.3%
	13	1.0%		23%	70%	10%	
	14A	----		23%	72%		
	14B	----		14%	78%	13%	
	14C	----		20%	73%		
9	25	2%		25%	73%	25%	25%
6	34	----		15%	85%	15%	28.5%
	35	----		42%	57%	42%	

Appendix 17

Community Telephone Survey Instrument

January 6, 1975

MEMO

To: All Interviewers
From: Donna M. Audette, Evaluation Specialist
Re: Community Telephone Survey

The purpose of this survey of persons randomly selected from the Crow Wing County community is to determine the interviewees' opinions regarding:

1. The major health problem in the county.
2. Whether or not there is a drug problem in the county.
3. What is being done to alleviate the drug problem in the county.
4. What facilities are available to treat chemical dependency.
5. Whether or not there is a need for additional facilities within the community to treat chemical dependency.

All interviews will be conducted by telephone. The seven-item questionnaire is attached.

Important

1. When doing a telephone survey, always introduce yourself by name first and say that you are calling for the Crow Wing County Drug Council.
2. Read the questions exactly as they are written on the interveiw form.
3. Record the interviewees' responses exactly as they offer them without interpretive or editorial additions of your own.

4. Refrain from responding to the interviewee by saying "good," "fine," "right," or "I agree." Responses such as these can bias the interviewee's answers to subsequent questions.

5. Assure the respondents that any information they offer will be kept confidential and that in the interest of the survey we would appreciate their candid responses.

CROW WING COUNTY DRUG COUNCIL PRE-CONFERENCE SURVEY

prepared in conjunction with
Health Professionals Drug Abuse Education Project and
University of Minnesota AHEC

Introduction

My name is _____ and I am calling for the Crow Wing County Drug Council. We are doing a survey of citizens randomly selected from the community and I would appreciate a few moments of your time to answer a few questions.

All of the information you offer will be confidential in that it will not be associated with your name; it will be used solely to inform the County Drug Council and for no other purposes.

1. What, in your perception, is the most serious health problem in Crow Wing County?

_____

_____

_____

_____

2. Do you think there is a drug problem in Crow Wing County?

_____ Yes _____ No

2a. (If yes), what do you perceive the problem to be?

_____

_____

_____

3. What, in your perception, is currently being done to alleviate drug problems in this county?

_____

4. What facilities are currently available to treat chemical dependency?

5. To which of these facilities would you refer someone with a chemical dependency problem?

6. Do you feel there is a need for additional treatment facilities to deal with chemical dependency?

_____ Yes _____ No Explain:

7. How would you define chemical dependency?

8. Are there any teenagers living in your household?

_____ Yes _____ No

Thank you for your time and input to this survey.

Appendix 18

Follow-up Questionnaire:

Crow Wing County Community Conference

Follow-up Questionnaire: Crow Wing County Community Conference

1. Approximately what percentage of the persons you see in your profession (e.g. students, clients, law offenders, patients, etc). have drug-related problems themselves or in their families?

   1. _____ % _____
   2. Don't know _____
   3. Does not apply _____

2. What is the average number of referrals for drug-related problems you make per month?

   1. _____ _____
   2. Does not apply _____

3. What is the approximate number of agencies (persons) to which you now refer clients with drug-related problems?

   1. _____
   2. Does not apply _____

4. What types of agencies (persons) do you routinely utilize when making referrals for drug-related problems?

   1. Individual counselor _____
   2. Drug information centers _____
   3. Outpatient counseling. _____
   4. Self-help groups _____

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5. Residential treatment _____
6. Therapeutic communities _____
7. Family counseling _____
8. Other _____
9. Does not apply _____

5. Do you routinely do follow-up on clients you have referred?

1. Yes _____
2. No _____
3. Does not apply _____

6. How often do your referrals actually go to the agency to which they were referred?

1. Always _____
2. Frequently _____
3. Sometimes _____
4. Not too often _____
5. Never _____
6. Don't know _____
7. Does not apply _____

7. How often do you visit drug treatment agencies?

_____

8. Are you currently helping drug treatment agencies with:

A. Medical/health input?
1. Yes _____
2. No _____
3. Does not apply _____

B. Volunteer activity?
1. Yes _____
2. No _____

C. Psychological support services?
1. Yes _____
2. No _____
3. Does not apply _____

D. Other _____

9. Have you attempted to distribute drug information to friends and/or colleagues since the workshop?

1. To a great extent _____
2. Some _____
3. Not at all _____

10. Have you encouraged any of your colleagues and/or friends to visit and/or help drug agencies?

1. To a great extent _____
2. Some _____
3. Not at all _____

11A. How do you feel about persons who use/abuse social drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

11B. How do you feel about persons who use/abuse illicit drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

11C. How do you feel about persons who use/abuse prescription drugs?

1. Very comfortable _____
2. Comfortable _____
3. Indifferent _____
4. Negative _____
5. Repulsed by it _____

12. To what extent do you feel your own attitudes about a person affect the kind of service or health care you can provide to that person?

1. Not at all _____
2. Probably, but I'm not aware of it _____
3. I don't know _____
4. Somewhat _____
5. To a great extent _____
6. Does not apply _____

13. Have you been responsible for or attempted to effect any procedure or policy changes with regard to drug problems in your institution?

1. Definite changes have occurred _____
2. Small changes have apparently occurred _____

3. Changes are now being considered _____
4. I've tried, but to no avail _____
5. No attempts have been made _____
6. Does not apply _____

14. Was the workshop helpful to you in handling personal situations with family and/or friends, concerning drug-related problems?

Please elaborate.

1. Very helpful _____
2. Helpful _____
3. No help that I'm aware of _____
4. Unhelpful _____
5. Very unhelpful _____

15. Have you discussed the similarities/differences of social, illicit and prescription drug use with your family and/or friends?

Please elaborate.

1. Yes, a great deal _____
2. Yes, some _____
3. Not at all _____

16. Have you attempted or been responsible for procedure and/or policy changes within your community with regard to drug-related probelms?

Please elaborate.

1. Definite changes have occurred _____
2. Small changes have apparently occurred _____
3. Changes are now being considered _____
4. I've tried, but to no avail _____
5. No attempts have been made _____

17. Since the workshop, how comfortable do you feel with your own drug use, or lack thereof?

1. Very comfortable _____
2. Comfortable _____
3. Not sure _____
4. Uncomfortable _____
5. Very uncomfortable _____

18. Since the workshop, to what extent do you feel you understand your own drug taking behavior, or lack thereof?

1. Much better _____
2. Somewhat better _____
3. No change _____
4. Somewhat more confused _____
5. Not at all _____

19A. Since the workshop, have you increased/decreased your use of social drugs?

Explain.

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any _____

19B. Since the workshop, have you increased/decreased your use of illicit drugs.

Explain.

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any. _____

19C. Since the workshop, have you increased/decreased your use of pychoactive prescription drugs?

Explain.

1. Great increase _____
2. Increased _____
3. No change _____
4. Decreased _____
5. Great decrease _____
6. I don't use any _____

20. Please list, in order of importance to you, the most significant things that the Crow Wing County Drug Council has accomplished since the workshop:

_____

_____

_____

_____

21. Please list, in order of importance to you, what you would like to see the Crow Wing County Drug Council accomplish in the near future:

_____

_____

_____

_____

22. Have you attended any other drug training programs since the workshop?

If yes, where?

1. Yes _____
2. No _____

23. Have you written for, or in any other way obtained, further information on drugs and/or drug use since the workshop?

If yes, where?

1. Yes _____
2. No _____

24. Do you have any suggestions on how the Health Professionals Drug Abuse Education Project workshop could have been more helpful to you?

_____

_____

_____

_____