Article

Should Relapse Always Be Punished? A Survey Study into Forensic Social Professionals' Attitudes to Substance Use

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Abstract

Health professionals' attitudes to substance abusers have been reported as suboptimal with potential adverse consequences for the quality of health care provided. Less is known about professionals working with addicted clients in mandated contexts. The aim of this study is to gain insight into forensic social professionals' attitudes to substance use and examine differences between subgroups of professionals. An online survey including the Brief Substance Abuse Attitude Scale was completed by 314 Dutch forensic social professionals. Overall, forensic social professionals' attitudes to substance use and treatability were positive, but there were differences regarding needed treatment interventions and ways of controlling substance use. Professionals who work within specialist addiction services had less moralistic and stereotypical attitudes. Professionals who have personal experiences with addiction reported to be more tolerant, but at the same time more convinced of strict control of substances use of their clients.

Keywords

substance abuse, attitudes, addiction treatability, involuntary clients, probation, forensic mental health care

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Introduction

Forensic social professionals have a crucial role in the resocialization trajectories of their clients with substance use problems. Most studies and theoretical work into the effectiveness of forensic interventions concern methods and policies, less is known about the influence of personality characteristics of the professional and his or her personal experiences or attitudes (Durnescu, 2012). For example, what attitudes do professionals have toward substance users and addiction treatment? Most studies into attitudes toward substance use have been conducted with health professionals working in emergency departments, general practitioners, or anesthesiologists. In a systematic review of 28 studies into health professionals' attitudes toward patients with substance use disorders it was concluded that, in general, health professionals hold suboptimal attitudes toward these patients. Moreover, these attitudes may have serious adverse consequences for the quality of health care these patients receive (van Boekel et al., 2013). Manipulation, aggression, and poor motivation were perceived as impeding factors in healthcare delivery with substance abusers. Health professionals were found lacking adequate training about addiction and to have a task-oriented approach toward substance abusers resulting in less personal engagement and empathic behavior. This may subsequently lead to limited treatment motivation, feelings of insecurity, and higher drop-out rates of these patients. Another risk of negative and stigmatizing attitudes is "diagnostic overshadowing," the misattribution of physical illness symptoms to substance use problems (Thornicroft et al., 2007).

van Boekel et al. (2015) conducted a large cross-sectional study and found the general public and general practitioners to be more negative in their expectations about rehabilitation compared to mental health professionals, addiction specialists, and clients. Generally, studies into attitudes to substance users of mental health professionals and professionals working in specialist addiction services have found more optimistic results than for health professionals (Kirby et al., 2006; Pinikahana et al., 2002). A possible explanation is the higher levels of education about addiction and more experience and personal interaction with addicted patients (Beryl & Völlm, 2018; Gilchrist et al., 2011). Research is still scarce, however, for professionals working within mandated contexts, like probation services or forensic mental health care. Two small-scale studies in forensic mental health care found tolerant attitudes of nurses to substance users (Foster & Onyeukwu, 2003; Richmond & Foster, 2003). To our knowledge, no empirical studies have been published yet on probation officers' attitudes to substance use. It is important to gain more knowledge about professionals working in mandated contexts, as substance abuse is highly prevalent in forensic clients (Fazel et al., 2017; van der Kraan et al., 2014), a strong predictor for recidivism and thus an important target for risk management (Douglas et al., 2013).

Furthermore, knowledge is limited about possible differences in attitudes between subgroups of professionals, for instance, according to gender, years working in the field or personal experiences with addiction. In their small-scale study with 63 nurses working in forensic mental health care, Foster and Onyeukwu (2003) found less moralistic attitudes for female compared to male nurses and more treatment optimism with

black nurses than non-black nurses. In a study examining attitudes toward substance abuse of 512 anesthesiologists, it was found that personal experiences with addiction, or having received education about it, contributed to a more positive attitude toward substance users (May et al., 2002). The same was found in a small convenience sample of 56 mental health professionals (Richmond & Foster, 2003) and in a study with 417 medical students (Linden, 2010). An important question is whether professionals working in specialist addiction services have different attitudes toward substance use compared to other forensic social professionals. In a multi-center study in 8 European countries, 866 professionals from different (mental) health disciplines were questioned about their regard for working with different patient groups (Gilchrist et al., 2011). Regard for working with drug or alcohol users was found to be consistently lower than for working with patients with diabetes or depression across all countries participating in this study. Especially primary care providers appeared to ascribe lower status to working with addicted patients. Professionals working in specialist addiction services, psychologists, and social workers were more positive and showed the highest regard for working with addicted patients. Practical experiences with substance using patients, training and education about addiction, and personal motivation to work with these patients may explain these differences. Furthermore, it was found that professionals with fewer than 10 years of professional experience reported higher regard for working with drug users compared to their more experienced colleagues.

In the present explorative study, we aim to examine attitudes to substance use of forensic social professionals working in mandated contexts like probation services or forensic mental health settings. Furthermore, the aim of this study is to examine whether there are differences in these attitudes between subgroups of professionals according to gender, years of professional experience, work setting (specialist addiction services or other), and personal experiences with addiction.

Methods

Procedure

A survey into forensic social professionals' attitudes to substance use was set up in an online survey program approved by the ethic committee of the Research Centre for Social Innovation of the University of Applied Sciences Utrecht. The online survey included the Brief Substance Abuse Attitude Survey (SAAS; Chappel et al., 1985) and several questions about personal background. It was distributed in October 2019 through channels like LinkedIn, websites of the three Dutch probation organizations, and forensic mental health care settings. All respondents were required to read and sign an electronically informed consent after explanation of the study and completed the survey anonymously. After 10 weeks, the online survey was closed. The survey was fully completed by 314 professionals, that is, they answered all statements of the Brief SAAS. Of these 314 respondents, 22 did not answer the questions about their personal background. Consequently, the subgroup analyses could be conducted for 292 professionals.

The subgroups were defined as follows: (1) Gender; male ($n = 95$, 32.8%) versus female ($n = 195$, 67.2%) (the option "other" was never ticked); (2) Professional experience; less experienced, that is, less than 5 years working in the forensic field ($n = 100$, 31.8%) versus experienced, that is, 5 years or more working in the forensic field ($n = 188$, 65.3%); (3) Addiction specialist; professionals working in specialist addiction services ($n = 81$, 27.7%) versus other forensic social professionals ($n = 211$, 72.3%); and (4) Personal experiences with addiction (see Table 2).

Measures

After a literature review into measures of attitudes to substance use, the Brief SAAS was selected. The original SAAS was developed in the USA for medical professionals and students and consists of 50 statements. The SAAS is widely used and its psychometric properties are found to be good (Jenkins et al., 1990), although it should be noted though that most of these results concern the full version of the SAAS. The Brief SAAS consists of 25 statements to be coded on a five-point scale: (1) strongly disagree; (2) disagree; (3) undecided; (4) agree; (5) strongly agree. The scores on the statements were summed up to calculate the five SAAS factors: Permissiveness, Non-moralism, Treatment intervention, Non-stereotypes, and Treatment optimism (see Table 3). Some of the scores were conversed as these statements were formulated in a reversed way. We chose the brief version as we aimed to include as many respondents as possible in the study. Considering the high workload of most forensic professionals, the survey had to be short and easy to complete. The Brief SAAS was translated into Dutch and back translated by a research assistant and the researchers (author 1 and 2). No formal permission for the Dutch translation of the Brief SAAS could be requested, as the authors could not be retrieved. During the translation, we came across some ambiguities with respect to the Dutch context. After consultation with this study's steering committee consisting of professional experts and policy makers, we made some modifications to the instrument to prevent confusion and to keep the survey as concise as possible. Several words were changed: "forensic social professional" instead of "physician," and "cannabis" instead of "marihuana." Furthermore, three statements were removed that were deemed irrelevant, not understandable or not applicable for the present context (statement number 13, 23, and 24).

Furthermore, several questions were included about the personal background of respondents; age, gender, profession, setting, years of work experience, personal experiences with substance use or addiction. It was also asked how strict they rated themselves on a scale 1 (not strict at all) to 10 (extremely strict) in case they were confronted with substance use relapse of a client.

Statistical Analyses

Data were analyzed with SPSS 25.0. Differences between subgroups of respondents were examined with independent samples *t*-tests and Chi-square analyses with supplementary *z* tests to compare column proportions.

Table 1. Characteristics of Survey Respondents in Numbers and Percentages ($n = 292$).

Characteristics	*N* (%)
Female	195 (67.2)
Male	95 (32.8)
Work setting	
Institute for social rehabilitation of addicted offenders*	80 (27.5)
Dutch probation service*	60 (20.6)
Salvation army probation service*	7 (2.2)
Forensic inpatient setting	92 (31.6)
Outpatient forensic treatment	23 (7.9)
Sheltered living organization	5 (1.7)
Inpatient mental health care	8 (2.7)
Other	16 (5.5)
Years of work experience	
Up to 2 years	37 (12.8)
2–5 years	63 (21.9)
5–10 years	65 (22.6)
10–15 years	50 (17.4)
15 years or more	73 (25.3)

Note. The reported percentages are valid percentages.
*These are the three probation organizations in the Netherlands.

Results

Respondent Characteristics

Table 1 shows the characteristics of the respondents who completed questions about their personal background ($n = 292$). The mean age of the total group is 37.8 years ($SD = 10.8$, range 19–63). Females formed the majority and their mean age in years ($M = 35.6$, $SD = 9.66$) was lower than of their male counterparts ($M = 42.2$, $SD = 11.68$); $t(288) = -2.87$, $p < .01$). Half of the respondents worked for one of the three Dutch probation organizations ($n = 147$, 50.3%), the rest in forensic inpatient settings ($n = 100$, 34.2%), forensic outpatient settings ($n = 28$, 9.5%), or other ($n = 17$, 5.8%). The professions were diverse, but usually concerned a supervising role, like probation supervisor, sociotherapist, or psychologist in a forensic mental health hospital. The mean score on the question how strict professionals rate themselves on a scale 1 to 10 when confronted with substance use relapse of their client was 5.38 ($SD = 1.6$, range 1–10). Most of the respondents ($n = 80$, 27.8%) gave themselves the score 5.

Table 2 shows the personal experiences of the sample with substance use or addiction. Most of the respondents answered to use or have used alcohol and about half of the respondents had used drugs. In total 71.8% of the sample had experiences with addiction of themselves or in their direct surroundings, most of them with friends.

Table 2. Reported Experiences of Respondents with Substance Use and Addiction in Numbers and Percentages ($n = 292$).

Personal experiences with substance use or addiction	*n* (%)
Alcohol use	
Daily	3 (1.0)
More than once a week	60 (20.9)
About once a week	84 (29.4)
About once a month	40 (13.9)
Only on special occasions	61 (21.3)
I used to, but nowadays not	21 (7.3)
Never	17 (5.9)
Drugs use	
Several times a week	3 (1.0)
About once a week	5 (1.8)
About once a month	10 (3.5)
Only on special occasions	33 (11.6)
I used to, but nowadays not	82 (28.8)
Never	152 (53.3)
Addiction	
No personal experiences	82 (28.2)
Addiction self	17 (5.9)
Addiction partner	26 (9.1)
Addiction family	103 (35.5)
Addiction friends	137 (47.6)

Note. The reported percentages are valid percentages. Six of the 292 respondents did not answer the question about alcohol use and seven did not answer the question about drugs use. Multiple answers are possible at the variable Addiction.

Overall Attitudes

Table 3 shows the responses to all SAAS statements and the mean scores for the total group. Many respondents hold optimistic, permissive views on substance users, and treatment interventions. The majority of the respondents disagreed with most of the moralistic and stereotypic statements.

Gender

Male compared to female professionals reported more alcohol use (more than once a week) (29.0% vs. 18.8%, $\chi^2[1, N=285]=3.85$, $p=.05$). Female professionals more often indicated that they have (had) a partner with addiction (12.0% vs. 3.2%, $\chi^2[1, N=284]=5.85$, $p=.016$). Male professionals had higher scores for *An alcohol or drug addicted person who has relapsed several times probably cannot be treated* ($M=1.87$, $SD=0.75$) than females ($M=1.65$, $SD=0.57$); $t(288)=-2.87$, $p<.01$. Females had

Table 3. Responses at SAAS-statements ($N = 314$), in numbers (percentages) and mean scores.

No.	Statement	Strongly disagree (1) *n* (%)	Disagree (2) *n* (%)	Undecided (3) *n* (%)	Agree (4) *n* (%)	Strongly agree (5) *n* (%)	Mean score
Factor 1: Permissiveness							
7	Daily use of one cannabis cigarette is not necessarily harmful.	28 (8.9)	110 (35.0)	64 (20.4)	95 (30.3)	17 (5.4)	2.88
10	Cannabis use among teenagers can be a healthy experiment.	14 (4.5)	46 (14.6)	75 (23.9)	153 (48.7)	25 (8.0)	3.40
14	Lifelong abstinence is a necessary goal in the treatment of alcoholism.	18 (5.7)	103 (32.8)	92 (29.3)	81 (25.8)	19 (6.1)	2.93
15	Once a person becomes drug-free through treatment, he can never become a social user.	8 (2.5)	76 (24.2)	68 (21.7)	136 (43.3)	26 (8.3)	3.31
Factor 2: Treatment interventions							
6	Forensic social professionals who diagnose alcoholism early improve the chance of treatment success.	2 (0.6)	24 (7.6)	70 (22.3)	190 (60.5)	28 (8.9)	3.69
8	Urine drug screening can be an important part of drug abuse treatment.	2 (0.6)	15 (4.8)	28 (8.9)	182 (58.0)	87 (27.7)	4.07
12	Long-term outpatient treatment is necessary for the treatment of drug addiction.	5 (1.6)	48 (15.3)	67 (21.3)	164 (52.2)	30 (9.6)	3.53
17	Group therapy is very important in the treatment of alcoholism or drug addiction.	3 (1.0)	24 (7.6)	117 (37.3)	137 (43.6)	33 (10.5)	3.55
25	Active participation in a program such as AA is essential for a patient to recover from alcohol or drug dependence.	2 (0.6)	58 (18.5)	131 (41.7)	108 (34.4)	15 (4.8)	3.24
Factor 3: Non-stereotypes							
3	Heroin is so addicting that no one can really recover once he/she becomes an addict.	75 (23.9)	176 (56.1)	38 (12.1)	22 (7.0)	2 (0.6)	2.04
5	Smoking leads to cannabis use, which in turn leads to hard drugs.	150 (47.8)	134 (42.7)	20 (6.4)	8 (2.5)	2 (0.6)	1.66
18	A hospital is the best place to treat an alcoholic or drug addict.	20 (6.4)	110 (35.0)	111 (35.4)	58 (18.5)	15 (4.8)	2.80
Factor 4: Treatment optimism							
2	An alcohol or drug dependent person cannot be helped until he/she has hit rock bottom.	110 (35.0)	182 (58.0)	14 (4.5)	7 (2.2)	1 (.03)	1.75
11	An alcohol or drug addicted person who has relapsed several times probably cannot be treated.	111 (35.4)	186 (59.2)	9 (2.9)	7 (2.2)	1 (0.3)	1.73
16	Drug addiction is a treatable illness.	3 (1.0)	9 (1.0)	23 (7.3)	220 (70.1)	58 (18.5)	4.01
19	Alcoholism is a treatable illness.	3 (1.0)	10 (3.2)	18 (5.7)	227 (72.3)	56 (17.8)	4.03
20	Most alcohol and drug dependent persons are unpleasant to work with as patients.	100 (31.8)	169 (53.8)	27 (8.6)	15 (4.8)	3 (1.0)	1.89
Factor 5: Non-moralism							
1	Alcoholism is associated with a weak will.	72 (22.9)	200 (63.7)	25 (8.0)	17 (5.4)	0 (0.0)	1.96
4	Alcohol and drug abusers should only be treated by specialists in that field.	34 (10.8)	150 (47.8)	43 (13.7)	78 (24.8)	9 (2.9)	2.61
9	A forensic social professional who has been addicted to narcotics should not be allowed to practice medicine again.	129 (41.1)	153 (48.7)	21 (6.7)	8 (2.5)	3 (1.0)	1.74
22	Coercive pressure, such as threat or punishment, is useful in getting resistant patients to accept treatment.	31 (9.9)	101 (32.2)	74 (23.6)	101 (32.2)	7 (2.2)	2.85
Not loading on one of the factors							
21	Pregnant women who use alcohol or other drugs should be punished.	54 (17.2)	136 (43.3)	78 (24.8)	38 (12.1)	8 (2.5)	2.39

higher scores on *Alcohol and drug abusers should only be treated by specialists in that field* ($M = 2.69$, $SD = 1.06$) than males ($M = 2.44$, $SD = 1.06$); $t(288) = 1.89$, $p = .05$.

Level of Experience

Professionals with fewer than 5 years professional experience were on average younger ($M = 30.5$, $SD = 8.19$) than colleagues with more than 5 years professional experience ($M = 41.7$, $SD = 10.0$); $t(282) = -9.44$, $p < .001$. They reported more personal experiences with addiction; of themselves (10.2% vs. 3.8%, $\chi^2[1, N = 284] = 4.73$, $p = .03$) or friends (58.6% vs. 41.6%, $\chi^2[1, N = 284] = 7.33$, $p < .01$). Less experienced professionals rated themselves as more strict when confronted with substance use relapse of a client ($M = 5.93$, $SD = 1.68$) compared to their more experienced colleagues ($M = 5.39$, $SD = 1.70$); $t(282) = -9.44$, $p = .01$. Less experienced professionals had lower scores on the SAAS-Factor Non-stereotypes ($M = 11.2$, $SD = 1.78$) than more experienced professionals ($M = 11.7$, $SD = 1.49$); $t(286) = -2.37$, $p = .02$. Furthermore, they had higher scores for *Smoking leads to cannabis use, which in turn lead to hard drugs* ($M = 1.76$, $SD = 0.83$) than more experienced professionals ($M = 1.56$, $SD = 0.66$); $t(286) = 2.26$, $p = .025$.

Addiction Specialists

Professionals working in addiction services less often reported to use alcohol compared to the other professionals (i.e., more often only on special occasions 24.7% vs. 12.8%, $\chi^2[1, N = 286] = 6.13$, $p = .013$) and reported less that they have (had) friends with addiction problems (37.0% vs. 51.7%, $\chi^2[1, N = 288] = 5.01$, $p = .025$). These addiction specialists rated themselves on average as less strict when confronted with substance use relapse of their client ($M = 5.06$, $SD = 1.44$) than the other professionals ($M = 5.78$, $SD = 1.77$); $t(289) = 3.27$, $p < .001$.

Significant differences were found between professionals working in addiction services versus the other professionals on 2 SAAS-factors and 10 statements. Addiction specialists had lower scores on the SAAS-Factor Treatment Intervention ($M = 17.15$, $SD = 2.09$) than other professionals ($M = 18.51$, $SD = 2.25$); $t(290) = 4.72$, $p < .001$. They had lower scores on the following statements: *Long-term outpatient treatment is necessary for the treatment of drug addiction* ($M = 3.23$, $SD = 0.98$ vs. $M = 3.62$, $SD = 0.88$, $t(290) = 3.25$, $p < .01$), *Active participation in a program such as AA is essential for a patient to recover from alcohol or drug dependence* ($M = 2.99$, $SD = 0.64$ vs. $M = 3.35$, $SD = 0.87$, $t(290) = 3.40$, $p < .01$), and *Group therapy is very important in the treatment of alcoholism or drug addiction* ($M = 3.30$, $SD = 0.78$ vs. $M = 3.68$, $SD = 0.79$, $t(290) = 3.72$, $p < .001$).

Addiction specialists scored significantly higher on the SAAS-factor Non-stereotypes, ($M = 12.20$, $SD = 1.40$) than the other professionals ($M = 11.29$, $SD = 1.60$); $t(290) = 4.46$, $p < .001$. They had lower scores on two statements: *Heroin is so addicting that no one can really recover once he/she becomes an addict* ($M = 1.72$, $SD = 0.73$ vs. $M = 2.15$, $SD = 0.85$, $t(290) = 4.08$, $p < .001$) and *A hospital is the best place to treat*

an alcoholic or drug addict ($M = 2.52$, $SD = 0.78$ vs. $M = 2.90$, $SD = 1.01$, $t(290) = 3.07$, $p < .001$). Furthermore, addiction specialists had higher scores on the statement *Coercive pressure, such as threat or punishment, is useful in getting resistant patients to accept treatment* ($M = 3.22$, $SD = 0.91$ vs. $M = 2.68$, $SD = 1.06$, $t(290) = -4.08$, $p < .001$) and lower scores on *Most alcohol and drug dependent persons are unpleasant to work with as patients* ($M = 1.72$, $SD = 0.76$ vs. $M = 1.96$, $SD = 0.82$, $t(290) = 2.34$, $p = .02$), *Lifelong abstinence is a necessary goal in the treatment of alcoholism* ($M = 2.67$, $SD = 0.98$ vs. $M = 3.06$, $SD = 1.02$, $t(290) = 2.99$, $p < .01$), *Alcoholism is associated with a weak will* ($M = 1.73$, $SD = 0.65$ vs. $M = 2.02$, $SD = 0.72$, $t(290) = 3.22$, $p < .001$) and *Alcohol and drug abusers should only be treated by specialists in that field* ($M = 2.32$, $SD = 0.99$ vs. $M = 2.73$, $SD = 1.07$, $t(290) = 2.94$, $p < .01$).

Personal Experiences with Addiction

Professionals who reported no personal experiences with addiction at all ($n = 82$, 28.2%) were younger ($M = 35.4$, $SD = 9.36$) compared to those who have been addicted themselves or witnessed addiction with their partner, family, or friends ($M = 39.3$, $SD = 10.88$); $t(231) = 2.60$, $p = .01$. They had lower scores on the SAAS-factor Tolerance ($M = 11.66$, $SD = 2.24$) than professionals with personal experiences with addiction ($M = 12.3$, $SD = 2.31$); $t(236) = 2.11$, $p = .036$.

Professionals who had been addicted themselves had higher scores on the SAAS-factor Non-moralism ($M = 16.88$, $SD = 1.87$) than professionals who did not report addiction ($M = 15.48$, $SD = 2.09$); $t(286) = -2.69$, $p < .01$. They scored on average higher on *Drug addiction is a treatable illness* ($M = 4.24$, $SD = 0.61$ vs. $M = 4.01$, $SD = 0.70$, $t(286) = -1.98$, $p = .049$) and lower on *A forensic social professional who has been addicted to narcotics should not be allowed to practice medicine again* ($M = 1.24$, $SD = 0.44$ vs. $M = 1.75$, $SD = 0.75$, $t(286) = 2.78$, $p < .01$), *An alcohol or drug addicted person who has relapsed several times probably cannot be treated* ($M = 1.35$, $SD = 0.49$ vs. $M = 1.74$, $SD = 0.64$, $t(286) = 2.44$, $p = .015$), and *Coercive pressure, such as threat or punishment, is useful in getting resistant patients to accept treatment* ($M = 2.12$, $SD = 1.11$ vs. $M = 2.88$, $SD = 1.04$, $t(286) = 2.93$, $p < .01$).

Professionals who reported having (had) a partner with addiction were older ($M = 42.1$, $SD = 11.2$) than those without this experience ($M = 37.4$, $SD = 10.6$); $t(278) = -2.11$, $p = .035$). On average, they had a higher score on the SAAS-Factor Treatment Interventions ($M = 19.2$, $SD = 2.64$ vs. $M = 18.0$, $SD = 2.22$, $t(284) = -2.59$, $p = .01$) and higher scores on the statements *A hospital is the best place to treat an alcoholic or drug addict* ($M = 3.15$, $SD = 0.93$ vs. $M = 2.75$, $SD = 0.96$, $t(284) = -2.06$, $p = .04$). Professionals reporting to have (had) friends with addiction had higher scores on the SAAS-Factor Treatment Optimism ($M = 18.4$, $SD = 1.54$) than those who did not report friends with addiction ($M = 17.9$, $SD = 1.62$); $t(286) = -2.39$, $p = .017$. Furthermore, they rated themselves as more strict when confronted with relapse of their client ($M = 5.84$, $SD = 1.73$) compared to professionals who did not report friends with addiction ($M = 5.38$, $SD = 1.64$); $t(285) = -2.32$, $p = .021$.

Discussion

In the present study, attitudes to substance use were examined in a sample of 314 Dutch forensic social professionals. The most important conclusion is that forensic social professionals' attitudes to substance users and treatability of addiction are generally positive and not moralistic or stereotypical. The great majority of the respondents believes that addiction is a treatable illness. These results are largely in line with previous studies into attitudes of mental health professionals (Kirby et al., 2006; Pinikahana et al., 2002), but in contrast with studies into medical professionals finding relatively pessimistic attitudes toward substance users (van Boekel et al., 2013). An explanation for the more positive attitudes of forensic social professionals is the assumption that the more interaction you have with these clients and the more knowledge about addiction, the better you understand them and have more positive expectations about treatment possibilities (Beryl & Völlm, 2018; Ding et al., 2005; Gilchrist et al., 2011). This will likely also explain the finding that addiction specialists had the most optimistic attitudes toward substance users. Another possible explanation is that many mental health professionals, and especially addiction specialists, deliberately chose to work with this group and were more optimistic about treatability on beforehand. The significantly lower mean score for addiction specialists on the statement that most substance users are unpleasant to work with confirms this assumption.

Although professionals usually agreed about treatability, there was more disagreement about the content of treatment, ways of controlling substance use, and the needed duration of treatment or aftercare. Especially the statement *Coercive pressure, such as threat or punishment, is useful in getting resistant patients to accept treatment* yielded divergent reactions. It would be interesting to further explore these statements and share experiences and knowledge in daily practice to come to a more shared vision on addiction treatment. This shared vision may also be beneficial for the continuity of care for these patients when they are discharged to other (voluntary) settings.

Several differences were found between subgroups of professionals in attitudes toward substance use. Most striking were the less moralistic and stereotypical attitudes of addiction specialists, which is in line with the study of Gilchrist et al. (2011). Furthermore, addiction specialists generally had a different perspective on necessary treatment interventions, for instance, they believed that treatment in a hospital, group therapy, and long-term outpatient treatment are less needed. It can be argued that their experiences and knowledge may lead to more realistic expectations of needed interventions. Another interesting finding is that addiction specialists rated themselves as less strict when confronted with substance use relapse of their clients, but at the same time believe that coercive pressure is useful for engaging resistant clients. More research is needed into the personal interpretation and specific examples of coercive pressure techniques being used to motivate resistant patients.

The finding that male professionals are somewhat more moralistic and less optimistic about addiction treatability compared to their female counterparts corresponds with

the results of Foster and Onyeukwu (2003) reporting higher scores on the SAAS-factor Non-moralism in female forensic nurses. It should be noted though that the mean scores of the male professionals in the present study are still low and that most men disagree with the moralistic statements. Professionals with less experience rated themselves as more strict and they have more stereotypical attitudes compared to their more experienced colleagues. This was also found in a North-American study into professionals' attitudes about addiction treatment in which less experienced and educated professionals were more supportive of using confrontational approaches (Forman et al., 2001). Professionals with personal experiences with addiction were found to have more tolerant and optimistic attitudes toward substance abusers, which seems logical, as they experienced it themselves and are currently capable of working as professional. In addition, they find coercive pressure less useful to get resistant patient to accept treatment. It would be interesting to explore whether this attitude stems from their personal experiences with treatment interventions.

Implications and Future Suggestions

Although this study provides insight into professionals' attitudes toward substance users and treatability, it is unknown if these attitudes affect their professional activities. Future research into the impact of attitudes, for example, on choices of intervention and whether or not to officially report relapse to authorities is needed. More dialog between professionals of different work settings about attitudes toward substance use and treatability can be valuable, also to improve collaboration and continuity of care as it may lead to more clarity and consistency in policies and interventions for the clients with substance use problems. In general, more education about (treatment of) addiction and sharing knowledge, vision, and experiences between professionals is necessary.

Study Limitations

Several limitations of the present study should be acknowledged. First, the instrument used was initially developed in the United States for medical professionals in 1985. Social circumstances and policies about substance abuse have changed substantially in the past 35 years and there may also be important cultural differences. Still, the SAAS is one of the most widely used and validated tools to assess attitudes to substance use (van Boekel et al., 2013). In the present study, we made several minor adaptations to the statements to make it suitable for the current Dutch context.

Another important limitation to this study is a possible sample selection bias. It is very well possible that especially motivated professionals took the time to fill out the survey. We do not know if the 314 professionals are a representative group of all forensic social professionals. Furthermore, the subgroups that we compared were unequal. Finally, there is risk of social desirability, for instance, about the professionals' own experiences with addiction. However, as the survey was fully anonymous, we do not expect that this was a major issue.

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