

Anglia Ruskin University

An exploration of student midwives'
attitudes toward substance misusing
women following a specialist education
programme

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Abstract

Substance misuse is a complex issue, fraught with many challenges for those affected. Whilst the literature suggests that pregnancy may be a 'window of opportunity' for substance misusing women, it also suggests that there are barriers to women engaging with health care. One of these is fear of being judged and stigmatised by healthcare professionals, including midwives. Previous research indicates midwives have negative regard toward substance users and that this in turn may lead to stigmatising behaviours and consequential substandard care provision. Midwives however, stress that they do not have appropriate training to effectively provide appropriate care for substance misusers. Research suggests that education is needed in this area to improve attitudes.

In this study, the role of education in changing attitude toward substance use in pregnancy was explored using case study methodology. The case was a single delivery of a university degree programme distance learning module 'Substance Misusing Parents,' undertaken by 48 final year student midwives across 8 NHS Trusts. The research was carried out in 3 phases, using a mixture of Likert style questionnaires (Jefferson Scale of Physician Empathy and Medical Condition Regard Scale), Virtual Learning Environment discussion board qualitative data and semi structured interviews.

The findings of the questionnaires showed empathy toward pregnant drug using women significantly improved following the module ($p=0.012$). Furthermore, exploration of the students' experiences of the module demonstrated the importance of sharing and reflecting on practice; the experiences of drug users, both positive and negative; and having an opportunity to make sense of these experiences, as key in influencing their views. Furthermore, the findings indicated value in the mode of delivery, suggesting e-learning to be an effective approach. This research demonstrates the potential of education in this area but also offers suggestions for educational delivery to reduce stigma in other areas of practice.

Key Words:

Substance Misuse

Pregnancy

Midwives

Attitudes

Education

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Copyright Declaration

‘Attention is drawn to the fact that copyright of this thesis rests with

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Chapter 1

Introduction

1.1 Overview

Prior to discussing the specific literature and studies that have been undertaken to inform the area of education and attitudes toward drug use in midwifery and midwifery education, it is important to set the context. It is useful to have some background regarding the nature, extent and problems associated with the use of substances both in the general population and the specific pregnant population. This section sets the scene for the study, highlighting some of the main areas of concern relating to substance use, and also providing working definitions for some of the common terms referred to throughout the work.

There is currently a global burden associated with the misuse of drugs and alcohol (Murray et al., 2013). Physical comorbidities of alcohol misuse are common and result in frequent attendance to hospitals, with an estimated £3.5bn annual cost to the NHS in England (Nazari & Raistrick, 2014). Similarly, in 2013 the National Treatment Agency for Substance Misuse (NTASM, 2013) estimated the overall costs of drug addiction to be in the region of £15.4 billion including the costs to health, deaths and drug related crime; with costs to the NHS in the region of £488million. While not all deaths in treatment will be attributable to an individual's substance use, the use of drugs is a significant cause of premature mortality in the UK (Murray et al., 2013).

Alcohol and drug misuse are a major public health concern and a globally recognised problem (World Health Organisation (WHO), 2011). In the most recent report of world drug use, it was estimated that at least 5% of 15-64 year olds in the world (246 million people) had used drugs at least once in the year 2012-13 (United Nations on Drugs and Crime, UNODC Report, 2015). Further, the association between substance use and physical harm has long been demonstrated (Watt et al., 2006), with both alcohol and substance use being directly attributed to up to 50% of hospital

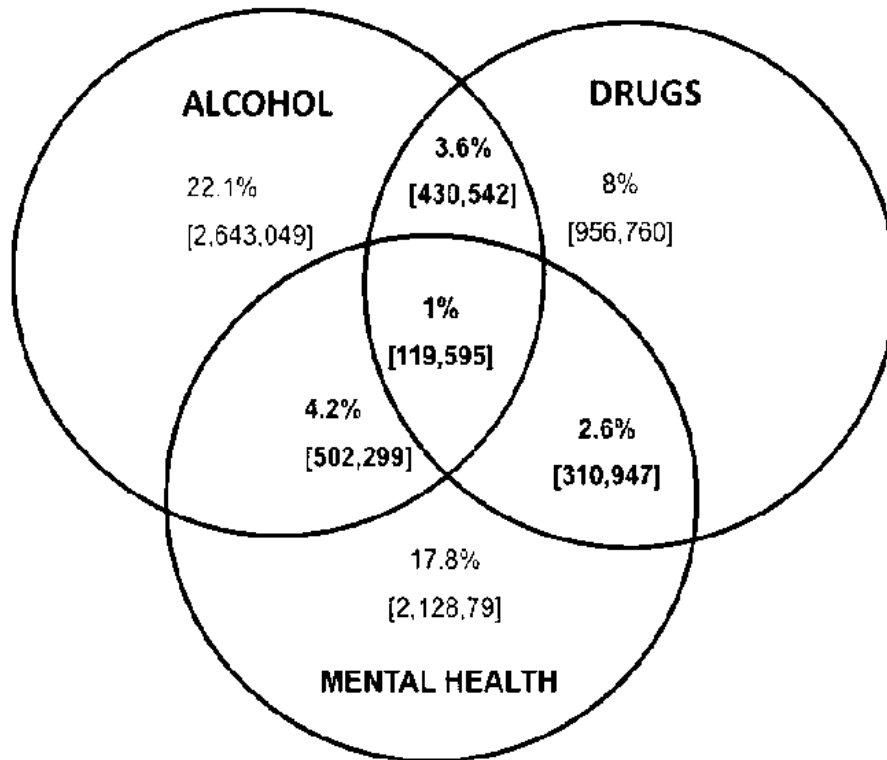
admissions (Cape, Hannah & Sellman, 2006; Kelleher, 2007) and alcohol, specifically, being labelled as the biggest risk factor for disease in many parts of the world (WHO, 2011). Costs to the NHS of alcohol use alone were estimated to be £3.5 billion in 2014 (Nazari & Raistrick, 2014). There has been an increasing emphasis therefore placed upon the role of nurses (and midwives) in the provision of effective services and interventions to support those with drug and alcohol problems (Rasool and Rawaf, 2008).

It is estimated that around 5% of all births in the UK are to women using illicit substances (Crome and Kumar, 2007). However, it is difficult to give an accurate figure for numerous reasons, including feelings of shame, denial and stigma experienced by the drug user, lack of awareness and knowledge among professionals in antenatal services, the presence of co-morbid psychiatric disorders, and socio-cultural barriers that may prevent assessment being carried out appropriately (Day and George, 2005). However, it is known that about one third of drug users in treatment in the UK are female, 61% of these are mothers (NTASM, 2012) and over 90% of these women are of childbearing age (15–39 years, with an average age of 32 (NTASM, 2010)). Findings from the NTASM (2015) suggest that in 2014-2015 the numbers of individuals accessing treatment for alcohol and drug addiction have increased by 3% since 2009-10. These figures also show that just over half of the total number of adults receiving drug treatment were either parents or lived with children and of these there were around 900 pregnant women starting drug treatment (6% of all women starting for the year). These women can present many challenges to health care providers, as discussed later.

This is supported by a study (Manning et al., 2009) which estimated that 3.4 million children were living with binge drinkers and almost 1 million living with drug users. Manning et al (2009) furthermore suggested that the numbers of drug users were likely to exceed this, based upon the fact that their data was extracted from household surveys, and illegal behaviours are notoriously underreported by self-report methods such as this. Manning et al (2009) in addition suggested that the combined effect of drug, alcohol and mental health problems in parents further exacerbate the risks to the child, providing the following visual representation (figure

1), where the figures given are the numbers of children effected in the UK (from extrapolated survey data):

Figure 1.1 Cumulative risk of harm. (Adapted from Manning et al, 2009 p10)



The combinations of these risk factors are shown to lead to poorer engagement with treatment services and more difficulties in parenting. Likewise, many mothers within this group of parents do not engage fully with maternity services during pregnancy, often having their first encounter with a midwife during labour. However, research (as presented herein) suggests that ensuring that women access care would potentially encourage the modification of risk factors and improve health outcomes for mother, child and society.

Furthermore, evidence from international studies reported by Kelleher and Cotter (2009) suggests that detection of substance use amongst health professionals is low and they estimate that up to 75% of substance users slip through the net undetected. This figure represents a significant challenge for health care professionals and is suggestive of underlying barriers. In 1977, Chappel and Schnoll made the link

between professionals' poor knowledge and attitudes toward substance users and the consequential failure to identify them, and anecdotal evidence suggests the situation remains today. Thus, to reiterate, poor attitudes and knowledge from health care professionals can in turn result in substandard care provision.

Whilst it is known that not all parents who use drugs harm their children, we know that parents who are dependent on drugs and alcohol present a much greater risk to themselves and their children. In 2010, the Department for Education (2010) reported that 22% of Serious Case Reviews mentioned parental drug use, and a further 22% parental alcohol use.

Drug treatment programmes are one way of protecting these families and children but it is vital that these parents get a broad range of support (NTASM, 2014) and early intervention is an effective strategy, for example prior to birth. It has been noted that having children at home may be a preventative factor in developing more serious drug-related problems and furthermore it is suggested that the greater awareness of the impact their drug use has on their children can be a powerful motivational force in recovering (NTASM, 2014).

Although the numbers of pregnant women known to be using substances is relatively low, it remains a serious problem for the individual, their family, society and their unborn child (Leggate, 2008; Hooks, 2015). Pregnant women with drug and alcohol problems are therefore encouraged to access antenatal care and drug treatment early, in order to maximise the health benefits and reduce the risks to both mother and baby (Casper & Arbour, 2013). With appropriate care, treatment and support the lives of drug and alcohol users can become more stable, and they can get help to address not only the substance misuse but also the underlying web of socioeconomic problems associated (NTASM, 2014; Hooks, 2015).

1.2 Maternal substance misuse

There is various evidence to support the risks to maternal and neonatal health of maternal substance misuse. These can be separated out into physical effects, wider ('other') effects and pregnancy specific effects.

Physical side effects include, for example, risks of contracting blood borne viruses such as hepatitis or HIV through the use of contaminated needles, or needle sharing. Furthermore, contraction of sexually transmitted infections (through sexual promiscuity, or prostitution), overdose, anaemia and poor diet and accidental and non-accidental injuries are also associated with drug use (Prentice, 2010, Siney 1999, Department of Health 2007).

Psychological issues related to maternal substance misuse include a life dominated by drugs, with drug taking becoming a priority, essential for everyday functioning. In addition there can be a range of mental health problems, anxiety, unpredictable behaviour and irritability, sleep problems, paranoia, depression, stress and memory lapses (Prentice, 2010).

Furthermore, there are a range of social and interpersonal problems including family break-up, unreliability, poverty, a need to engage in crime or prostitution to pay for drugs, becoming a victim or perpetrator of physical, sexual, or psychological abuse, loss of employment, being evicted or homeless, social exclusion or isolation and frequently associations with other persistent offenders (Prentice, 2010).

Financial concerns can also be an issue due to a constant requirement to find money to buy drugs, leading to debt and an inability to pay for basic needs. The wide range of possible effects suggested then lend themselves to a greater potential for legal repercussions such as, arrests, fines and probation orders, all making employment chances much more difficult and increasing associated stigma (Prentice, 2010).

In addition to the effects outlined, pregnant substance misusing women and recovering women are at risk of poorer maternal and fetal outcomes compared with non-substance using women; these include: miscarriage, pre-term delivery, intrauterine fetal death, placental insufficiency, eclampsia, septic thrombophlebitis, post-partum haemorrhage, fetal distress, low birth weight and fetal malformations

(Corse & Smith, 1998; Huestis & Choo, 2002). Among the risks to the fetus or baby (in addition to drug specific effects outlined above) are: a risk of mother to baby transmission of blood borne infections, either in utero, at delivery, or through breast feeding; poor growth, due to placental insufficiency and maternal stress; sudden infant death, still birth and when the drug supply is withdrawn from the neonate following delivery, neonatal abstinence syndrome (Drugscope, 2005; NOFAS, 2011). These effects are further exacerbated by the external effects indicated above including any social, economic, environmental or cultural inequalities that the mother may already face, together with a frequently chaotic lifestyle and potentially poor parenting ability (Advisory Council on the Misuse of Drugs, ACMD, 2003; Department of Health 2007; Social Care Institute for Excellence, SCIE 2005).

Despite these underlying risks, women who use drugs often enter antenatal care late in pregnancy, and frequently miss appointments. It is reported that these women are concerned about the psychological, social, and legal consequences of their drug use (Roberts & Nuru-Jeter, 2010). Furthermore, pregnant drug-using women report that they are subject to condemnatory remarks and stigmatisation by health care professionals and this presents a barrier to them accessing care (Radcliffe, 2010).

Concurring with this, McLaughlin and Long (1996) found that the majority of nurses interviewed felt that drug users constituted a threat to society and therefore also to them. In addition, Lee, Haynes and Garrod (2010) interviewed 15 midwives, who reported that they lacked time, resources and knowledge and thus did not feel confident dealing with pregnant substance users. Furthermore, the midwives made stereotypical assumptions relating to the background of users of illicit drugs, thus reinforcing the concept of health care professionals' prejudice (Lee, Haynes & Garrod, 2010). The literature and research pertaining to the position felt by both midwives and pregnant drug users is outlined further in chapter two.

These misconceptions, preconceived or stereotypical views held by health care professionals can lead to stigmatising behaviours and thus potentially substandard care provision. One aspect that the literature suggests may be the cause of such stigma, and a consequential avoidance of care by midwives, is a lack of knowledge and education in the area of drugs and alcohol for midwives, either pre or post

registration (Lee, Haynes and Garrod, 2010). Education has been suggested as a means to reduce stigma and to improve attitudes toward drug users, both pregnant and non-pregnant (Boyle et al, 2008; Jenkins, 2013) and thus improve confidence in dealing with drug use encountered in practice. However there is a paucity of research that actually measures the effectiveness of education for altering attitudes toward drug users and even less for drug use during pregnancy. The few studies which do look at this do not explore the nature of the education, or type of delivery and are mostly quantitative in design, highlighting the need for this study.

In a review of health inequalities in the UK (Marmot et al., 2010), it was suggested that the health of both mothers and their children is strongly associated with socioeconomic status, those coming from disadvantaged backgrounds were more likely to experience poorer health and increased risk factors during pregnancy. Such inequalities in socio-economic status, can have an impact not just upon pregnancy but also on the health of the child at birth and have lifelong consequences. In addition, pregnant women who are recovering from substance abuse and not currently using drugs or alcohol remain at an increased risk for poor perinatal outcomes because of pre-existing poor health related to their prior substance abuse (Hanson et al., 2002).

In 2011, an Australian study (Taplin and Mattick 2011) verified this link; using a collaboration of drug treatment records, child protection records, questionnaires and interviews with 171 women, they reported that women who misused substances were disadvantaged; they tended to be single, have little formal education, were frequently on benefits; experienced financial problems; and were often living in social housing. A significant number also had mental health problems, associations with crime and had experienced some type of physical or sexual abuse as a child. Whilst of course this is an Australian study, it reflects a similar profile in the UK, both evidenced in my own practice and presented in the sparse UK literature (NICE 2010, supporting evidence document; Adams, 2008).

It has been suggested by epidemiologist Richard Wilkinson that 'the more unequal a society, the higher the level of drug use' (Wilkinson and Pickett, 2010:4). This persistent inequality that has been outlined (fuelled by stigma; discussed later) leads

to a cycle of inequality and a near complete inability to escape. Promoting better health is an essential part of empowering those who are poor or disadvantaged to escape from poverty.

This range of social, economic and cultural inequalities has been highlighted in the past three confidential enquiries into maternal and child health as a major contributing factor to maternal and perinatal morbidity and mortality (Lewis, 2007; RCOG, 2011; Knight et al, 2015). It has consequently been one of the driving forces behind the production of the 'Pregnancy and Complex Social Factors' NICE guidance in 2010. Amongst other things, this guidance suggests that early, regular access to good quality antenatal care in pregnancy can vastly improve the poor outcomes associated with social complexities (NICE, 2010). However, the guidance makes no recommendation as to the manner in which this can be achieved, and neither does it make mention of the barriers to achieving this, such as stigmatisation. It should be noted that, from scoping the literature and discussion with colleagues around the country, complete guidelines regarding specific illicit drug use during pregnancy appear extremely scarce, and any that do exist are not standardised, limiting their usefulness in practice.

Despite the complications outlined, it appears from the literature that health care professionals, including midwives, are not engaging with their public health role with substance users in practice (Tsai et al., 2010). Rassool and Rawaf (2008) suggest that this is at least in part due to a lack of education and training for professionals. However, there is currently no mandatory requirement for drug and alcohol education within UK midwifery curricula (Nursing and Midwifery Council, NMC, 2009).

1.3 Researcher background and study context

As a practicing midwife and midwifery lecturer currently employed at a UK higher education institution, I am interested in the value and role of education in general, and of particular interest to me are pregnant women who misuse substances and their experiences of care. Throughout my midwifery career to date, I have worked with this vulnerable group both in the community and in hospital settings, and have witnessed the effects of both good and bad experiences of care upon women and

their families. I have also worked sporadically as a volunteer recovery worker for a local drug and alcohol charity, and in this capacity I have been involved in the delivery of a project aimed at improving the lives of women on probation, all of whom were mothers. Following this passion, in my current role I have been responsible for the delivery of a third year degree education module which helps students explore the effects and implications of parental substance use (discussed in greater detail later). In my current role as senior lecturer, I also have a personal tutor and undergraduate major project supervisor responsibility for some of the students; again the implications of this will be discussed later in the work.

This study brings together my areas of interest and explores the delivery of this module, 'Substance Misusing Parents' (an educational intervention) in terms of the role it may play in altering attitude toward pregnant drug using women in a cohort of third year student midwives. It uses a case study approach, and within this, the aim is to measure the attitudes of student midwives pre- and post-module, and explore the students' experiences and attitudes toward pregnant drug use pre- and post-module using qualitative means (detailed in Chapter 3). The following research question was derived from the literature review to be explored in the study:

'What place does drug and alcohol education have in relation to attitudes of student midwives toward pregnant drug users?'

At the time of data collection for this study (2014), entry to the Nursing and Midwifery Council register as a midwife was only by university degree completion. This could be either direct entry (DE) following completion of a three year pathway, or post registration (PR), which constitutes an eighteen month course for those who already hold Registered Nurse status in the UK. However, at the university where this study was conducted, there is no shortened midwifery pathway provision, and so all participants were on a three year degree pathway, and none of the students on the course at the time of the study held a nursing qualification previously. The university programme in both pathways requires an approximate 50:50 split between theory and practice. This is important to consider for a number of reasons: firstly because it means that there are time constraints and competing demands on delivery of theory content, which Rassool (2009) suggests as a reason drug and alcohol education may

be compromised. Secondly, because students spend over half of their three years in practice, where they are exposed to, and learn a variety of approaches to management and care, good or bad. Whatever the theoretical content delivery at university, this has to be considered in the context of their practice experiences, and an opportunity has to be given to make sense of these and so complete the learning cycle (see literature review). It is important that the potential influence of mentorship and practice-based learning is not underestimated in a study such as this one.

1.4 Definition of Terms

In a study of this nature, which essentially involves the coming together of a range of academic disciplines (for example; psychology, sociology, philosophy, education and medicine), it is important to define the terms used, because there is a degree of ambiguity and debate regarding the use of language and terms to describe individuals who use substances. This section will therefore lay the foundations for the terms used within this work as they have been understood and applied.

Belief, attitude and opinion

It is important to make the distinction between attitude, belief and opinion; beliefs are fictional or factual cognitions of information, and whilst they provide the cognitive component for attitude, attitudes also incorporate the feeling toward these beliefs (Shrigley et al., 1988, p.669). As such, all attitudes include beliefs, but not all beliefs are attitudes (Katz, 1960, p.169). In addition, opinion is a cognition that can occur without caring and it does not necessarily predispose action; conversely, attitudes do involve a strong evaluative component and thus are more likely to predispose behaviour/action (Shrigley et al., 1988, p.670). Opinions are only the verbal expression of an attitude, while attitudes can be verbal or nonverbal in nature (Katz, 1960, p.169). In this work then, attitude in relation to substance use and users is used to describe the combination of beliefs, opinions and consequential behaviour toward substance users and their lifestyles.

Stigmatisation

There is much debate in the literature around stigmatisation, some of which is explored further in Chapter 2 (Literature Review). In the context of this study, the definition from Oxford Dictionaries (online, 2016) has been used: 'describe or regard as worthy of disgrace or great disapproval.' As such, the term has been used to mean both explicit and implicit stigmatising of individuals.

Stereotyping

Within this work, stereotypes have been interpreted according to the Cambridge Dictionary (online, 2016) definition to mean: *'to have a set idea about what a particular type of person is like, especially an idea that is wrong.'*

Substances and drugs

Substances in the context of this work refer to legal substances, or drugs such as alcohol and tobacco and illicit (illegal) drugs, detailed as such by the Misuse of Drugs Act (1971). The terms substance and drug are interchanged, but refer to this working definition.

Substance use and misuse

Use versus misuse of substances has been the subject of debate for many years and worthy of a doctoral study of its own, therefore consideration has been given to the various positions held in the definition used within this study, but this is with recognition of the simplicity of such a definition.

The term 'use' is often used to acknowledge infrequent use (once, or occasional), of legal and illegal substances, without addiction (Boyd, 2015), whereas the term misuse according to the Mental Health Foundation (2015) describes the continued use of mind altering substances that severely effect an individual's physical, mental, health and social situation. Similarly, WHO (2015) suggest that misuse is the use for purposes not consistent with legal or medical guidance, leading to dependence. The term 'problematic' also has such a range of debate; to whom is it a problem? And so on, but again, this will largely be put aside, with the focus on the 'problem', which is the use and effects of the illegal substance (Lloyd, 2010a), as this relocates attention

from the characteristics or representation of the person taking the substance (discussed in chapter 3), which is the very nature of stigma, and one aspect of this review.

Recognising the value of each of these positions, but furthermore acknowledging the complexities and debates regarding the subjectivity of 'harm' caused by various substances, the volumes required to cause 'harm' and the nature of dependence, within this work, the following definition, albeit somewhat broad, has been created and used: *The use of any substance (as defined above), that is perceived to cause harm to either the taker, their wider family, or society.* Thus the terms substance use, misuse and drug use, or abuse will be interchanged and are intended to refer to the use of any substances.

Identity

Identity in the work has been taken to mean an individual's or group's unique characteristics, or qualities; the aspects that make them different to others.

Educational Intervention

This term is used to mean the deliberate delivery of any educational material around substance use. It therefore only refers to formal education courses, modules and so on, and not to the delivery of material for example via media sources, television programmes etc. unless these are incorporated and used within an educational intervention. In the case of this research, educational intervention refers to and is used interchangeably with 'the module,' 'the substance misusing parent's module,' or, 'this module' because the focus of this study is exploration of an educational intervention which is a formal university module, 'substance misusing parents.' Further details of this intervention are outlined in chapter 3 (Methodology).

1.5 Chapter Summary

This chapter has provided some context for the study, highlighting the nature, extent and concerns relating to substance use, both in the general and pregnant population. It has also laid out working definitions of many of the common terms referred to

throughout the work for reference. Chapter 2 explores the more specific literature and research relating to the attitudes held toward substance use in pregnancy, both by society and health care professionals, including the nature of stigma and attitude formation. It also identifies current research and literature discussing the role of education designed to improve working practices and attitudes in the clinical arena.

Chapter 3 discusses the research design, and specifically the methodology (case study) used to conduct the study, and the rationale for this. The benefits and limitations of this approach, together with the research methods used to collect the data and method of data analysis are discussed.

The findings are then presented for each phase of the study independently (Chapters 4 and 5). Chapter 4 outlines the findings of phase one (questionnaires) and also those of phase 3 (the VLE discussion board data). Chapter 5 contains the findings of the semi-structured interviews (phase 2). The findings of all three phases are then drawn together in discussion (Chapter 6), consideration is given here as to where the findings are conflicting, congruent or offer new insights. The limitations of the research and findings are also discussed in Chapter 6.

The work is then summarised, including an overview of the main findings and the contribution of this work to the knowledge base both in healthcare and education practice in Chapter 7. In this chapter recommendations for practice are made, as are suggestions for future research. The thesis culminates in a personal reflection of the research journey at the end of Chapter 7.

Chapter 2

Literature Review

Following on from the previous chapter, which laid the context for the study, this chapter looks at the literature and research in the area of attitudes toward substance users within health care, and particularly the maternity setting. The stigmatisation of substance users is discussed, along with consideration of the experiences of both midwives and substance using pregnant women. Further, attitude formation and attitude change theories are explored, along with research that looks at the place of drug and alcohol education interventions in altering attitudes toward substance users. Lastly, there is a brief look at the nature of education within the healthcare setting and discussion regarding where this may fit with education around drugs and alcohol.

2.1 Literature Search Strategy

It is suggested that one of the most important parts of performing research is in reviewing the literature that has already been published on the study topic (Levy, 2013). To ensure a broad range of evidence informed the literature review, a thorough and methodical approach to searching was undertaken. Various databases were searched via the university's online digital library, including AMED, British Nursing Index (BNI), BioMed Central, CINAHL plus, Education Database, ProQuest Central, Academic One File, Cochrane Library, SCOPUS, Science Direct, MEDLINE, Maternity and Infant care, MIDIRS, PubMed Central, PsycINFO, PsycARTICLES, Psychology and Behavioural Science Collection, Wiley Online Library and British Education Index (BEI).

Strategies for searching also included manual searching of journals and bibliographies for relevant articles and citations. In addition, Google Scholar was used to ensure a

wide range of available literature was viewed and also that potentially non peer-reviewed sources were also found, as this was deemed relevant to the topic.

Restrictions were applied to searching to only include literature that was available in the English language and where 'full text' was available for journal articles. To get a sense of the development of research and literature in these fields over time, date restrictions were not applied. However the age of the sources was considered where applicable in the literature review.

Key words used included: 'Substance', 'Drug', 'Alcohol', 'Misuse', 'Illicit', 'Addiction', 'Use', 'Pregnancy', 'Parental', 'Parenting', 'Maternity', 'Attitude', 'Opinion', 'Belief', 'Stigma', 'Stereotype', 'Judgement', 'Knowledge', 'Health Care Professional', 'Midwife', 'Student', 'Education', 'Intervention', 'Change.'

Boolean operators 'OR' and 'AND' were applied as relevant to connect and define the relationship between search terms. In addition, advanced search included truncation (* or \$) to include keywords or phrases.

Search results were skim read and excluded based upon duplication and relevance to the topic. The relevant literature was then used to inform a critical discussion of the current understanding and knowledge base in the area of substance use, attitudes and education. The included literature was grouped together into similar themes for discussion which included stigma and shame of drug users, pregnant women's experiences of maternity care, the role of the midwife, midwives' attitudes, stigma and attitude formation, attitude change, the role of substance misuse education and the nature of substance misuse education.

The quality of the research papers was critically assessed using various critical appraisal skills programme (CASP) frameworks (2013) depending on the methodologies used, and where relevant, any particular strengths or limitations were discussed in the course of the literature review.

2.2 Stigma and Shame of drug users

For some substance misusing women, pregnancy can be seen as an opportunity to make changes (Radcliffe, 2010), but others do not feel able to attend for care, potentially putting themselves and their unborn child at even greater risk, despite all the research identifying the benefits. The primary cause of this is stigma, perpetuated both by general society and many professionals, including midwives. Users frequently describe how they are looked down on and how they try to hide their drug user status at all costs, often to the extent of avoiding treatment (Lloyd, 2010b).

Hepburn (2004) found that women who use illicit drugs are often alienated socially and in addition have less support financially, socially and from social care and health care. Hepburn (2004) further noted that such women are unlikely to attend health care services until late in pregnancy, and one of the reasons for this is their mistrust of professionals. This is related to the fear that the women feel of legal consequences and also of having their existing children, or unborn children, removed at birth (Adams 2008; Hepburn 2004; Jos et al 2003). DeVille and Kopelman (1998) believe that women who are known to be users of illicit drugs experience public scrutiny during pregnancy, including increased criticism of their parenting capacity.

The term 'stigma' is not a new term. It originated from ancient Greece and was used to describe the signs that were cut or burnt into a person to mark that person as someone of unusual or bad moral status. These were often slaves and traitors: they were people to be avoided in public places (Lloyd 2010a). Referring to the work of Goffman, Hopwood (2007), states that;

'... two and a half thousand years later the term stigma has come to describe the disgrace or social disqualification which arises from possession of an attribute, visible or unseen, that is considered deeply discrediting.' Hopwood, 2007, p 45.

Women who use illicit substances are viewed as *'tainted, blemished and polluted'* (McLaughlin & Long 1996, p. 284). In addition, there is the linked perception that illicit drug users are of weak personality and in some way corrupt and flawed (Norman 2001). This idea feeds the notion that drug users are violent, manipulative and

engage in criminal activity. In line with this perception, a study by McLaughlin and Long (1996) found that the majority of nurses interviewed felt that drug users constituted a threat to society, further perpetuating and reflecting the fear beliefs that society hold. Pregnant substance misusing women's views and experiences of services confirm this (Neale et al 2008; Klee et al 2002), as discussed in the next section, highlighting, from the perspective of the substance user, that one of the barriers to accessing care was fear of staff attitudes and of being judged or treated differently or unfairly.

The beliefs of society and consequently health care professionals are not founded in evidence from the drugs field. Evidence has shown that parental substance misuse can be associated with higher rates of child maltreatment, but substance use itself does not necessarily mean that parents are abusing or neglecting their children (Barnard, 2005). In addition, research from overseas has also found that families in which alcohol or other drug use is present are more likely to come to the attention of child protection services, more likely to be re-reported, more likely to have children removed from their care, and more likely to have them remain in care for long periods of time, than are families with the same characteristics but no substance use (Taplin & Mattick, 2011). Contrary to the views of nurses expressed above, whilst there is a link to a small amount of crime associated with substance misuse, it is acquisitive, not violent crime (Australian Injecting and Illicit Drug Users League (AIVL), 2011).

O'Reilly, Reaper and Redmond (2005) ascertained the views of pregnant substance misusers on health care in Ireland. One such woman reported that she felt she was treated differently to other women who were pregnant, just because of her substance use. She reflected that it made her feel as though she had 'leprosy' and that there was an assumption from the medical staff that she didn't care about her unborn child, when, to the contrary, that was why she was attending the clinic.

Many of the participants in this study (O'Reilly, Reaper & Redmond, 2005) felt they were treated differently because they were drug users. However, they spoke affectionately regarding individual health care staff that had shown real interest. This view was reiterated by a similar study in Aberdeen (Hall and Van Teijlingen, 2006),

where amongst the most highly valued aspects of care were non-judgemental attitudes of staff.

The UKDPC (2010a) 'Getting Serious About Stigma' report highlighted a range of problems relating to stigma including feelings of shame and worthlessness preventing people and their families seeking help; low self-esteem reducing the belief in recovery and concerns; and experiences of negative attitudes of health carers, preventing access to support and much needed health care. It is fear of being seen as irresponsible or inadequate carers which often results in such poor self-esteem, guilt, depression and then ultimately, denial of drug use (Klee *et al*, 2002), and this consequently compounds the attitudes and labels attached to stigma. The potential effect is that this reflects back upon the user, who as a result eventually becomes what they have been labelled; in essence, a self-fulfilling prophecy (Goffman, 1963).

This concept of self-fulfilling prophecy I have observed and heard reports of in practice too. It is my experience that, as a result either of the effects of the substances being taken, associated mental health issues, or low self-esteem, substance misusers can become paranoid regarding how others see them, and their feelings are not always grounded in reality (Hooks, 2015). Goffman (1963 p14) discusses a double perspective, whereby the stigmatised individual either assumes that their differentness is known about or evident, or conversely they assume it is neither known about, nor perceived by others. This distinction is important as it will likely have an impact both upon the individual's reality, and also the relationship they will have with others, for example care givers.

I would suggest that it is a sense of paranoia and not persecution that is sometimes the cause of social isolation and associated problems for substance misusers (Hooks, 2015). Notwithstanding this, there is also clear evidence from studies that stigmatisation *is real*, does exist and that it can have a significant detrimental effect. The ability to apportion blame and ascertain cause and effect in relation to this dichotomy, paranoia vs. persecution, however, is impossible to accurately determine. It is certainly an area that warrants further research. After all, it is likely to have an impact on the effectiveness of interventions designed to change attitudes and thus

reduce stigmatisation; that is to say, if the issue is one of paranoia and not so much about persecution, tackling the perceived perpetrators will likely have minimal effect.

In spite of the stigmatisation, perceived or otherwise, becoming pregnant raises the need for a substance misusing woman to manage her identity in order to avoid becoming the stigmatised figure of the 'junkie' (Radcliffe, 2010). Radcliffe (2010) suggests that pregnancy raises the possibility for a substance misusing woman to align herself with normalised discourses of femininity, in other words, to become 'normal', by becoming 'clean' and, as suggested later, pregnancy has been associated with a motivation to make this change. Radcliffe also argues that by acknowledging women's progress through drug treatment, midwives and other health care professionals can also aid in endorsing this new sense of self.

2.3 Pregnant women's experiences of maternity services

For drug using women pregnancy can be a motivator for change, driving them to seek treatment for their drug problem, improve their lifestyle choices and consider the impact upon their unborn child. Radcliffe (2010 p12) suggests that *'the figure of the drug using pregnant woman/mother is extremely stigmatising.'* In her UK based study which included looking at pregnant substance users' experiences of maternity services, Radcliffe found that many women described how they kept their drug use secret from people they knew and that pregnancy was sometimes the first time that they acknowledged their drug use to health professionals.

Confronting the effect of this stigma, some women have reported that pregnancy was their impetus to change. In Hall and Van Teijlingen's study (2006) the women reported that their unborn child was a significant focus and drive to stop using. In addition, the women in this study showed great determination not to return to their drug use in the future, for the sake of their child.

2.4 Role of the Midwife

As suggested by Hall and van Teijlingen, (2006) the unborn baby can provide a real focus for the lives of substance using women, prompting a willingness to adopt healthier behaviours in regard to their substance use. When considering this in the context of the Stages of Change model¹ developed by Prochaska and DiClemente (in Connors et al., 2001), this motivation is akin to the contemplation stage, whereby awareness that a need for change exists and there are thoughts by the individual of changing the behaviour, but the individual has not yet made a commitment to take action. The person is more worried by the problem behaviour and has often begun to weigh the positives and negatives. For the midwife this is an ideal time to assist the individual in evaluating his or her environment and to help them identify triggers which contribute to the behaviour, and to assist the individual in engaging in preliminary action.

Affirming this important role of the midwife and unique opportunity, a retrospective audit of services for substance misusing pregnant women by Leggate (2008) found that although the women's lives were often complicated by social problems such as criminality, homelessness and poverty, women who were well-supported and felt they developed a relationship with an individual health carer, such as the drug liaison midwife (with specialist knowledge in the area), were more successful in achieving stability and improved health outcomes for both themselves and their infants. The women reported that they developed a relationship over time with their midwife and during this time their motivation for change and compliance with treatment also improved. This highlights the need for education and knowledge in the clinical area in relation to drug and alcohol use to maximise this potentially life changing opportunity.

Non-punitive, non-judgemental, nurturing and supportive care was found to be most effective in forming a positive and effective relationship with substance misusing

¹ The Stages of Change model has provided the basis for much of the research that has been conducted on issues of substance abuse and a person's willingness or readiness to change his or her patterns of behaviours. The current model describes five stages of change that individuals use when moving toward behaviour change and recovery. These stages flow from pre-contemplation, the beginning stage, through contemplation, preparation, action and maintenance, where the individual is able to continually carry out strategies necessary to prevent relapse into addictive behaviours.

women. The women receiving this type of care were more likely to voluntarily admit to substance use or relapse, thereby facilitating the midwife to provide appropriate care (Corse & Smith, 1998).

Studies such as those by Leggate (2008), Radcliffe (2010) and Corse and Smith (1998) advocate the role of specialist drug liaison practitioners. However, these are not the main facilitators of primary health care practice. Within maternity services, most midwives are not specialist drug workers and the research presented herein suggests that the majority of stigmatisation occurs within the generic health care setting. Therefore it is this group of workers that need to be targeted to improve engagement and experience for substance using women.

2.5 Midwives' Attitudes

Research by Bartu et al (2006), as outlined in Chapter 1, has suggested that access to antenatal care for substance using women throughout pregnancy can significantly improve outcomes for mother and child. When such pregnant women attend for antenatal care, this enables midwives to facilitate and promote good health through education, prevention and intervention. Despite the research that suggests pregnant women who use drugs may present late for maternity care (Klee, 1998), this is still a vital opportunity to encourage change in lifestyle and behaviours, and may, as Radcliffe (2010) has suggested, represent a defining moment in their lives.

The midwife's role in public health has been given increasing importance in the last twenty years, with health promotion becoming a much more significant part of their role. Health promotion can be defined as '*the process of enabling people to increase control over, and to improve, their health*' (Lavender et al., 2001 p4). Therefore midwives are in an optimum position to engage with pregnant women to enable changes in their health (Klee et al, 2002). In the case of substance using pregnant women however, this requires midwives to be able to recognise and respond to those presenting. Whilst there is no specific research looking at midwives in the UK and their ability to detect substance use, findings reported by Kelleher (2007) suggest that in the general healthcare setting only around 25% of users are identified.

Furthermore, midwives stress that they do not have the time, resources or access to appropriate training to be able to effectively provide many aspects of health promotion, including in the area of substance misuse (Lee, Haynes, Garrod, 2010). Interestingly, midwives also believe in relation to health promotion advice that their input will not have any significant impact on the behaviour of substance misusing women (Lee, Haynes, Garrod, 2010), despite evidence to the contrary from the pregnant substance misusers themselves already highlighted.

Very few studies have explored the role of the midwife in health promotion for substance abuse, and those that do are mainly non-UK-based. Findings from these non-UK-based studies include midwives' reporting difficulties in interviewing clients about drug use, and the studies generally suggest further training is needed. One UK-based regional study was conducted using grounded theory. Lee, Haynes and Garrod (2010) interviewed 15 midwives to explore their opinions and current working practices in relation to health promotion, and as a part of this included questions relating to substance misuse. The study reported that, in relation to a disclosure of illicit drug use, midwives felt they didn't have sufficient knowledge themselves, and so would refer women on.

Furthermore, the midwives made many assumptions relating to the background of users of illicit drugs, thus reinforcing the concept of stereotyping and stigma. They suggested, for example, that white and middle class clients know not to take drugs. To the contrary, findings from the latest Crime Survey in England and Wales (Home Office, 2014) highlights that, whilst there are links between drug and alcohol use and living in deprived areas, drug use is still prevalent in higher income groups (>£50,000 per year). Furthermore, the statistical evidence showing correlation between ethnicity and drug-taking indicate that the lowest rates of use are amongst Asian, Asian British and Chinese populations. Similarly, regardless of where rates are highest, there is still use within white ethnic groups and so stereotypes such as this are misleading and can exacerbate the failure to recognise substance use and refer appropriately, as indicated earlier. Further, there was a perception in Lee, Haynes and Garrod's study (2010) from midwives that those who are taking drugs are already identified or involved with other agencies, and therefore they probably wouldn't need to do anything further.

Assumptions such as this may hinder appropriate referral and consequential support even further. The majority of midwives in the study (Lee, Haynes & Garrod, 2010) reported that their knowledge of drugs and using them during pregnancy was insufficient and that they did not feel confident discussing drug use, which may explain their responses. They also suggested that their knowledge of referral processes was lacking, with some midwives stating that they would only offer a referral to a woman if it was “appropriate” or “if they need it”. The study did not, however, ask the midwives how they perceived or felt about substance misusing women and as such did not ascertain the underlying attitudes of these midwives toward substance using woman.

Another, more recent quantitative study surveyed 123 UK midwives to look at their attitudes toward illicit drug use in pregnancy (the first such study in the UK). The findings of this study bucks the trend of previous research, concluding that, overall, midwives demonstrated positive attitudes to pregnant drug use (Jenkins, 2013). Whilst the findings of this study are a useful addition to the field, it should be noted that upon more detailed analysis of the results, 23% of participants showed a lack of empathy and 36% felt that women were responsible for their misuse of drugs; 23% and 36% may represent a minority ‘overall’, however such views are not indicative of accepting, non-judgemental attitudes and without further analysis of these views by more qualitative means it is difficult to accept the conclusion made. The study also found that less than half of the midwives questioned felt sympathetic toward pregnant drug users. Nonetheless, it is a good basis upon which to develop the research profile in this field in the UK.

Research, as indicated above, has shown that negative attitudes of health carers toward drug use can have a detrimental effect on patients suffering a stigmatised medical condition (Link et al., 1997). Furthermore, there have been studies that have measured the attitudes of health care professionals toward substance users and deemed them to be generally more negative than to other medical conditions. Christison, Haviland and Riggs (2002) used the *Medical Condition Regard Scale* (MCRS) to determine and measure attitudes towards patients with specific medical conditions.

Overall, the various studies using attitude scales to measure health carers' attitudes have mostly looked at professionals and not students, but in general have shown that health professionals show less regard for patients with substance misuse conditions than other stigmatised conditions such as acute mental health problems, or intellectual disability (Boyle et al, 2010). They have also demonstrated less regard for substance use than for less stigmatised conditions such as renal failure, or heartburn (Dearing & Steadman, 2008; Christison, Haviland & Riggs, 2002; Christison & Haviland, 2003).

As indicated, very few studies using attitude scales have been conducted in the UK and only one has looked at student midwives. An Australian study conducted by Boyle et al (2010) used both the MCERS and also the Jefferson Scale of Physician Empathy (JSPE – Health Professional version) to determine the extent of empathy and attitudes toward specific medical conditions, including substance misuse. They found no statistically significant difference in mean empathy (general empathy levels) between the professional groups when using the JSPE. However, there was a difference in the results looking at specific medical conditions, which suggested that all student groups held substance misuse in the lowest regard compared to acute mental illness and intellectual disability. Furthermore, student midwives held substance misusers in less regard than other student professional groups such as paramedics, nurses, physiotherapists and occupational therapy students by a significant margin ($p=0.033$). It should be noted, however, that the student midwives were a smaller sample group than the other professional groups ($n=52$, compared to 120:107:109:92 respectively) and this may have affected the result because it is usually harder to show a statistical difference with a smaller sample size. In addition, this was an Australian-based study, with a different health care and higher education system for midwives than the UK and so it may not represent the situation in the UK. The results do however give a valid rationale for similar research in the UK and provide a model for similar research to establish whether or not negative attitudes toward substance misusing pregnant women by midwives and student midwives exist in the UK.

Whilst some of this literature alludes to the lack of comfort in dealing with substance users felt by health care professionals, none of it directly highlights avoidance of the

client group by midwives (or other health care professionals). However, this is mooted in the work around stigma by Goffman (1963 p23), who suggests that *'the very anticipation of such contacts can of course lead normals and the stigmatised to arrange life so as to avoid each other'*. This lack of contact can, on the part of health care professionals, cause misunderstanding and a lack of knowledge, and on the part of the stigmatised women, the lack of social interaction can result in further social isolation, suspicion, depression, hostility and bewilderment (Goffman, 1963 p24).

2.6 Stigma and attitude formation

A key aspect when looking at how to address both the barriers to substance misusers accessing care and to educating health care professionals is surely to consider what basis and origin they have. There are many views offered as to why stigmatisation exists: for example to enhance the perpetrators self-esteem through downward comparison with the noted group, or individual (Lloyd 2010a), or as an aid to making sense of the world by helping to develop a set of expectations regarding the stigmatised group; how they are expected to act and behave. It is also suggested that stigmatisation serves some type of protective function against the perceived or potential danger of the stigmatised. However, as already ascertained, this notion of real threat to the health care professional is not grounded in strong evidence and whilst it may be the experience of health care workers that 'some' substance misusers they have encountered are violent, manipulative and irresponsible (Ford, 2011), this, in the same way as any stereotypical view, does not represent *all* users. My own experience in practice reflects that substance using women frequently hold the view, even if subconsciously, that they are in some way 'not quite human' (Goffman, 1963 p15). Furthermore, maternity staff I have worked alongside have been fearful of users, both in an emotional sense and also physically: fearful of violent outbursts, fearful of being manipulated and fearful of what they may catch (Personal Correspondence, 2012). Supporting this concept of fear of harm, quantitative research conducted by Wright and Baril (2011) found that considerations of harm and fairness stand at the core of human morality; suggesting that it is evaluation of these concepts that drives an individual's emotional response. There are, however, many

concerns with such stigmatisation, not least that the assumptions made lead to discrimination, through which, without thinking, we reduce life chances for the individuals concerned (Goffman, 1963).

Thus, as illustrated by AIVL:

"Attitudes towards injecting drug users are negative, entrenched and generally unhelpful. They leave the general population living in fear of a subset of the community they really have no need to be afraid of, and the people they are stigmatising and discriminating against are left with reduced access to health care, housing, employment and other social needs. This must inevitably be a net loss to society." AIVL, 2011, P46.

Whilst the above is from an Australian report, the UKDPC report (UKDPC 2010a), a large UK-wide survey of public attitudes towards drug users, demonstrates similar public views of substance users. It reports that 58% of people thought a lack of self-discipline and willpower is one of the main causes of drug dependence; only 5% of people considered that people with a mental illness 'don't deserve our sympathy,' however, 22% took this view towards those with drug dependence; 93% of people said that those with a mental illness deserve the best possible care, but only 68% took the same view toward those with drug dependence. Many people have little sympathy for drug addicts because they feel that the drug user should be culpable for their actions; they took illegal substances in the first place and so, if they want to, they could just simply stop using. In his report, 'The Sinned and Sinned Against,' Lloyd (2010b) states that such attitudes demonstrate a lack of understanding of the nature of addiction.

It is little wonder that these views are held in society when a similar UK survey (UKDPC 2010b) reported that drug-using parents were the subject of condemnatory remarks in the media almost as frequently as offenders (35% of remarks were condemnatory). The most significant group of users condemned in the tabloid press were offenders and parents who used drugs, where adjectives were used by the press, they were more likely to be negative, with words such as 'vile', 'hopeless', 'dirty', 'squalid' or 'evil' (UKDPC 2010a) being assigned.

Goffman (1963) suggests that the demands that we place on others regarding their social identity (personal and structural attributes, for example, honesty and occupation) are initially unconscious; that is we do not become aware that we have made such demands, or preconceptions, until we are actively questioned regarding their reality, or our thoughts are put into practice. As such, the way in which we 'view' an individual (or our attitude toward them), conscious or otherwise, is to some degree an indicator of how we might behave toward them. In this way, attitude and behaviour are connected, and thus, when considering behaviour change, as in this study, it is important to have an understanding of attitude and its origin. Given that stigmatising behaviours are largely grounded in the attitudes held by the individuals expressing them, it is also important to consider how attitudes are formed, particularly in relation to substance misuse, and further, if and how such attitudes may be altered and thus bring about change. These aspects are crucial both in understanding and making sense of individual behaviours in the clinical setting and also in beginning to see what place education may have in altering such behaviours.

The term attitude comes from the Latin, *aptus* (aptitude) and *acto* (postures of the body) (Cacioppo, Petty & Crites, 1994). At different points in its history, the concept of attitude has been linked to emotional, behavioural and cognitive processes (Breckler & Wiggins, 1989; Eagly & Chaiken, 2007; Fazio, 2007; Zanna & Rempel, 1988). Today, Social scientist Donald Clark defines 'attitude' as: *'A persisting feeling or emotion of a person that influences choice of action and response to stimulus. Defined as a disposition or tendency to respond positively or negatively towards a certain thing (idea, object, person, situation). They encompass, or are closely related to, our opinions and beliefs and are based upon our experiences.'* (online, Social Sciences Dictionary, 2016). There are a variety of similar definitions, but all emphasise four important predisposing characteristics of attitudes: Action, evaluation, an affective component and that they are learned (Breckler & Wiggins, 1989; Maio & Haddock, 2015). Put simply, our attitudes refer to how much we like/dislike something (Maio & Haddock, 2015 p1) and are crucial in understanding human thought and behaviour.

There are a number of theories regarding attitude formation and function which are summarised in Table 2.1 (below). These functions allow us to understand the reasons

why people hold the attitudes that they do (Katz, 1960, Wang, 2012). Each of these theories is important to consider when exploring ways of changing attitude, which is part of the intention of this study.

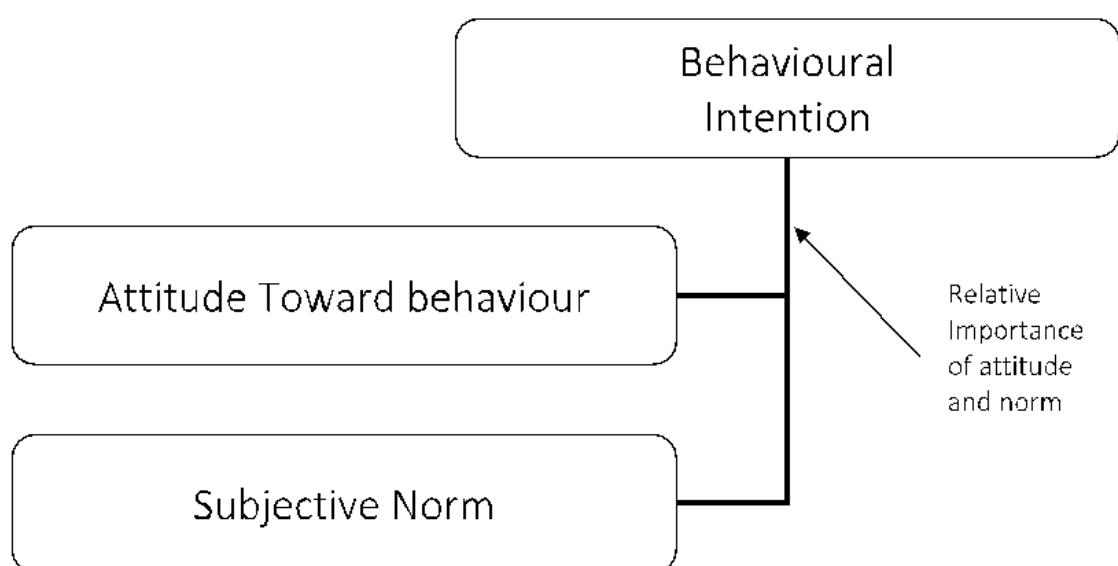
Table 2.1 Summary of the key theories of attitude function and formation.

Theory	Key Elements	Application
<i>Attitude Functional Theory (Katz, 1960)</i>	There are four functions of attitude: Instrumental (utilitarian), knowledge, ego-defensive, value expressive.	These functions guide behaviour, help to manage information processing and memory, protection of self and allow expression of values. This may have a role in social decision making.
<i>Theory of Planned Behaviour (TPB) (Ajzen, 2001)</i>	People act according to their intentions and attitudes toward the behaviour.	Attitude and intended behaviour arises from subjective norms; past experiences and society views affect these. Gives some indication of the motive behind the attitude (Shavitt & Nelson, 2002)
<i>Multicomponent model of attitude (Eagley & Chaiken, 1993)</i>	Attitudes are formed through our beliefs, or perceptions regarding the characteristics of the object. Based upon cognitive, affective and behavioural (CAB, Maio & Haddock, 2015) elements.	Attitude is formed through direct observations, acceptance of this information, and new beliefs formed as a result. These are built on what is already known about the object by the individual, so thoughts, beliefs and perceived attributes (cognitive); feelings and emotions (affective); past experiences and behaviours (behavioural).

One of the roles of attitude is to allow our behaviour to be influenced by earlier experience. This is likely to be an especially important concept, given that a large proportion of student midwives come to the profession as ‘mature students’ (aged over 25) (Carolan, 2011) and so have a range of experiences (life- and work-based) which may have had a place in formation of their attitudes toward drug using women.

Another important aspect to consider with attitudes held by those in health care professions is whether or not attitudes held by individuals are predictive of their behaviours in practice, or are indicators of intended behaviour. Research suggests that strong attitudes are more stable, resistant to persuasion and more predictive of behaviour (Ajzen, 2001, p37). It is suggested that behaviour intention is affected by not only the individual’s attitude toward the behaviour, but also social factors such as the individual’s perception that ‘important others’ would accept or oppose the behaviour (their ‘subjective norm’) (Figure 2.1). In the context of a learning approach that is formulated around a community of learning and interaction, as is the case in this research, this idea of social influence on subjective norms may be especially pertinent.

Figure 2.1. The Formation of Intention by attitude and Norm (Adapted from Ajzen, 2005)



Therefore, to change an individual's behaviour, it is necessary to consider and subsequently alter what affects the intention, so either an individual's attitude, or their perception of 'norms' in relation to the behaviour. Whilst attitude is usually a more important influence (Ajzen, 2005), both factors will have an impact, and so to alter behaviour, both factors need to be considered. This notion of 'subjective norms' may well be culturally constructed and constrained. Therefore, when exploring the influences of such factors in the context of attitudes to substance use, or misuse, the country (and indeed culture) of origin of the participants and the research is a key consideration. This research was conducted in the UK and so it is these social norms in relation to substance use that have been considered in this work and which are explored in the Educational Intervention. Furthermore, the influence and impact of others upon an individual in terms of shaping their subjective norms may be important when education is delivered in a 'social' or group way.

2.7 Attitude Change

Health professionals are just as affected by societal norms as those in society and are equally influenced by their own past experiences, training and socialisation, and, as noted above, these aspects all feed into an individual's likely behaviour. Long-held beliefs and attitudes are difficult to overcome, especially when they are seen as going against the grain of dominant practice and beliefs (Lyons 2002), either in the practice setting, or in wider society. Thus, it is important to consider these aspects when delivering education to alter attitudes as in this research.

When considering the concept of long-held beliefs and attitudes as suggested, the literature and work around morality and the impact of a person's morals should also be considered. One such idea, moral foundations theory (Graham et al., 2011) makes the suggestion that we all come with certain moral 'foundations', which represent a set of 'innate but modifiable mechanisms' (Graham et al., 2009 p1030) sparking 'automatic, emotionally-laden moral responses to a range of features within our physical/psychological/social environment' (Wright & Baril, 2011 p1007). Moral foundations theory furthermore suggests that, whilst we may all possess the same moral foundations, we respond to similar situations in different ways and to varying

degrees. Wright and Baril (2011 p1007) suggest that this is because, although our moral foundations are innate, they are also modifiable, so there is opportunity for 'parental, cultural, and even temperamental influence'. When considering attitude formation regarding substance misuse in pregnancy, this concept resonates with the variation in moral position expressed both in society and practice. In establishing effective methods of education it is vitally important, because, as outlined in the early part of this chapter, the moral position of society (and indeed practice) in relation to substance use in pregnancy is on the whole negative in nature.

Empirical research measuring attitude and other subjective mental properties dates back to the early 20th century (Maio & Haddock, 2015). Significant early researchers in the field included Louis Thurstone and Rensis Likert, who both developed ways of measuring attitudes, such as Likert Scales, which remain important tools today (Maio & Haddock, 2015). These early works paved the way for the concept that attitude can be quantifiably measured. Such scales have been used on numerous occasions to determine attitude and empathy by health care professionals in relation to care in general and also a range of conditions, include substance misuse (Christison, Haviland & Riggs, 2002; Christison & Haviland, 2003; Dearing & Steadman, 2008; Boyle et al, 2010; Boyle et al, 2012).

Following on from the works of Likert and Thurstone, LaPiere's work (1934, in Maio & Haddock, 2015), went further and demonstrated the important concept that an individual's attitude (and moral stance) did not necessarily affect their behaviour. Cacioppo, Petty & Crite's (1994) work supported this notion, defining attitude change as an individual's modified evaluative perception of a stimulus or set of stimuli. La Piere also noted that change in knowledge or skill is not attitude change, though it may of course influence it; again a crucial concept to consider both when designing education and also when conducting research looking at measures of attitude change, as in this study.

The works of Lewin (1951) added further insight to the field of attitude change, by looking at the driving and restraining forces to managing change in the 'real' world, and others such as, Festinger, Sherif, Adorno, Frenkel-Brunswick, Levinson, Asch, Altemeyer (in Maio & Haddock, 2015 p6) by examining the effects of conformity,

power, group dynamics and the persuasion of telecommunication messages for example, all of which may be of importance in the delivery of an online education module. Informed by Lewin's work, Hovland, Janis and Kelley (1953) researched how and why attitudes were most likely to change and laid the foundations for models of attitude change, which need to be considered when evaluating an education programme's ability to affect this.

Over time there have been many approaches to attitude change. Understanding each of these approaches gives insight into the way to effect changes in attitude and may be of use in understanding how or why education has, or hasn't, been effective in altering attitude. The main theories and approaches can be summarised as:

- *Cognitive dissonance theory* (Festinger, 1957). This was one of the first proposed, and refers to an imbalance of beliefs, such that inconsistent beliefs produce negative feelings that individuals are then motivated to reduce through change.
- *Conditioning, or modelling approach*. Where attitudes toward stimuli that are more positive result in greater pleasure being associated with the outcome and vice versa.
- *Verbal learning approach*. Where attitudes are determined and influenced by what a person is told, for example by the media.
- *Judgemental approach*. This describes attitude change based upon understanding the past experiences and stimulus in which the attitude is embedded.
- *Motivational approach*. Focuses on human motives as they relate to attitudes and persuasion.
- *Attributional approach*. This suggests that a person's inferences regarding the cause of the behaviour are what results in the attitude.
- *Self-persuasion approach (SPA)*. This states that attitude change is not a consequence of externally provided information per se (so not the module

content directly in this research), but rather the consequences of the thoughts, ideas and arguments that individuals generate themselves.

(Adapted from Cacioppo, Petty & Crites, 1994).

Petty and Cacioppo (1986) considered that the predominant route to persuasion (or effecting attitude change) is that attitude change occurs following careful and considered thoughts regarding the merits of the information presented in support of the view. They reasonably suggest that such thinking and consideration can result in new arguments becoming integrated into an individual's underlying belief structure. If this is correct, then there is an implication here for the education approach to be used, in particular the way in which teacher and student activities are designed and integrated. By scrutinising the relative strengths and weaknesses of an argument, both the information and the consequential attitude become more 'persistent, resistant to counter-persuasion and predictive of behaviour' (p266). This would imply that educational methods need to employ strategies for facilitating this.

Cacioppo, Petty and Crites (1994) also suggest there is a more 'peripheral' element, which effects change by more simple cues in the persuasion context, and that this induces change without necessitating consideration of the merits. This concept is important when we consider that it is not always possible to have had the luxury of time and cognition to consider one's attitudinal reactions in all situations (p268). What does appear to be important, however, when considering the longevity of attitude change and the prediction of behaviour, is the underlying motivation and intention to process the new persuasion in the first place. This intention is affected by many variables, such as the accessibility of the message and the individual's ability (capacity) to engage with the message and so on. For attitude to change for the long term, all of these components need to come into play. Therefore an intervention that seeks to alter attitude in a positive manner needs to stimulate thinking in a persuasive way, with strong arguments presented and an opportunity for consideration (time). There is also a suggestion here that an individual's learning propensity (or cognitive abilities), will also affect attitude change, which has huge implications for higher education teaching and learning strategies with this aim: does this mean that a more academically able student is more likely to change their attitudes, for example?

Research by Cacioppo, Petty and Crites (1994) demonstrates that when the source giver is trustworthy and deemed knowledgeable the message is more likely to be received positively, unless there is a consequential effect of the information on them individually, in which case the students' ability to scrutinise the arguments was the most influencing element. Again, this has an implication for the teacher or facilitator in any educational intervention.

Crucially for the development of educational material designed to affect attitude, is the suggestion that the presentation of a persuasive message in a rhetorical way, as opposed to a declarative way, improves the likelihood of the individual *thinking* about the message and considering carefully their response (Cacioppo, Petty & Crites, 1994). Edwards (1990 p202), suggests, *'whether in the form of propaganda or education, whether the desired end is virtuous or evil, persuasion plays a central role in social behaviour ... teachers use persuasion to instil appropriate attitudes ... and to modify attitudes they consider inappropriate'*. Acceptance of this message or persuasion can be provided by argument and reason constituting rational or logical support for the conclusion (Hovland, Janis & Kelley, 1953 p11). In the case of this study, this is an important consideration as the module involves all of the students developing and giving their own reasoned arguments, which may of course in turn influence, affect, or change the views of others.

Other theoretical perspectives and models of attitude change suggest that emotional (affective) factors are also important in addition to the cognitive component discussed. Many empirical studies have demonstrated the involvement of fear arousal (Maddux and Rogers, 1980), positive mood (Janis, Kaye and Kirschner, 1965) and importantly for this study, empathy (Shelton and Rogers, 1981) as all having a role in attitude change. Traditionally, the affective component involves emotions, feelings and drives toward the subject, whereas the cognitive component is associated with beliefs, judgments and thoughts (Edward, 1990). Given that the subject matter of this study, substance using pregnant women, has been shown to evoke strong reactions as highlighted earlier in this chapter and in Chapter 1, the affective component to attitude is something that one may expect to be affected by education.

Despite the research into the field of attitude formation and change being available for many decades, there is a notable absence of qualitative research exploring why and how these factors have such an effect. Furthermore, as suggested, the overarching research in the field suggests in some situations the cognitive component may be dominant, in others the affective, or a mixture of both: what the research does not yield, however, is an exploration of why cognition plays a greater role and vice versa. Knowledge of this would support the development of education designed to affect attitude in particular areas.

2.8 The role of substance misuse education

This section examines the evidence for the effect of education on attitude change and its role and effectiveness in tackling stigma and change in the clinical setting. Raeside's study (2003), looking at attitudes of staff in a neonatal unit toward substance using women, concluded that the attitude of nurses and midwives towards mothers affected by substance abuse was generally negative and judgemental, and their knowledge base was low. The study indicated a need for formal education on substance abuse amongst neonatal staff. This was, however, a very small study and not conducted in the UK, where midwives do not work generally in neonatal units, therefore the applicability to UK practice is questionable. Jenkins' (2013) study also suggests education as a means of ameliorating a lack of knowledge in practice. Similarly, Kelleher and Cotter (2009) surveyed doctors and nurses working in emergency departments to ascertain their knowledge and attitude toward substance use and substance users, and they also identified educational deficits. All of these studies consider that education is needed in the area of substance use to improve knowledge and change attitudes.

Whilst there is a range of education materials relating to drug and alcohol use, there has been very little evaluation of their effectiveness (McAvoy, 2000). Within the medical fields, and in particular nursing and midwifery, this is especially limited (Kelleher and Cotter, 2009).

Selleck and Redding (1998) explored the relationship between demographic variables and nurses' knowledge and attitudes toward perinatal substance use; the study of 393 nurses from a variety of backgrounds found that substance misuse education was the only key predictor of attitude and knowledge. Those who had undertaken formal training in substance use had more knowledge and positive attitudes than those who had not. This study established a connection between education, knowledge and attitude, however, it did not deliver any education to confirm this effect. Hagemaster et al. (1993) on the other hand delivered an education programme over two and a half days (over two weeks) to 58 nurses, and found that, following the intervention, psychiatric nurses had improved positive attitudes and optimism about treatment. Similarly, a study by Anderson et al. (2004), evaluating education for GPs in relation to brief intervention screening for alcohol use, found that education increased the use of brief intervention as a tool. Arthur's (2001) study examining student nurses knowledge and attitudes toward problem drinkers, and a study by King et al. (2004) of an intervention aimed at improving knowledge and skills of emergency department staff, both similarly reported improvements following education.

More recently, Rasool and Rawaf (2008) assessed the effect of educational intervention on confidence skills when working with substance users using quasi-experimental, pre and post-test design. Their findings support the notion that a short-term education programme could positively impact upon the confidence levels of undergraduate nursing students. This study did not however assess attitudes, or the effect of education on these. As part of a larger study looking at the effect of a specific education intervention upon pharmacists' ability to deliver health information around alcohol use, Dhital et al (2012) found a positive change in attitude toward hazardous drinkers, pre- and post-education. Whilst this aspect of the study was purely quantitative in nature and had many different variables which may have affected the findings, it does suggest that targeted education in this field can have a positive impact.

Similarly, Gerace, Hughes and Spunt (1995) found significant improvements in post education knowledge and clinical intervention ratings amongst a cohort of 32 nurses. Perry (1999) also found that following an education programme, nurses showed improvements in screening rates for alcohol use. The last two of these studies suggest

that the 'theoretical' educational knowledge gain may importantly transfer into clinical improvement and confidence as well.

In summary, these studies all indicate the potential positive benefits of education in the area of substance use for professionals. What they fail to offer however, is insight into midwives as a professional group, and additionally, suggestions as to *why* education helps and what such education should look like, suggesting the need for further research looking specifically at the evaluation of substance use education, including that for midwives.

Despite these findings, there continues to be a void in education for health care professionals in this area, including midwives. Whilst a search of the literature showed no reference to the drug and alcohol content of midwifery education, a wider search revealed a limited number of reviews of drug and alcohol content in nursing curricula in England (Rassool, 2009; Rassool and Rawaf, 2008; Holloway and Webster, 2013; Cund, 2013). All of these studies have shown that there is a deficiency and provision of alcohol and drug education is inadequate.

Currently in the UK there is no overview of education related to drugs and alcohol in undergraduate nursing, or midwifery curricula. There appears to be no requirement for mandatory content in this area (Holloway and Webster, 2013). This lack of education, Rassool suggests, may be reflected in the research outlined herein, which shows that health care professionals have negative attitudes toward users and are often moralistic, punitive and pessimistic (Rassool, 2009). The evidence clearly purports that without such interventions, the challenges and barriers to providing effective care in this field will continue to arise.

2.9 The nature of substance misuse education

Boyle et al (2010) similarly highlight a need to better educate undergraduate health students towards medical conditions such as substance abuse, as this may be an endpoint to an underlying medical condition like depression. However, they pose the question of how university-based curricula can best facilitate this, and whether a

didactic session is the best way to 'educate' students, or if a variety of blended teaching and learning methods would better meet the students' needs.

The concepts and theories regarding attitude change already outlined also need to be considered in the context of the way in which individuals learn, as this informs the way in which education is designed to support this. With these ideas in mind, approaches to educational delivery and learning styles need to be considered. In this section a few of the theories and approaches that may have relevance to the field of alcohol and drug education have been considered, although it is acknowledged that many others exist and may have a place.

It is important in an interactive (with peers) approach to education, as is the case in this study, to acknowledge the theory around the construction of knowledge within learning. In the context of education, Piaget described constructivism as the process whereby students construct their own individual systems of knowing (Pritchard, 2014). Piaget's approach takes into account the environment in learning and making sense of this as learning. However, its focus is on the individual constructing their own knowledge (Pritchard, 2014). The important aspect here is that to facilitate such knowing, teachers perhaps should focus on this internal construction rather than taking a didactic pedagogical stance. Thus in education, constructivism is about individual cognition, as opposed to physical response, although these may of course be aligned (Papert and Harel, 1991) and this is an important consideration in educational design. Social constructivism, however, as proposed by Vygotsky (Pritchard, 2014) takes Piaget's ideas a stage further and considers that learning (and thus new knowledge construction) takes place through interactions with others. We therefore build our internal realities in response to our perceived constructs we receive from others. Constructivism is thus as a social process whereby constructs (and 'reality') emerge from ongoing conversations and interactions (Berger and Luckmann, 1966). 'Dialogue with peers becomes the vehicle by which ideas are considered, shared and developed' (Pritchard, 2014 p26). The educational intervention used in this research has a strong element of dialogue with peers through online discussion boards, and therefore it may be that the idea of social constructivism is important to the students' learning.

In some areas of enquiry, including psychology, social constructionism essentially shares the same premises of social constructivism as described thus far. Pioneers for social constructionism, Berger and Luckmann, also questioned the existence of purely rational, objective knowledge and suggested that knowledge comes from other processes related to ideology, interests and power.

'Common-sense knowledge rather than ideas must be the central focus for the sociology of knowledge. It is precisely this knowledge that constitutes the fabric of meanings without which no society could exist. The sociology of knowledge, therefore, must concern itself with the construction of reality.' Berger and Luckmann (1966 p27)

The premise is that we share the world with others, and in order for life to not become chaotic, social order is required. Berger and Luckmann (1966) suggest that even the concept of 'self' is developed through interaction with others. People remove or isolate themselves out of necessity through their actions and this represents the social order (Berger and Luckmann, 1966 p69-70). 'Bodies of knowledge' (Alvesson, 2001) develop in this way, with such knowledge being externalised by individuals, carried back by other individuals and then internalised by them in turn.

'Knowledge, in this sense, is at the heart of the fundamental dialectic of society. It 'programmes' the channels in which externalisation produces an objective world. It objectifies the world ... as reality. It is internalised again as objectively valid truth in the course of socialisation.' Berger and Luckmann, 1966 p83-84)

Such knowledge is not only passed between individuals in society at a given time, but passed between generations and thus creates traditions (Alvesson, 2001) and to some extent ingrained beliefs and views. So, overall, these views become social norms and knowledge in their own right. As a child we learn from 'significant others' and throughout the rest of life our subjective reality (knowledge) is affirmed by conversations, experiences and the words of others. There is a distinct connection between individuals and society. This is affirmed by Gergen (1993, 2002) who suggests that knowledge is never abstract, but always situated and tied to human practice; there is no truth, only local truths. Given the suggested views of society

toward drug and alcohol using parents outlined earlier in the chapter, this theory may also have relevance within the study and so needs to be considered.

Another learning theory that may have some role within drug and alcohol education is behaviourism. Behaviourism focuses on the outcome of changed behaviour as evidence of learning. It looks at the behaviour of individuals and the changes to this behaviour when learning has occurred (Bates, 2016). The basic premise is that individuals are directed toward a stimulus (object of learning); this stimulus then provokes a positive or negative response and a subsequent change in behaviour. It is generally an approach to teaching used with children (Pritchard, 2014) to steer them towards or away from positive or negative behaviours. Its critics suggest that the autocratic nature of behaviourism fails to recognise the independent and enquiring nature of people (Bates, 2016). Whilst perhaps not being a suitable pedagogical approach which would be chosen when designing education to stimulate thinking, given the social stigmatisation faced by substance users, some of which is grounded in fear, it may represent how the students undertaking the module have learnt (in life) prior to the module.

Within the health care setting, reflective learning forms a large part of teaching approaches, and so warrants mention as potentially important in this research. Reflection is a way of learning by accessing previous experience, helping to develop tacit and intuitive knowledge (Johns & Freshwater, 2005). It provides a process for individuals to change, along with their future actions (Ghaye & Lillyman, 2010), and helps individuals to make sense of what has occurred (usually within the practice setting, but not exclusively) and why (Johns, 2010). Howatson-Jones (2013) suggests that reflection is not an unusual phenomena and in fact most of us do this, much of the time; what it does require however, is the space (time) to do it.

Jasper (2003) describes the important role that reflection makes within practitioner learning, that is, in establishing the link between theory and practice. Howatson-Jones (2013) asserts that this is especially important for novice practitioners, so in the case of this study (or any other with undergraduate student practitioners), where the students are in the early stages of their career.

Schon (1991) outlined his understanding of reflective practice as being either undertaken at the time of the event (reflection in action), or after the event (reflection on action). The former provides the practitioner with a way of dealing with the situation as it unfolds in front of them; the latter provides a way of considering the event later along with exploration of other possible actions which may then affect decision-making in the future. Reflection in action very much involves and is driven by previous experiences and feelings and emotions at the time, whereas reflection on action enables the practitioner to access further knowledge, theories and so on and think about these (i.e. it involves cognition). This is what education as in this study could potentially facilitate. Argyris and Schon (1978) suggest that reflection is especially important when what is experienced (practically) does not match the theoretical concepts presented, and given the potential disparities seen between societal views and evidence from research regarding substance users, this may be applicable to the study.

Argyris and Schon (1978) said that people have mental maps with regard to how to act in situations. This fits with the concept of an inbuilt, or pre-learned way of how to respond in situations, including exposure to substance users, and these 'mental maps' can thus affect our actions, including planning, implementing and reviewing actions. For Argyris and Schön (1978 p2), learning involves the detection and correction of error. They suggest that when something goes wrong, people look for another strategy. In other words, given or chosen goals, values, plans and rules are operationalised rather than questioned. Individuals draw upon their 'learnt' or 'inbuilt' systems as a first line response. Argyris and Schön (1978) refer to this as single-loop learning. Usher and Bryant (1989 p 87) suggest that single-loop learning occurs when strategies are taken for granted, with the emphasis on 'techniques and making techniques more efficient.' This is as opposed to critically considering and framing the strategies in the context of theories that may underpin them. An alternative response, which allows this critical consideration, is to question what has happened and subject it to critical scrutiny. This is what education, and arguably this educational intervention, is capable of encouraging and facilitating. Argyris and Schon (1978) call this double-loop learning and assert that this type of learning may lead to

a shift in the way in which the problem is framed and thus change attitude and hopefully behaviour.

The notion of repertoire is a key aspect of the reflective learning approach. Practitioners build up a collection of images, ideas, examples and actions that they can draw upon. Donald Schon, like John Dewey (in Bates, 2016), saw this as central to reflective thought.

Atkins and Murphy (1995 p45) sum up the basic premise in all reflective cycles:

Stage 1 – Awareness of uncomfortable feelings

Stage 2 – Critical analysis of the situation

Stage 3 – Development of new perspectives related to the situation

When considering this in the context of attitude change theory, this seems to mirror the ideas of Festinger's (1957) cognitive dissonance theory, suggesting that a reflective learning approach may aid attitude change; the focus of this study.

2.10 Chapter Summary

Previous research in this field looks at attitudes in relation to substance use from the perspective of health care professionals, but is rarely UK-based, nor does it relate to student midwives (Boyle et al, 2012; McKenna et al, 2011). There are studies from pregnant women's perspectives that report stigmatising attitudes of midwives (Radcliffe, 2010) and in other fields of health care stigmatising attitudes have been shown towards substance users from professionals. It may then seem reasonable to postulate that these also exist amongst midwives and student midwives; however, this assumption needs to be tested.

In addition, the UKDPC (2010a p2) suggest that there is:

'a need to challenge the entrenched and widespread assumption that drug users are solely culpable for their condition by educating people at all levels in society, including health professionals and the media, about the causes and nature of addiction.'

They suggest the need for workforce development across the range of professions that work with people with drug problems to improve service responses and provision. Similarly, Gleeson (2011) makes the suggestion that we need to foster an acknowledgement that we are all drug users, illicit or otherwise, and thus we should embrace, and not isolate, to avoid creating the sense of 'otherness' experienced by some in our communities. We can do this, he suggests, by ensuring that we regularly question and test our own beliefs and prejudices regarding drug use and drug users; though I question the simplicity of this statement.

Indeed, this literature review highlights that people often hold beliefs that are demonstrably untrue and in these cases their attitudes and thus behaviours could potentially be influenced by the provision of accurate information. It is clear that although the voice of the women has been heard to some degree, there is a real lack of research based in the UK. There is a similar lack of research about the way in which 'general' midwives frame substance misusing women (which, as discussed, can be reflective of their attitudes and hence behaviour) and also regarding the effectiveness of educational intervention, both in terms of firstly changing midwives attitudes and secondly in improving engagement and experience of maternity care by substance users. There are both theoretical concepts and research linking education to improved knowledge and understanding in practice. The theoretical concepts suggest that attitude is influenced by a variety of factors, and equally, that there are many approaches to achieving changes in attitude. Appropriate education that challenges thought and increases knowledge is proposed as one way of achieving such change. Furthermore, there are studies linking education in substance use to improved attitudes for health care workers. Improving attitudes, reducing stigmatisation and thus increasing engagement for substance users is essential. What is lacking, however, is exploration of what education to change attitudes might look like and contain for health care professionals, and in the case of this research, midwives (student midwives).

From reviewing and refining the literature, the following research question and aims were derived as a focus for the study:

Research Question

'What place does drug and alcohol education have in relation to attitudes of student midwives toward pregnant drug users?'

Aims

- **To measure the attitudes of a group of student midwives toward substance using pregnant women before and after an educational intervention.**
- **To explore the attitudes and opinions of student midwives toward drug use before undertaking an educational intervention.**
- **To explore the role, or place of the educational intervention on any attitude change toward pregnant drug users following an educational intervention.**

The next chapter builds upon the literature presented here, and outlines the approach to be taken and the underpinning philosophical perspectives for the research.

Chapter 3

Methodology

This chapter follows on from the literature review, which gave an overview of the relevant research and theoretical perspectives in the area that inform the study. This chapter provides the philosophical underpinning for the research design adopted for the study. The methodology chosen is thus outlined, together with a rationale for the methods and procedures undertaken to address the research question.

3.1 Philosophical Perspectives

Demonstrating my philosophical underpinning will secure the quality of the research produced (Snape and Spencer, 2003). Furthermore, because doctoral research contributes new knowledge to a field, it is essential that justification for my episteme, or ways of thinking, are explicitly stated, as this is what fundamentally underpins every single action taken in the course of the research: the implicit becomes explicit. It is a crucial element in ensuring the contribution is unique: / am unique and thus bring a fresh and new perspective, which unfolds within my own conceptual framework. It is essential that any reader of my research findings is able to do so within the parameters of its intended conceptualisation, or as Sikes (2004, p17) suggests my 'researcher positionality' and my philosophical assumptions.

Developing my own conceptual framework for this work has ensured that I have considered a variety of theoretical perspectives and so has made me really think about what I am doing, what is important to me and why at every stage. It has enabled me to adopt approaches that support my episteme and dismiss those that do not.

Positionality

An important aspect of choosing methodology is to consider the researchers 'position', or 'positionality'. Jackson (2013, p50) suggests that:

'research is subjective – even the most scientific, positivist, objective, quantitative researcher will make a subjective choice, for example, of which statistical measure to apply – and interpretative as the researcher's perceptions are utilised in all stages of decision-making throughout a research project.'

Furthermore, Wambui (2013) suggests that an awareness of one's own position is essential, as the researcher often fails to see much of what is there because of their own assumptions, experiences, and the knowledge constructed through literature. Thus it is important to consider my beliefs, values and assumptions; in essence, to gain understanding of where I have come from when conducting the research, as ultimately this shapes the outcomes of the research (Jackson, 2013).

At the start of my research, my conceptualisation demonstrated the world (or field) of my research as I saw it then. It was reflective of what I considered to be taking place within the phenomenon I chose to study; the effectiveness of education regarding attitudes of midwives toward substance misusing pregnant women. Having critically discussed the research and some of the theories postulated through which the issues around stigma and attitude formation can be viewed in my literature review, it became apparent to me that there were many uncertainties and gaps in evidence. Previous research in the field looked at attitudes in relation to substance use from the perspective of health care professionals, but rarely midwives or student midwives, and much was not UK-based (Boyle et al, 2012 and McKenna et al, 2011). There were studies from pregnant women's perspectives that reported stigmatising attitudes of midwives (Radcliffe, 2010) and in other fields of health care stigmatising attitudes had been shown towards substance users from professionals (Rasool and Rawaf, 2008; Kelleher and Cotter, 2008). It therefore seemed reasonable to postulate that these attitudes might also exist amongst midwives and student midwives in the UK, and I wanted to determine if this were true of student midwives in my educational institution. I also wanted to gain understanding as an educator of the value of an educational intervention that I delivered, a module called 'Substance Misusing Parents', in potentially altering these attitudes and in exploring what may have influenced any changes. My field of interest was therefore complex, with the interaction of many social and educational phenomena that I felt needed to be investigated, or explored. As such, from the outset, as the module leader for

'Substance Misusing Parents', which I delivered to third year student midwives, I had a clearly defined focus of investigation: my module, or educational intervention (this educational intervention is detailed further in the chapter), which brought together many of the phenomena.

Research Question and Aims

From the literature review it became apparent that there was very little research looking at the attitudes of midwives (or student midwives) toward drug using pregnant women. There was also a paucity of research exploring ways of addressing attitudes toward substance using pregnant women, and even less looking at the effectiveness of midwifery education in doing so. This said, Klee et al (2002) did say that health care professionals reported they lacked knowledge about the issues that substance using women may face, and Rassool and Rawaf (2007; 2008) suggested that educational intervention can be effective in improving practitioner confidence in this area. In light of these findings, it was my view that this lack of knowledge could in turn lead to, or at least be perceived as, judgmental attitudes. It was my intention then to address the following research question and aims:

'What place does drug and alcohol education have in relation to attitudes of student midwives toward pregnant drug users?'

The main focus of the research was to explore a particular phenomenon using case study according to Yin (2014); the case being my educational intervention (module) '*Substance Misusing Parents*'. Within this case, a variety of issues, or aims, were considered;

- To measure the attitudes of a group of student midwives toward substance using pregnant women before and after an educational intervention.
- To explore the attitudes and opinions of student midwives toward drug use before undertaking an educational intervention.
- To explore the role, or place, of the educational intervention in any attitude change toward pregnant drug users following an educational intervention.

In the development of these aims, I wanted to ensure that none became more important (or bigger) than the case as a whole, as this was of primary interest to me as an educator and a researcher. As suggested by Yin (2014), case studies arise out of a desire to understand complex phenomena, because they allow the researcher to retain the holistic characteristics of real-life events.

It was important to establish what exactly I wanted to find out before settling on any methodology or methods to use. In this way, the design and tools could be matched appropriately (Denscombe, 2010). Choosing methodology based upon the research questions to be answered means that the credibility of the research can be strengthened (Sikes, 2004). In the construction of this piece of work, however, the above aims and a less concrete research question were originally used to consider the approach to take, and to give rationale to the choices made regarding how exactly I would research my question. These were influenced from the outset by what I wanted to find out: what effect the educational intervention I was providing could have upon student midwives attitudes toward drug using pregnant women.

Thus from the beginning I had a focus of enquiry, a 'case'. The purpose of defining the methodology is *'to help us understand ... not the products of scientific enquiry but the process itself'* (Cohen, Manion and Morrison, 2007, p46). Study of a case, or 'case study' is a focus upon one 'thing', it involves the 'thing' to be studied in depth and from a variety of angles as indicated (Thomas, 2011); these angles were influenced by my ontological and epistemological positions. For me, I located the need and position of case study as a methodology in terms of the whole orientation towards my research from the outset. I recognised the depth and insight that case study would allow me to gain. So in my study, this was an in-depth exploration of the complexity of various interactions that existed in the context of a single delivery of my educational intervention: Substance Misusing Parents module (see later). It was a real life situation that would enable me to generate knowledge that could be used to inform policy and practice (potentially both clinical and educational) (Simons, 2001, p21), given my position as a midwife, educator and researcher.

In highlighting my 'position' as a researcher it is necessary to discuss the concept of research paradigms and thus where my research fits within this. Guba (1990)

suggests that paradigms can be characterised through their ontology (perception of reality), epistemology (way of knowing) and methodology (way of finding out). Together these form a holistic view of how we see knowledge, how we see ourselves in relation to this knowledge and finally the methodological strategies needed to discover this knowledge. Put simply, within research paradigms are a belief system (or theory) that guide the way the research is done; this includes the thoughts underpinning the research and the physical 'doing' of the research. These paradigms are often linked to specific disciplines and types of research and include; positivism, post-positivism, critical theory and constructivism (or interpretivism), some of which are discussed in more detail below in the context of this study.

Ontology

As a researcher, a part of the process of ensuring research that is ethical, strong and stands up to peer scrutiny is to take a reflexive approach. This means both with regard to the physical and psychological power and dynamics I may exert upon the research (both processes and individuals) and its outcomes (Padgett, 2012). In addition, but of no less importance, is to consider carefully my own epistemological and ontological stance and how this may affect the way in which the research is conducted, interpreted and presented (Gilbert, 2008). As encapsulated by Foucault:

'People know what they do; frequently they know why they do what they do; but what they don't know is what what they do does.' (Foucault, 2005 p39)

Ontology refers to one's 'reality', or the way in which we view the world. In research it is important to outline how, as a researcher, you see the world, and to consider why you do what you do, because this reflexivity strengthens the outcomes and ensures transparency.

Reality, then, can be seen from many perspectives. In research literature, the continuum model suggests that the two main and opposing perspectives presented are positivist and interpretivist (or constructivist); there are also a range of positions in between these, such as post-positivism and critical theory. Positivism is reflective of reality existing independent of our perceptions or interpretations of the real world

(Plowright 2011). It is based upon reality being objective and universally applicable, generally being associated with scientific experimentation, whereby the observations made are free of personal value, interests and purposes (Plowright, 2011). Positivism therefore views the world as having a single reality which could in fact exist in the absence of humans. Whilst my scientific self-values the place and importance of positivism (rationalism, order, cause and effect, life is what it is, deduction and so on), I don't think this is the only way; I believe there is more depth to be explored than the observed, fixed, and measurable reality of my students. Interpretivism, on the other hand, is reflective of a reality which is constructed by humans. Interpretivists believe that individuals construct their own realities and, as such, there are many equally valid versions of it.

Given these opposing views of reality, it is of no surprise that the research designs adopted by researchers in each paradigm are completely different. For example, a phenomenological approach which is centred on valuing individual voice and experience and which, as such, would produce multiple realities, would be an inappropriate choice for a researcher in the positivist paradigm. For my research I do not entirely reject the positivist approach; I see its value and place. However, I am attempting to *'harness it within a more complex research design'* (Adam, 2014, p5), whereby a *'more integrated and deliberate methodological approach'* (Adam, 2014, p6), involving interpretivism as well, is achieved through the exploration of a range of phenomena and relations in the context of my case. The data produced can then be viewed as a *'whole'* contextualised and concrete case (Bryne, Ragin and Charles, 2009).

Ontologically, my position has some similarities to postpositivism. Rather than attempting to find cause and effect, as positivism does, postpositivism seeks to identify correlational relationships and asserts that the nature of knowledge is probabilistic (Parahoo, 2006). One truth can never be reached, and so the aim is that one attempts to capture, using multiple methods or examinations, as much of this reality as possible. Tobin and Begley (2004) suggest that postpositivism is more realistic than positivism because no study of humans can be completely free of the researcher's influence and so true *'objectivity'* is not possible. Postpositivism therefore resides on an element of deductive logic, influenced by hypotheses and

theory; however, it also acknowledges that that reality is constructed and that a researcher influences their study (Onwuegbuzie 2002). Personally I believe that, far from being irreconcilable, as suggested by Howe (1988), positivist and interpretivist methods and approaches can co-exist in social research. Plowright (2011) concurs with this, stating that the social world is transitive, in that it is not permanent, but ever changing, and that the natural intransitive world *constrains* and *contains* the transitive social world, thus there is a relationship between both realities. In agreement with Giddings (2006), my view is that approaches used in research, rather than being purely inductive or deductive in isolation, should allow for diversity in the methods used, particularly for research into complex problems (Giddings 2006). For my research the question and aims were quite complex and broad, needing a methodology and methods that could both quantify and allow exploration of the effect of educational intervention. Giddings (2006) suggests that research which combines qualitative and quantitative findings can add to the 'truth value' of the research findings. A case study approach allowed me to incorporate both quantitative and qualitative elements, with the focus being upon exploration of the overall 'case'.

Overall, however, no one theoretical framework fully encompasses the world as I see it, or the way in which I have approached my research. Sometimes termed the 'lens' through which one views the world, my framework is concerned with addressing the issues, as I see them, of social injustice and inequalities. There are a range of theories and frameworks that articulate where I sit, some of which are discussed below; the reality is that I take an approach to life that sees worth in aspects of a range of ideas and ideals, which all add to and shape my own thinking and knowledge. It therefore helps to uncover the reason for being, highlighting the concrete and specific (C.E. Montague (n.d.) in Thomas, 2011 p 7):

'The great escape should be from, "mere intellectualism, with its universals and essences, to concrete particulars, the smell of human breath, the sound of voices, the stir of living."' (Thomas, 2011, p7)

In this way, I am not just interested in the academic arguments relating to what stigma is and what influences attitude, or indeed the theory of how and why we learn,

but in the lived experience of the students undertaking the course. In this study then, what is of interest is: What has happened? How did it happen? What was it connected to? And why did it happen? I considered that this was best achieved through exploration and analysis of the many and varied components and angles which would allow interactions and voice to be heard, and that may explain any phenomenon that had occurred; thus my choice of a case study.

As a practitioner, my ultimate allegiance lies with people, however, and their 'lived' experience, and thus in the realm of social interaction and social theory. I am a supporter of social justice and strive to effect change in practice in order to reduce the inequalities that stigmatised groups (in this case substance misusers) face. In the case of this research at least, I am interested in the influences upon the construction of views and knowledge of substance use, in order to further understand what impact education can have upon changing them. Critical reflection of relevant theory has helped me to construct my distinctive view of the field to be studied and to identify the key issues and problems that could be approached through research (Cooper, 2008). It has also formed the basis of the approach taken to conduct the research.

As a midwife, whose primary focus of work is 'women', it is necessary to consider where feminism fits within my work. A feminist approach to research challenges knowledge that excludes, while seeming to include, women. It explores and critically challenges the notion that there is social justice independent of gender (Hesse-Biber, 2012). Primarily, feminist research places women's lives, or the lives of other marginalised groups, at the centre (Hesse-Biber, 2012, p2). Feminism is basically a critical theory that amongst other things challenges the notion that 'biology is destiny' (Jenainati and Groves, 2010); it aims to understand the nature of gender inequality. For me as a midwife researcher my interests are of course with women and in particular any inequalities they face; however, my experience, and indeed research, has led to my view that the stigmatisation and judgement of substance users is not unique to women, despite a small degree of evidence that it may be slightly worse for them (UKDPC, 2010), and the injustice and social and health inequalities users face is apparent regardless of gender. Thus, I am a feminist and as such I am concerned about unequal power distribution, especially regarding 'women's lives', and social justice as described (Olesen, 2011). In the context of my

research, if I were looking at the women who substance misuse in particular (as the focus), my choice would be a feminist approach; however, what I am interested in looking at is education and its impact, and so this is not necessarily a gender issue. Therefore, while I am a feminist, I did not take a feminist approach to my research, though my feminist views may influence it.

There is a strong argument and case within sociological research for social constructivism (an interpretivist approach). This is the belief that social norms and values are socially constructed (Gilbert, 2008). This idea is considered in the writings of the French philosopher, Michael Foucault; who suggests that as a result of developments in human sciences, society has evolved a system of deciding what normal and abnormal behaviour is, and as such, this has opened up a basis or platform for placing judgements, thus perpetuating stigmatisation. In this way, what is considered 'normal' and 'abnormal' is influenced and crafted by society, so in the case of attitudes to substance misuse in the UK, the attitudes and beliefs that as a society we hold would be said to be socially constructed and influenced. In social constructivism, meaning is seen as being influenced by social structures and processes, including taking into account the influence of culture and tradition (Wimpenny, 2010). I have no doubts at all that this is true to some extent and that society's 'norm' does have an impact, as demonstrated by the first two sessions of my educational programme, 'Normalisation of the Drug Culture' and 'Experiences and Attitudes', and indeed the literature outlined in Chapter 2. Again, the choice of a case study approach to this research is ideal, because it allows both individually and socially constructed views to be appreciated if applicable within the case.

Essentially, as outlined when discussing constructivism as an approach to education and learning in Chapter 2, constructivists believe that reality is constructed in the mind of the individual, rather than being an external entity (Hansen, 2004). In research terms, the constructivist position sometimes suggests that meaning is hidden and must be brought to the surface through reflection (Schwandt, 2000; Sciarra, 1999), for example through researcher-participant dialogue. Taking this approach entirely would not allow for quantitative approaches such as 'survey' or 'closed questionnaire' to be used as these do not facilitate such depth of interaction between researcher and participant.

Constructivists, however, believe there exist multiple, constructed realities. Reality, according to the constructivist position, is subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and the researcher: all of which I do hold to be true.

So a constructivist researcher may interview only a handful of participants for longer periods of time, and when analysing the transcript data, may not seek other researcher consensus on identified themes, because there are multiple realities and meanings of a single phenomenon.

In addition, as a practitioner bound by a code of professional conduct (NMC, 2015) outlining a series of 'duties', I also believe there is some merit in the Kantian categorical imperative, which is defined as *'an objective, rationally necessary and unconditional principle that we must always follow despite any natural desires or inclinations we may have to the contrary.'* (online Stanford Encyclopedia of Philosophy, 2016). Kant's work highlights a central tenet of constructivist thinking: that you cannot partition out an objective reality from the person (research participant) who is experiencing, processing, and labelling the reality (Sciarra, 1999). However, whilst I agree with many of the Kantian principles, I believe it to be too rigid and inflexible, raising questions regarding, for example, the view to be taken following killing. However, it does refer to positive moral obligations toward one another and views the person in a holistic and valued way and few would deny the merit of this.

My position and approach to this research from an ontological stand, considering the various realities that I hold, is on a continuum of post-positivism – interpretivism (constructivism), veering mainly toward the interpretivist side. As indicated previously (and discussed in more depth later in the chapter), the fact that my position is fluid along this continuum makes case study an ideal methodological approach because it facilitates such a flexible approach.

Epistemology

My choice of undertaking a professional doctorate, as opposed to a PhD, is testament to where I sit epistemologically in many ways; I am an academic (currently an educator) and also a practitioner (a midwife). My epistemological stance is juxtaposed between these two: theory (intellectual knowledge) and practice (experiential and 'real' knowledge).

In the context of this research, if attitude has any element of social constructivism, as a result of learnt behaviour, experiences or exposure to the influence of what society deems to be abnormal over time for example, then these views may be entrenched. Therefore, any education may then require a social approach that addresses and confronts beliefs and attitudes crafted through social interaction over time, in order to alter them. This then adds a further dimension to be explored in the research; does the nature/detail of the educational intervention matter? In the approach to this research then, it is imperative that there is the opportunity to observe and elicit social interactions and processes, through the use of case study, which enables various approaches, deductive and inductive, to be included.

Given that interpretivists hold that views are socially constructed and thus it is associations with this that underpin the research, it is logical then that knowledge of this social world is both socially situated and has social consequences (Moses and Knutsen, 2007). Therefore, in the case of my research, an interpretivist view would hold that results from investigation are not usually universally applicable, but bound by context (Parahoo, 2006). Furthermore, interpretivists seek to understand socially constructed patterns within the world and use methods which allow knowledge to be gained from observation in context, so as to allow a meaning or meanings to be arrived at (Moses and Knutsen 2007). A post-positivist approach conversely holds that knowledge is time- and context-free (Parahoo, 2006) and so can be applied to a variety of contexts. In the area of my research, it was deemed that the students' knowledge (and thus, possibly, attitudes) were arrived at not only as a result of the module content and experience (context-bound), but in addition based upon their prior knowledge, practice and other experiences (so not time- and context-bound), and so again a methodology was needed that could explore a range of realities, making case study the ideal choice.

In some areas of enquiry, including psychology, social constructionism essentially shares the same premises of social constructivism described thus far. Berger and Luckmann (1966) suggest that social constructionism similarly questions the existence of purely rational, objective knowledge, and suggest that knowledge comes from other processes related to ideology, interests and power. This position lends itself toward an interpretivist approach to research, which Gergen (2015) advocates as a way of enabling reflexivity to challenge long-held assumptions that have emerged as knowledge over time.

As an educator, I subscribe to this view that knowledge is not absolute or abstract, and an individual's reality is socially entwined, or constructed, as outlined by my ontological stance. Therefore, I believe knowledge is arrived at by experience, sense-making and meaning. By virtue of the fact that these concepts are individualistic, a methodology and methods were needed that allowed a naturalistic and interpretivist exploration of the education delivered.

3.2 Methodology

In line with my philosophical perspectives, a study design approach was needed that could answer my research question; not only providing a measuring element but more importantly an approach that valued the individual, and gave voice and an opportunity to express the individual's reality. Given that from the outset I already had a focus of enquiry in my educational intervention, case study methodology was chosen as being the most suitable; enabling me to answer my research question using appropriate methods from the post-positivist and interpretivist paradigms. Yin (2014) suggests that case study is distinctive in its ability to study complex social phenomena, especially when there is a need to answer 'how' or 'why' questions, and when the researcher has little control over the events.

A useful image to conjure characterising a case study is that of a suitcase; it contains all things within a defined and identifiable boundary. Likewise the case study needs to have distinct edges, and the focus, then, of this study was the interactions and

connections of everything inside, all explored in the context of the specific module delivery (Thomas, 2011).

'Case study approach is used to build up a rich picture of an entity, using different kinds of data collection and gathering the views, perceptions, experiences and/or ideas of diverse individuals relating to the case' (Hamilton, 2011 p1).

Using a range of perspectives and types of data collection is a key strength of the case study.

The case itself was already in existence, a single cohort of 48 potential third year student midwives undertaking a 'Substance Misusing Parents' module (see below; educational intervention). As such it was not artificially generated for the purpose of the study; as outlined by Yin (2014), it was a 'naturally occurring phenomenon'. This in itself is a distinct advantage of case study as a methodology, as Flyvberg (2001 p132) suggests, allowing the researcher to get '*close to reality*'. In my case, the students change annually. However, the educational intervention was consistent and 'real', thus this helped to reduce some of the limitations associated with other research methodologies which are artificially contrived, for example experimentation, or some types of behavioural observation (Silverman, 2007). Thus, in similarity to an ethnographic approach, this was a 'real time' live study. However, unlike ethnography, I as the researcher was not directly observing and emic (inside), immersed 'in' the study alongside the students (Padgett, 2012).

In addition, whilst ethnography would allow the humanistic aspects and social interactions of interest to me to be closely studied, the primary reasons for not taking an ethnographic approach to this research, which as stated would also have value, was twofold: Firstly, the resource implication in terms of my time, because full immersion in the research setting with ethnography (Hamersley 2007) was not feasible within the limits available to me; and secondly, given my position as the students' tutor, despite a relaxed and good relationship between myself and my students, the power I potentially held over them – as for example the marker of their assignments – could have significantly influenced both their behaviour and potentially my interpretation and observation of interactions and events. This said, my interpretation of the students' views may be biased by me being the researcher

anyway, influenced by the module being one which I deliver and my ontological position. This could be lessened with a case study approach which has a range of elements, including quantitative data, which Oppenheim (1992) has suggested is more objective than qualitative data,

In case study, detail needs to be paid to the processes by which the outcomes are ascertained. In this way, case study allows the opportunity to not only answer 'what' the outcomes are, but also to get some insight into 'why' these outcomes are so; that is, what has led to them for the specific case (Thomas, 2011). It looks at the subject of study (the case) from many and varied angles, and by looking from such a range of intricate ways, develops a richer, more insightful and crucially balanced picture.

It has been suggested that case study is therefore a particularly useful tool in programme evaluation, due to its specific in-depth study of the particular 'case' (programme) (Greene, 2000; Simons, 2012). As such, case study had distinct advantage over straightforward evaluation in this study; case study allows for this in-depth analysis of the specifics. As suggested by Yin (2014), case study is an appropriate methodological design choice if to answer your questions an in-depth and extensive description of some social phenomenon is required. Unlike a straightforward module evaluation, which measures expected impact against a set of predetermined baseline statements, a case study design can go beyond this and further explore unintended impacts, and gain insight into why such phenomenon may have occurred, thus adding valuable information. As such, it can encourage the consideration of social processes and relationships (Denscombe, 2010) (possible reasons for the outcome) as well as quantifying any resultant change (outcome). Given the postulation of the socially constructed nature of stigma and attitudes, this was of vital importance, and I anticipated that some useful insights would be identified around the construction of such views in the context of education. That is to say, in case study all findings are 'contextualised', which is what adds to their value.

Whilst it is true that most commonly case studies are associated with the discovery of information, i.e. they are inductive (Denscombe, 2010), this study needed to employ both deductive and inductive logics and thus methods to achieve its aim. As

with many studies using a combination of methods, the different methods were not hybrid, but juxtaposed, thereby retaining the integrity of each.

The rationale for using methods that collect both quantitative and qualitative data was to allow a deeper exploration of the case from many angles. This is in line with Stakes' (2000 p143) observation whereby case study is '*... a choice of what is to be studied. By whatever methods, we choose to study the case.*' Kohlbacher (2006 p4) concurs, stating that '*case study as a research strategy comprises an all-encompassing method, which means that a number of methods may be used – either qualitative, quantitative, or both.*' To answer my research question, first, a measurement of any change needed to take place and then exploration to explain any changes. First, a measurement of attitude change was used, using a scale which could be repeated and generalised to an extent. This data was then used to inform and set out the exploration and deeper analysis of why and how the education had altered attitudes to enhance understanding and provide rich data for application to practice. Case study as a research design, unlike many other approaches, is not defined by its use of research methods, however, but by its theoretical orientation and the focus upon the individual case of interest (Kohlbacher, 2006).

As an educator I wanted to know what the 'education' I was delivering was doing and determine and establish its 'worth' in this sense. Whilst an approach such as a straightforward survey could answer such questions, and may have in this case elicited a range of useful and pertinent data that might have added to the field of knowledge, it would only have given a scale of the views held within the definitions and parameters of measurement laid out in the questions asked (Cresswell and Plano Clark, 2011). This could be useful in that it might give an overview of 'how student midwives feel about substance using pregnant women', and these findings could then be correlated to other studies of different health care professionals to compare the degree to which attitudes are better or worse for midwives. It would also mean that greater numbers of participants could be sought, improving the reliability and validity of this aspect of the results (Cresswell and Plano Clark, 2011). However, whilst the research question posed required measurement to be made (i.e. before and after questionnaires), what a survey/questionnaire approach alone would not

have demonstrated is why these views were held, and what about education in this field actually makes a difference and improves attitudes.

A straightforward module survey (or evaluation) approach would also not, as Yin (2014) suggests, have allowed contextualisation of the conditions and parameters of the case to the findings. Yin (2014) further states that in using case study to do evaluations, there are four important applications: firstly, to explain the presumed causal links that are too complex for survey methods; secondly, to describe an intervention and the real-world context in which it occurs; thirdly, to be able to illustrate certain topics of focus within an evaluation; and fourthly, to enlighten the situations where the intervention being evaluated has no clear, single set of outcomes.

It was important also to note that, in the context of evaluation of a programme, the programme may prove to be successful, or indeed a failure, but may not be for the reasons assumed (Padgett, 2012; Simons, 2012). Quantitative measurement alone would not allow for explanation of this. In relation to my research, all stakeholders had an interest in this particular aspect.

Furthermore, given my own ontological standpoint, it was important as a researcher to value individuals and their different and useful viewpoints, each constructed differently. I was therefore interested in finding out how the students felt with regard to substance misusing pregnant women, what their ideas were and their experiences. I valued their views and wanted to hear their 'voice' and the richness of what they were telling me; therefore an exploratory approach was also needed to develop this line of inquiry (Cresswell and Plano Clark, 2011).

The Educational Intervention (The Case)

Yin (2014) identifies the importance of defining the 'case' and its parameters at the outset. The education intervention used was a pre-existing university module, 'Substance Misusing Parents'. This university module is delivered at level 6 (3rd year undergraduate level), and is worth 30 academic credits. For the purposes of this research, the case was a single cohort delivery of the module, consisting of third year

student midwives only, who selected the module in year three as an option - this was 48 students in total, all of whom were invited to participate. As the module leader for this module, I was also supervisor to four students in this group undertaking their undergraduate major project (UGMP) alongside the module, and personal tutor to eight students. However, as outlined in phase one and three, I was not aware of which students chose to participate. In the phase two interviews, two of the participants were my personal students; however, none were my UGMP supervisees.

Like all modules at the academic institution, its development and inclusion in the BSc Midwifery curriculum was subject to rigorous quality assurance standards, both from the university and from the NMC (Nursing and Midwifery Council). This took place during five-yearly curriculum revalidation and yearly annual monitoring processes. Along with all modules at the university, module evaluation was conducted following each delivery and on the basis of this (which included student feedback), staff development (by way of annual teaching reviews), and developments in the subject field, the module was continually updated. At the time of data collection for this research, I had been leading and developing the module for four years. Whilst I did not originally write the content, I had updated much of it with my experience in the subject field, and also following attendance at specialist e-learning conferences for health and in-house and self-training in distance learning as a pedagogical approach.

The module was originally designed for a multi-disciplinary audience to be included as one of two option modules for third year student midwives. The purpose of the module was for students to gain experience, knowledge and understanding of the reality of some of the issues associated with substance misuse and the effect on the lives of women and their families. It aimed to improve the ability of the practitioner to recognise and respond appropriately to the effects of substance misuse on families both in the short term and the long term. It was also designed to help practitioners to understand the support that is needed by a child and its family when substance dependence is part of their physical, social or psychological requirements, and explores agencies available to assist and support the children, families and the practitioners.

The module was taught as flexible distance learning (online) using a virtual learning environment (VLE) with corresponding tutorial support with the module leader (myself) via email, telephone, or face to face. The module was delivered over 15 weeks, where the students were required to undertake approximately one section per week (11 sessions; Table 3.1), including an online e-activity. The e-activities were collated and submitted for assessment at the end of the 16 weeks. Each e-activity required the student to reflect on experiences and research relating to the week's online content and write a fully referenced 'post' as directed of around 300 words for each week, to be posted on the communal discussion board. In addition, the students had to read and write a fully referenced reply to at least one other student's post on the discussion board for each activity.

The purpose of using this module as the 'case' was to provide an in-depth analysis of a specific teaching intervention on practice (potentially clinical and educational).

Table 3.1 Outline content of Substance Misusing Parents module

Main Section	Sessions
Part 1. Substances and everyday life	1. Experiences and attitudes
	2. Consumerism and normalisation of drug culture
	3. Who misuses and why
Part 2. Exploring substances	4. Implications for practice
	○ Alcohol
	○ Depressant/sedative drugs
	○ Stimulant drugs
	○ Hallucinogenic Drugs
	○ Tobacco
Part 4. Recommendations for practice	5. Recommendations based on drug choice above
Part 3. Legal and ethical issues	6. Legal and ethical challenges
	7. Professional challenges
Part 4. Recognition and effects	8. Recognition of substance misuse
	9. Motivational interviewing
Part 6. Clinical management	10. National guidance
	11. Local practice policies

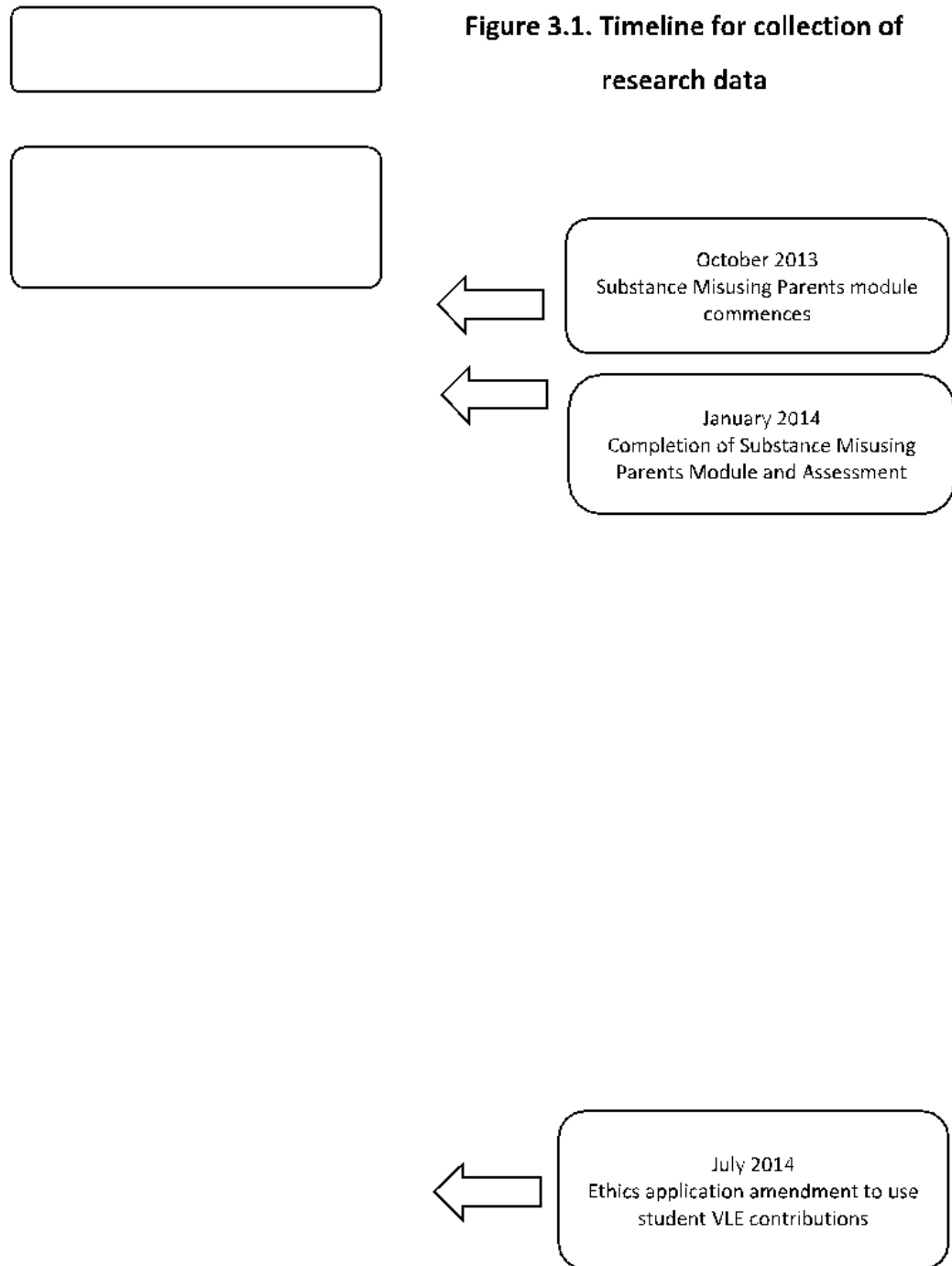
Methods

A benefit of case study is that it allows the use of a variety of sources and methods to investigate the question (Denscombe, 2010). Any combination of appropriate methods can be drawn on, thus giving a real strength to the approach (Simons, 2012). Research methods refer to the approach or approaches used to gather the data, which then forms the basis of interpretation, inference or explanation (Cohen and Manion, 2007). In this study, the methods or instruments of data collection used were, for phase one, a psychometrically tested attitude scale to determine empathy levels before and after the module, and in phase two, in-depth semi structured

interviews to get students' views of both the educational intervention and of any changes in their views whilst undertaking the course. In addition, a small part of the students' narratives, or 'discussion posts' (from the university's Virtual Learning Environment, VLE), submitted for assessment for the module, were collected and analysed. In this way the use of the methods was sequential, the results of the first phase informed selection of approximately 8-10 participants for the second, and only those students who consented to participation had their narratives collected following the completion of the module.

Data Collection Timeline

The data collection took place over a 13 month period with different phases of data collection being conducted concurrently as indicated in figure 3.1.



Study Participants

The participants and 'case' for this study were purposively selected. Purposive samples are used when the researcher is studying a particular phenomenon and wants to ensure examples of it show up in the study (Balbach, 1999). The object of case study is not to find out how often something occurs in a population, but rather

what occurred, why it occurred, and what relationship exists among the observed events. Therefore in this study, I needed to select participants who had knowledge of the case and therefore the potential to shed light on the 'what?' and 'why?' questions posed.

The participants invited to take part in phase one were all 48 undergraduate midwifery students aged over 18 undertaking the Substance Misusing Parents module (the case) during a single delivery at the institution in which I was employed.

For phase two, 10 students were purposively selected from within the respondents to phase one, representing a range of different results from phase one. The participants were all female student midwives (because there were no male students in this cohort). The students had all completed two years of undergraduate midwifery education and associated practice successfully. The students came with a variety of backgrounds and life experiences. They had all had opportunity for contact with women, to have an understanding of the role of the midwife in this field, through a variety of midwifery and non-midwifery (such as sexual health and neonatal) placements. The age range of the participants was 20 – 48 years.

48 students were invited to participate; 40 completed questionnaire one and 29 completed questionnaire two. Eventually 10 students were interviewed, and the VLE posts for the original consenting 40 students were collated for analysis in phase three.

Phase one

Questionnaires

Given the aims of the study the following hypotheses were generated to be tested:

1. There is a significant positive difference in the general empathy levels shown by students before and after an educational intervention around substance misuse.
2. There is a significant positive difference in the regard shown by students toward women with reduced fetal movements in pregnancy (as discussed later) before and after an educational intervention around substance misuse.

3. There is a significant positive difference in the regard shown by students toward women who misuse substances during pregnancy before and after an educational intervention around substance misuse.

These were tested using questionnaires to measure any differences pre- and post-module. The advantages of using surveying methods of this kind is that they are relatively inexpensive, can use a variety of modes of distribution, and large numbers of participants can be accessed. If completed appropriately and with appropriate numbers, statistical significance and a high degree of reliability can be easily determined (Denscombe, 2010). However, they require a good response rate for this and have no flexibility to evolve the questions asked during data collection, which interviewing and focus group techniques could potentially do (Denscombe, 2010; Gilbert, 2008). In addition, there is always the risk that participants answer what they feel they should rather than what they actually think. In the context of this study, then, there was a detachment of the context in which students were being asked their views of substance misusing women from the clinical setting, and so what they said might not accurately represent how they in fact behaved in practice. To mitigate against some of these pitfalls, a variety of different survey and questionnaire methods were explored, selecting those that had already demonstrated reliability (Oppenheim, 1992; Gilbert, 2008).

Attitudes have long been shown to be predictors of behaviour (Eagley and Chaiken, 1993 and La Piere, 1934). Valid and reliable means of assessing attitude therefore were key in this study, which could help to reduce the effects described above. When assessing a psychological construct such as attitude, it was important to ensure that it would be a true indication of the individual's views in relation to attitude. Thus, a range of already established attitude scales relating to substance use were looked at and considered for use in this study (Watson et al, 2003; Christison, Haviland and Riggs, 2002; Hojat et al, 2001); the specificity of these were favoured over one constructed by me as the researcher, mostly due to time constraints given the complexity of questionnaire design. Most of these attitude scales were based upon psychometrically tested stigma measures and were selected for consideration because of this, as well as their already established efficacy, reliability and validity (Gilbert, 2008; Polit and Hungler, 1997). When considering these scales, most only

covered substance use as a general concept and not within pregnancy, or did not actually test from the health carer's perspective or the latter's attitudes towards drug users. In light of all of this, I decided that, following a study by Boyle et al. (2010), which measured general empathy levels of undergraduate students and also specific empathy toward certain medical conditions, I would use the same two scales. These were the Medical Condition Regard Scale (MCRS, Christison, Haviland and Riggs, 2002) and the Jefferson Scale of Physician Empathy – health professional version (JSPE-HP, Hojat, et al, 2001).

The Medical Condition Regard Scale (MCRS) was developed to determine the attitudes held toward specific medical conditions (Christison, Haviland and Riggs, 2002) and allow comparison between a variety of conditions. It can be used with any medical condition, making it a useful tool in this study. The respondents answered eleven questions using a six point Likert scale (1 = strongly disagree, 6 = strongly agree), with five of these questions being negatively worded to reduce acquiescence in response. The MCRS has proven reliability and validity and its authors found the scale to have a Cronbach coefficient alpha of 0.87 and a test re-test reliability of 0.84. (Christison, Haviland and Riggs, 2002; Boyle et al, 2012; McKenna et al, 2011). In this research, the medical conditions compared were attitudes toward substance misuse in pregnancy, compared to reduced fetal movements (reduction in movement, or perceived movement of the unborn baby; Macdonald, Magill-Cuerden and Mayes, 2011). These conditions were chosen due to both being pregnancy conditions with associated pathologies. Substance misuse in pregnancy was the nature and focus of the study and reduced fetal movements was a condition which is not associated with negative attitudes from midwives and generally attracts empathy (Macdonald, Magill-Cuerden and Mayes, 2011).

The Jefferson Scale of Physician Empathy Health Professional (JSPE-HP) version is a psychometrically validated measurement of empathy, again with proven reliability and validity (Hojat et al, 2002; Hojat et al, 2005; Hojat et al, 2003). The JSPE-HP required the students to answer 20 questions using a seven point Likert scale (1 = strongly disagree to 7 = strongly agree). Ten of the 20 questions were negatively worded in order to decrease acquiescence responding, and these were reverse-

scored after for analysis. The scale has a range of scores 20 through to 140. The higher the score, the higher the participant's level of empathy.

The MCRS and JSPE-HP were used in conjunction with a simple self-report questionnaire to elicit a small amount of demographic data giving quantifiable information demonstrating student midwives' empathy levels specifically toward substance misusing women (Appendix 1). This questionnaire was used prior to the start of the module (Q1) and repeated again upon completion of the module (Q2). Kumar (1999) suggests that the use of a before and after design is a useful tool to assess the cross-sectional observation of the same population to find out the change in the phenomenon between two points in time (p83).

Pilot tests are used to help refine data collection, both in regard of the content and the collection procedure (Yin, 2009). The pilots usually represent a formative version to help develop the lines of questioning and also aid conceptual clarification if required (Yin, 2009). As such, each of the scales to be used and the questions to be asked during phase two were piloted on another student who had already completed the module. Minimal amendments were then made to the format of the questionnaire, which contained some errors, and to the wording of the questions in the interview schedule.

Ethics

As I recognised the potential that my position as module leader could make an invitation to participate seem coercive, all 48 students undertaking the module were invited to participate by a third party (a colleague running a module alongside mine). All participants were given a participant information sheet (PIS Appendix 2) detailing the nature and purpose of the research and their role, together with a consent form (Appendix 3) for their consideration, one week prior to completing the questionnaires. Questionnaire one was completed before the start of the module (in September 2013) by all those agreeing to participate, and the responses collected and securely stored by the third party recruiter. The process was repeated for the second questionnaire, which was completed in February 2014 following completion of the module. At this stage the completed questionnaires were passed to me for matching (individuals who had completed both questionnaires) and analysis.

A response rate of over 50% is required to gain representativeness (Moule and Goodman 2009) and this criteria was met. All 48 students were invited to participate in each of the questionnaires; two students were absent from class on each occasion, leaving 46 possible participants. Forty students agreed to complete the initial questionnaire (an 87% response rate) and 29 completed the second questionnaire (63% response); these 29 students had completed both questionnaires, thus producing a matched sample. The drop-out rate between the two questionnaires may have been due to the timing of completion of the second questionnaire. To coincide with the completion of the module (and marking) meant that they were asked to complete the second questionnaire whilst also studying for their undergraduate major project, or dissertation; a module that students often find stressful. However, if the date of the second questionnaire had been delayed until after the submission of their dissertations, it would have been nearer to 4-6 months following completion of the Substance Misusing Parents module and this may have affected the results.

Phase Two

Interviews

For the second phase of the study, the method used was in-depth individual interviews, which allowed for each individual voice to be heard and valued (Simons, 2012). Whilst this method was more time consuming than focus groups would have been, it took place after the delivery of the module, at a time when the students had a lot of study leave and there was therefore more flexibility with timings. Overall, this approach ensured that the depth of detail sought was facilitated. Focus groups may have been an appropriate method of exploring and explaining the impact of education and how the students felt about the intervention. In addition, they would have allowed observation of the interactions between participants, and would have been a quick and relatively cheap method of data collection (Denscombe, 2010). However, there may have been an element of 'peer pressure' that might have affected the students' responses and meant the depth of individual response wasn't

clearly determined, especially given the sensitive nature of the research topic (Creswell and Plano Clark, 2011).

Given that the focus of this case was establishing and exploring the effect of the educational intervention, these interviews were conducted after the module was completed, in the students' final semester of training; between one and three months following module completion. This meant that the students had completed the module and had had time to reflect on its content and what it had meant to them.

The primary question in relation to practice was regarding any positive change that the education could have, and so consequently, eight participants were invited to take part in semi-structured interviews based upon a positive change in their scores (from phase one questionnaires) regarding their empathy levels toward substance using women. The remaining two participants had negative change results from the matched questionnaires (although only minimal). These two were chosen to see if their perceptions of the intervention and its effects gave any different perspectives compared with those who had a positive response.

An interview schedule was developed and refined, in consultation with the supervisory team, based upon the broad themes emerging in the literature review and the outline content of the module (Appendix 4). Primary questions were outlined and then prompts were available if required. The interviews all took place on university property in a small interview room, which was set up to facilitate an informal discussion. Each participant was asked to verbally give consent to be interviewed and for the interview to be recorded.

Participants were all given the opportunity to review their own interview transcripts when completed to check for inaccuracies.

Phase Three

Data Collection from VLE Posts

Following a more detailed literature review undertaken for the study, it became apparent that there were multiple aspects that could affect and potentially form an

individual's attitude and opinions (or level of empathy) regarding substance use. This study was designed to capture the effects of the educational intervention upon changing these attitudes, and also to explore in greater depth what impact the module had upon these opinion, or attitudes. However, given the theoretical perspective that to some degree attitudes toward pregnant drug use would be formed and influenced by factors (affective or cognitive) arising prior to beginning the module, or for most individuals prior to commencing the course, it seemed reasonable to attempt to capture these 'prior' experiences and attitudes. When initially writing the research proposal and designing the research, the importance of this aspect did not seem apparent. However, when as module leader I began marking the students' assessments for the module in January 2014, I noticed the depth of student voice representing their previous experiences, attitudes and opinions toward substance use in general in the 'Experiences and Attitudes' posts, and saw the richness of this data. The session e-activity is shown in figure 3.2.

Figure 3.2. Experiences and Attitudes online session task

In light of this, I submitted for ethical approval an amendment to my research design to include the post 'Experiences and Attitudes', for all students who had agreed to participate in the study. This was granted in August 2014 and so the anonymised VLE posts for the session 'Experiences and Attitudes' were collated into a single document from 40 consenting students, together with their replies to others posts (also anonymised). I was aware that these posts had not been written for the purpose of being used in research, and this was reflected in the analysis. It was also for this reason that I grouped the responses all in together rather than matched them to the participants' other data, such as questionnaire scores and interview transcripts.

3.3 Data Analysis

Yin (2014) highlights that the use of inductive and deductive strategies may offer additional insight to the case. The outcomes of the case (in this study, the quantifiable

effect of the intervention) are measured using a quantitative approach and the qualitative techniques are then used to explore, describe and explain the events. Whilst Yin's (2014) techniques for analysing case study data (pattern-matching, explanation building, time series analysis and logic models) were considered and the ideas that were appropriate to this study (predominantly pattern-matching and logic models) had characteristics in common with elements of the approaches used, I considered that Yin's approaches did not offer enough structure, or guidance for me as a novice researcher.

Quantitative analysis

Statistical analysis is common in survey and experimental research designs. However, it can also be used in case study research, either by itself or in combination with qualitative analysis (Korzilius, 2012). In the study, both descriptive and inferential statistics were used. Descriptive statistics were used to describe the basic features of the data in the study. They provided simple summaries about the participants and the measures. Descriptive statistics are, however, limited inasmuch that they only allow the researcher to make summations about the people or objects that have actually been measured. The data collected cannot be used to generalise to other people or objects (i.e. using data from a sample to infer the properties/parameters of a population), although as discussed generalisation was not the intention or purpose in this case. The aim was to provide an analysis of the context and processes and give deeper insight into the phenomenon being studied (the educational intervention) and not the wider population. Korzilius (2012) iterates that whilst quantitative analysis is not the most common way to analyse data in case study, it can nonetheless be very useful as a way to explain and describe phenomena that would not have been possible with a qualitative approach alone. However, it must be considered within the frame of the case study design, which examines a phenomenon in its real-life context.

For the purposes of this research, I wanted to be able to determine more than the 'appearance' of a connection between the 'case' (module) and any change in scores shown by the questionnaires, which is all descriptive statistics would allow. I wanted to establish if the findings were a fluke, how strong the connection was, and to some

degree whether the module had 'caused' any change (Denscombe, 2010). There appeared to be a link (or change in scores pre- and post-module), but I wanted a more positive determination of this; thus the use of inferential statistics to statistically test if there was a significant change in the participants scores pre- and post-module.

Furthermore, whilst the descriptive statistics add useful information about the study, they do not allow depth to consider associations and differences between the different data sets. So, for example, the mean score for my participants in either MCRS or JSPE may be different in number before and after the module, as determined by descriptive statistics. However, the only way to confirm whether this difference is significant (statistically) is the use of inferential statistics, which would take account of the variability of the data in each group as well as the mean values. The physical difference between two mean values in two different sets of data may be the same, however, in one set there could be a statistically significant difference and in the other (due to the variability in values within the dataset), there may not be. In essence, the story with each two sets of data is different and the best way to assess this difference and 'tell the story' is to use inferential statistics. In this case, the appropriate test that would compare the means in two sets of data, taking into account the spread or variability of scores, was the t-test. According to Gillham (2000, p80), *'case study research does not equate qualitative (descriptive, interpretative) methods and data only. They are predominant, but quantitative data and its analysis can add to the overall picture.'*

The participants' questionnaires were numbered and matched for before and after the module. The data were inputted from each individual questionnaire response into an Excel spreadsheet. One was completed for data before the module and one for after the module. The electronic software package SPSS (Statistical Package for Social Sciences; Thomas, 2011) was used to prepare the data for exploration and statistical analysis (Cresswell and Plano Clark 2011).

The data was viewed in its 'raw form' prior to any statistical tests being applied to undertake what Nieswiadomy (2012) calls the 'intraocular method' of data analysis, i.e. simply looking at it and visualising it. Nieswiadomy (2012) suggests that doing this

can lead the researcher to detect errors in data inputting and analysis prior to any further analysis.

Initially, simple descriptive statistical analysis was carried out ascertaining the mean values and ranges for the age of the students. Then the mean cumulative scores and ranges were calculated from the questionnaires before and after the module (Q1 and Q2) for each of the attitude scales used; JSPE, MCERS (substance misuse SM) and MCERS (Reduced Fetal Movements FM). The cumulative scores for individual students were then compared for MCERS SM before and after the module and an indication of whether their score (and thus empathy) had increased, decreased or stayed the same was made. Based upon this indication, students were selected to be invited for interview in phase two. Eight students were selected whose increase in scores were the greatest, and two students whose scores decreased.

Whilst inferential statistics are often used in order to be able to generalise findings to the wider population, in this study this was not the case, hence no power calculation was performed. However, I wanted to be able to compare the results of the scales used against each other, to see if any differences noted were significant in a statistical sense. This involved the use of inferential statistics and in particular t-tests.

Given that one of the aims of the study was to measure changes in student empathy, especially toward substance use in pregnancy, before and after education, the means were compared before and after the module for each MCERS SM and MCERS FM and also JSPE as this would indicate any changes. This was undertaken for the matched students (that completed both Q 1 and Q2) and also for the two participant groups as a whole (for Q1 n=40 and Q2 n=29).

Furthermore, the mean score for MCERS SM before the module was compared with the mean score for FM before the module, to see if there was any significant difference in the scores. This was repeated following the module and the results compared. Lastly, to see if there were any specific individual questions with significant changes in response, the individual question cumulative means were compared before and after the module for each of the scales used.

To enable the correct tests to be selected and applied, i.e. parametric or non-parametric, the data was examined and tested to ensure there was a normal distribution of data; Kolmogorov-Smirnov's test was used for this and all sets of data were shown to be normally distributed. As all data were normally distributed and the participant group before and after the module were not independent of each other i.e. the participant population was the same (Field, 2005), paired t-tests were used to compare the means, with a significance value set at less than 0.05.

The t-test assesses whether the means of two groups are *statistically* different from each other. This analysis is appropriate to compare the means of two groups. Denscombe (2010) suggests that a particular benefit of the t-test is that it works well with small sample sizes (less than 30), and the groups being compared do not have to be the same size.

In summary, paired (dependant) and independent t-tests were used to compare means for:

- JSPE before and after the module
- MCRS SM before and after the module
- MCRS FM before and after the module
- MCRS SM compared to MCRS FM before the module
- MCRS SM compared to MCRS FM after the module

In addition, the cumulative means for each individual question on the MCRS SM, MCRS FM and JSPE, before and after the module, were compared using t-tests to see if there were any changes on individual item scores.

The size that a participant group needs to be in order to conduct an adequate piece of research is often subject to debate. Cohen, Manion and Morrison (2011) suggest that there is no clear cut answer to this, and that it depends upon the purpose of the study. As suggested by Denscombe (2010), a size of 30 is the minimum number required if the researcher is planning to undertake some form of statistical analysis. One of the main considerations in determining the participant size needed, and thus for also undertaking power calculations in quantitative research, is so that the researcher can confidently generalise their results by being able to assert that theirs

is an accurate representation of the wider population being studied. In this study, however, no such claims are being made. The participants may reflect a typical population of student midwives; however, this is not established, tested or claimed. Neither is it of interest for the given project which is focused upon the in-depth study of an individual 'case' and not the implications of the findings to the wider population. That is not to say that the findings will not be applicable to other settings. However, it is not the aim of the study to establish this (discussed in greater detail in 3.8 and 6.5).

Crucially, it is important to note that the statistical significance shown doesn't necessarily imply a social significance, as discussed in Chapter 6. This is something that needed to be shown or confirmed elsewhere by other means, and as such was an important part of the methodology chosen of 'case study,' in that the other aspects to the study helped to support and add to the findings of the quantitative elements.

Qualitative data Analysis

Interviews

There are many options available for the analysis of qualitative data, depending often on the philosophical underpinning of the research. For example, discourse analysis or ethnomethodology take into account the language used in social interactions; phenomenology and narrative analysis are concerned with the experiences, meaning and language used; while in grounded theory, the derivation of new theory is gained through a set of procedures and stages. For me and my research question, what was important was to 'hear' the student voice and let the data 'speak' to me; initially I was unsure if the nature of the language used was important in answering my questions. My findings needed to be iterative in nature, building exploration through analysis (Yin, 2009). Thus I needed to take a more flexible approach to the data analysis, such as thematic analysis (Denzin and Lincoln, 2011). Some argue that this type of analysis is 'fraught with dangers' (Yin, 2009, p144), the main being the tendency to drift off the target. Arguably, being aware of this potential downfall should lessen this risk, while the use of a third party (supervisor) to check at each

stage of analysis was beneficial. The potential to drift off target as described was of concern to me as a novice researcher, and as such, it was important to ensure that my chosen method of data analysis had some structure and 'robustness' to it. I decided that the Framework Method for management and interpretation of data would be best suited to both my research and also myself as a researcher.

The Framework Method

The Framework method is a systematic and flexible approach to analysing qualitative data, developed by Ritchie and Spencer (1994). It is essentially a method of thematic or qualitative content analysis (Gale et al, 2013) using a defining 'matrix' to reduce, present and group the data, looking for similarities and differences, ready for analysis. One particular aspect of this method that appeals to me is that, whilst the matrix allows themes and analysis to take place across the whole dataset, the context of views and opinions held by individual participants is preserved. The framework method outlines a clear sequence of steps to produce highly structured, summarised data.

Critics of the framework method have suggested that it is qualitative analysis for the quantitative researcher, because it is so systematic in its approach and thus an easy option for qualitative analysis (Ritchie, 2013). However, whilst it enables a method of ordering the data and so on, interpretation and analysis choices are just as difficult as other qualitative methods, and qualitative research skills are still required to interpret and generate themes and explanations from the matrix. Furthermore, as a method of analysis, it is neither inductive, nor deductive, but could be adapted for use for questions which require a qualitative or quantitative approach (Smith and Firth, 2011). What is certain, though, is that the clear visual outlay of the matrix provides a rigorous, clear and auditable approach to the analysis of data.

In this research, a combined approach to analysis was taken, enabling themes to be developed from the existing literature (deductive) and from the accounts of the participant's experiences and views (inductive). The stages undertaken using the framework method are detailed below:

Transcription

For me, transcription and analysis of my own interviews was important to enable me to become immersed in the data. I recorded the interviews and transcribed them verbatim. Transcripts were checked for errors by listening back over the audio and reading the transcript simultaneously. Notes were made at each interview and then at each transcription and these were added by hand to the transcripts. Each student was offered the option of checking their transcript for accuracy; however, none took up this offer.

Following review of the initial two interviews, it was decided that it was the content that was important and not the nature of the response (i.e. laughing, pauses and so on) and therefore in transcription these aspects were not included, although interview notes were kept during the interview in a notebook to record any initial impressions or pertinent points that might have been forgotten later.

Familiarisation with the interview

Each transcript was read and re-read whilst listening to the audio recording to enable familiarity with the data. At this stage, thoughts were noted regarding the students' responses (for example any particularly strong views, or views that differed from peers). These notes were typed at the end of the transcript, for ease of recollection later.

Coding

Each transcript was then individually coded. Particular points of interest in relation to the research question and aims were underlined in the text and using the left margin a code/word that described the sentiment was assigned. These varied from a single word to a few words. In addition, more detailed notes were added to the right margin, either in relation to why the code was assigned, or detailing pertinent questions or points to explore further later in analysis, or discussion.

Whilst the use of software such as NVivo or CAQDAS to aid preparation and organisation of the data was an option, I felt that as a researcher I would gain more insight by organising and preparing the data myself as this would allow me to get closer to it and be more familiar (Braun and Clark, 2006).

Developing a working analytical framework

After the first two interviews had been coded, I met with my supervisory team to go through and discuss why I had coded in this way and why the notes made were pertinent or meaningful. In this way, I hoped to reduce personal bias in the interpretation. We also discussed how these points may help to answer the research question. At this stage, the main headings of my working framework were expanded and refined following discussion. We also discussed the anomalies which did not appear to fit in to any particular heading.

Following this, I proposed a set of codes, each having a brief description of meaning which then fitted within wider categories (an example of one of the categories is shown in Table 3.2). This was the initial analytical framework. The next three interviews were coded using this initial framework, during which any additional codes and notes were added to the transcript. Some of these codes were then grouped together into categories with similar conceptual meanings. The remaining interviews were coded using the same process, each time adding and refining the framework until no further codes emerged. The final framework contained 33 codes, collated into six categories, each with an explanation of its meaning and, where relevant, examples of ideas under its heading.

Table 3.2. Example of students' perceptions of practice category, analytical framework

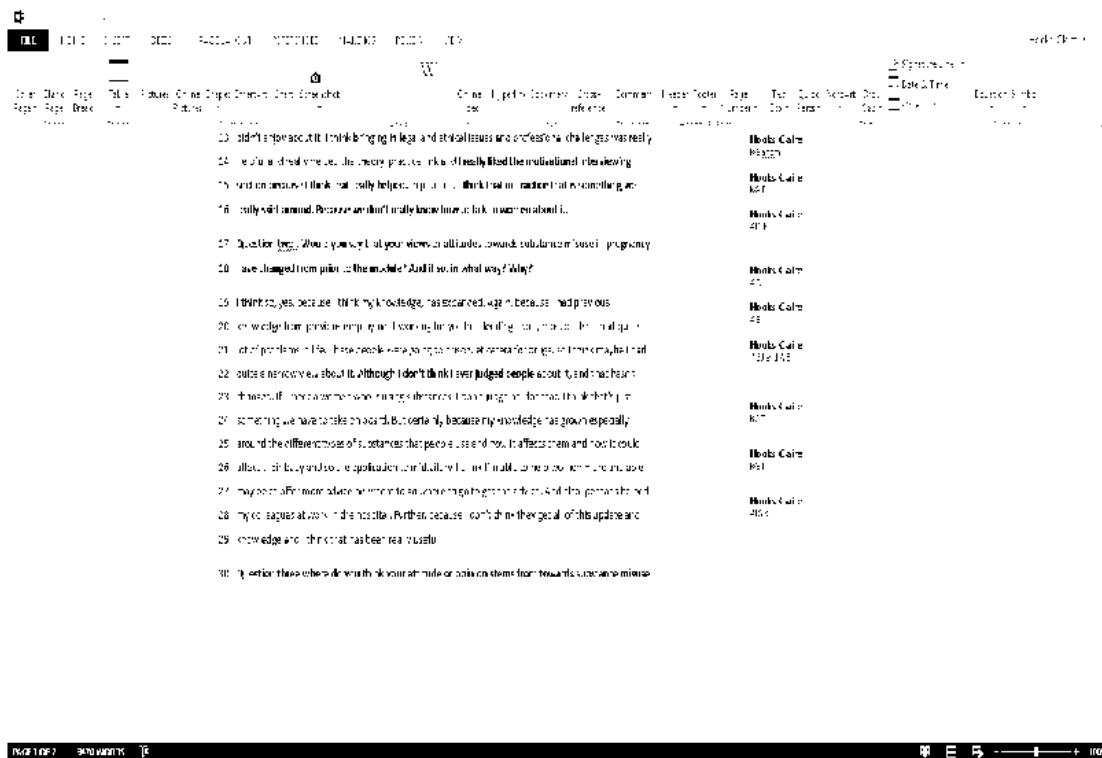
Perceptions of Practice – student views of practice

CODE	Description
Guidelines/processes (AIP G)	Reference to written guidance/guidelines in practice and the quality of these. Processes of care. Referrals. Specialist posts present
Training needs (AIP T)	Any discussion of the need for training or what training is available for midwives in trust
Attitudes/Judgments of staff (AIP A)	Staff attitudes and views toward users or the way staff are with women, or questioning of women
Knowledge base of staff (AIP K)	Drug use, classes, types, recognition, reasons for use, or reference to being unsure of knowledge base.
Avoidance of care by midwives (AIP Av)	Both expression of women's willingness to attend for care/disclosure and midwives' willingness to tackle the issue, including passing on to specialist post or consultant
Different view of licit vs illicit drugs (AIP Dif)	Staff views different regarding legal and illegal drugs
Anomalies (AIP anom)	Anything representing students' views in practice, but not fitting other codes

Applying the analytical framework

This final analytical framework was then applied to each of the transcripts, to ensure the agreed codes were used and that no elements had been missed. Text was highlighted to support the code assigned (Figure 3.3).

Figure 3.3 Example of text coding and highlighting to support codes



Charting data into the framework matrix

Once all the data had been coded using the framework, it was summarised into a matrix for each category; one row for each participant and one column for each code (Figure 3.4). Text to support the coding was extracted verbatim from the transcripts and placed in the relevant cell. Quotes which seemed to strongly support the code were highlighted, for ease of extraction and use in write up. All extracts were assigned the page and line number, to aid recall later.

Figure 3.4. Example of charting data into matrix

1 Student Perceptions of Practice

AP = associated with, AD = associated with, B = best interests, M = medical professional

	Cultural responsiveness (AP/CP)	Timing needs (AP/CP)	Attitudes/expectations of staff (AP/CP)	Knowledge base of staff (AP/CP)	Attitudes of care by midwives (AP/CP)	Different views of life with ill/diagnoses (AP/CP)	Normal or OUP (non)	
particip1	I was really surprised that there are gaps in my knowledge, for example in how to support a child because I was in a room when there is a substantial issue with the child, particularly around supporting the child, particularly that are relevant to the OUP, as well as education above and below.	There are needs to be met, but it's not always clear when there is a need to be met, particularly in the context of the OUP.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I don't think there's much support for the women, they are just sort of going through the motions, they're not really there to support the women, it's just a box to tick, they just do it because they have to, they just do it because they have to, they just do it because they have to.
particip2	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.	I think it's important to have a good understanding of the needs of the child, particularly in the context of the OUP, as well as education above and below.

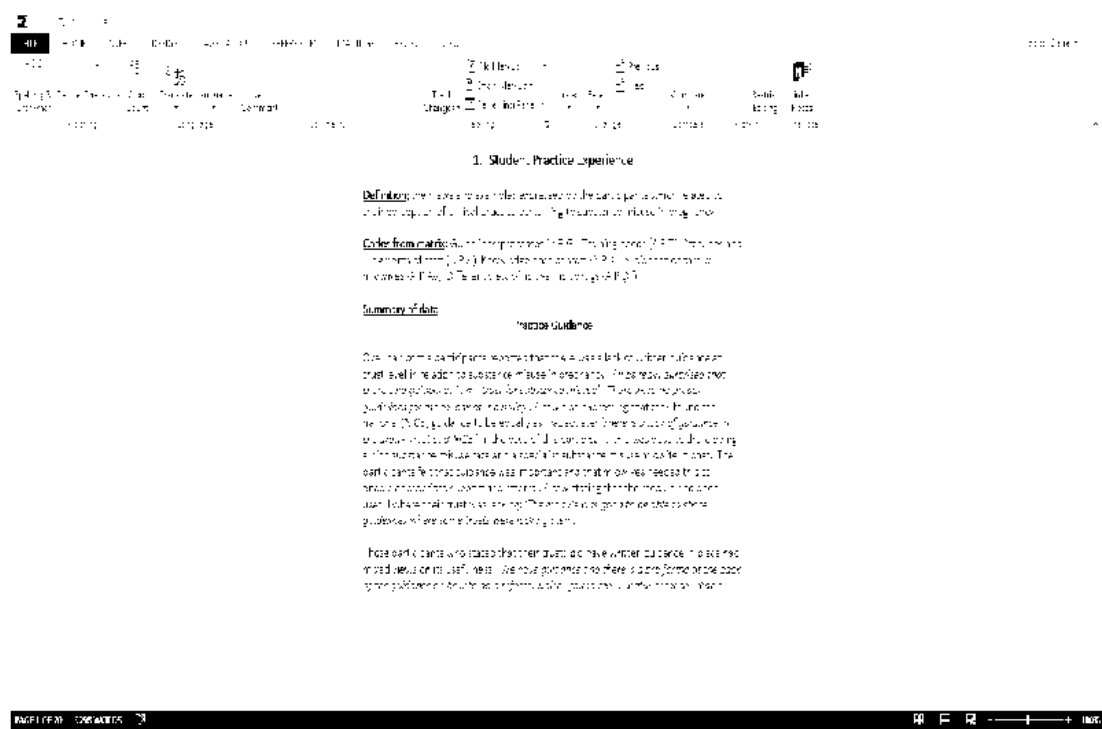
Interpreting the data

Themes were generated by reviewing the matrix and making connections between the categories and the participants. This was influenced by concepts that emerged from the data in the matrix. The data was viewed for each individual; however, to answer the research question, the data was also seen as a ‘whole’ dataset, and thus I tried to explore what was happening within the ‘data’, rather than for individuals alone. For this reason, and to ensure individual participants could not be identified, the references to participant, page and line number was removed.

Each of the main categories was used as a heading, and within it, sub-headings were used to represent the codes, which, where it was felt applicable and meanings were similar, were grouped together under a single sub-heading. The codes placed under the ‘other’ category were moved and integrated into the other sections as was felt appropriate.

Memos were created for each of the main categories and sub-headings (Figure 3.5) were used to include a definition of the category, which codes applied to it, and then a summary of the raw data relating to it, including direct quotes where applicable. Deviant cases were noted and discussed with the supervisory team to ensure pertinent data was not excluded and to reduce researcher bias in interpretation. Points arising for later discussion were also noted. Deviant cases were then highlighted in the discussion.

Figure 3.5. Example of data interpretation



Analysis of VLE Posts

Qualitative Content Analysis

The VLE documents were analysed using content analysis. This was used to build a model of the concepts that described the students' experiences and attitudes toward substance use and pregnant substance users (where detailed) prior to completing the educational intervention. Content analysis is a method of analysing written, verbal or visual communication messages (Cole, 1988). Whilst content analysis can be deductive or inductive in purpose (Elo and Kyngas, 2008), in this study the aim was to inductively attain a condensed and broad description of the phenomenon, by

drawing together particular instances and combining them into larger groups or statements, thus making the data more manageable. It is suggested that conventional content analysis is a suitable method to describe a phenomenon where existing theory or research literature is limited (Hsieh and Shannon, 2005). There are several studies that look at the attitudes of health care professionals toward drug users; however, there are limited theories and studies looking at student midwives and their experiences and attitudes.

According to Elo and Kyngas (2008), whose approach was followed, content analysis involves three stages: preparation, organisation, and reporting. In preparation, the collated documents were read through and words and phrases that it was considered might be important to the study were physically highlighted. In order to grasp the content, the whole text was read and re-read several times. Latent content was not considered of importance for this study, given that the documents were written for a different purpose; that of student assessment. It was deemed that care needed to be taken in assessing 'meaning' by what the students wrote, as these were historical documents. A benefit to using the students' work after the assessment was completed was that the students' behaviour could inadvertently have been affected by their being researched (Newby, 2014) and this might have affected the way in which they wrote the posts, focusing on the aims of the research rather than their assessment task.

Next, the data were organised using open coding and creating categories in accordance with the research questions and study aims. For this stage, headings were placed in the margins (categories) that described the highlighted aspects of the content. These headings were then collected and placed on a separate 'coding sheet' and from these categories were generated. These categories were then further grouped under higher order headings (Elo and Kyngas, 2008). The purpose of this was to provide a way of describing the phenomenon, increasing understanding and generating new knowledge (Cavanagh, 1997 in Elo and Kyngas, 2008).

Abstraction provided a way of formulating more general descriptions of the research topic provided through the data and generated categories (Polit and Beck, 2004). Each category was named using content-characteristic words. Subcategories with

similar events and incidents were grouped together as categories and categories grouped as main categories (Elo and Kyngas, 2008; Figure 3.6). In this way a conceptual map was generated to represent the data. Following this, the data was ready for reporting.

Figure 3.6. Conceptual map of emergent themes

Main Category Generic Category Sub Category



The following stages were completed:

1. Text was read and re-read to familiarise myself.
2. Words, sentences and phrases were underlined and notes written in the margins that represented what the text was saying. These related to how the students felt, their experiences and knowledge.

3. Initial notes were made regarding the overall impression of the data as a whole. Thus contributions were not viewed individually, but as a collective. These were recorded in the findings section.
4. Categories and subcategories were formed as above (figure 3.6). Higher order categories were created and a chart representing this produced.
5. This chart was applied and redeveloped as needed to represent the data.
6. The data were presented with reference to the text (findings, Chapter 4).

A limitation of this data produced was that it was written for a different purpose than what it was used for and thus any inferences drawn from it had to be viewed with caution. This crucial aspect was one of the reasons that the same method of data analysis was not used for the VLE posts and interview transcripts; I wanted to clearly distinguish between and view the two sets of data entirely differently, taking into account the purpose for which each was originally intended. Care was taken to ensure that analysis and interpretation of the VLE posts was done within the social context in which they were written, namely within a discussion board task (or e-activity) for the Substance Misusing Parents module.

One challenge of content analysis is that there is no 'right' way to complete it. It is flexible, and researchers have to judge themselves how to proceed. To improve the trustworthiness in this research, I ensured that, at each stage of the process, I gave, where possible, an account of my actions and insights to enable reader scrutiny and to ensure the process was easier for someone external to follow. I also ensured that the data was read and re-read at each stage to ensure that I had not misinterpreted the data, or missed alternative explanations.

3.4 Ethical Considerations

Researcher Reflexivity

As a reflexive practitioner I was very aware of the influence I could have upon the research at all stages. As outlined in 3.2 above, I ensured that at each stage of the study my ideas and design were discussed with my supervisory team, and also ensured that the way I conducted the research was ethical. During data analysis (as outlined in 3.3 above) the data was read and re-read and along the way my interpretation of the data was 'checked' by my supervisory team. This was both to improve the credibility of the research findings (see 3.7 below) and to reduce any potential bias due to my awareness of the relationship I had with both my research subject (due to my interest and passion for the subject area) and also my research participants (who as outlined, were my students). My statistical data was viewed by my supervisory team and I additionally sought the advice of a medical statistician to help guide the process and ensure I carried out the relevant tests accurately.

In particular, I was aware of the potential power relations between myself and my students, who may have felt a sense of coercion to participate in the research (Brown, et al., 2007). Two of the students who took part in the interviews were my personal tutees, as well as undertaking the module I had module leader responsibility for. It was important to me that, in valuing the voice of my students, I anticipated and attempted to lessen these aspects. I therefore conducted my research strictly adhering to ethical guidance, both educational, university-led and professional (BERA, 2011), to ensure all participants were treated with respect and dignity, that appropriate valid consent was gained, the right to withdraw made explicit, findings were anonymised and all data were collected, stored and used in accordance with the Data Protection Act 1998.

Dimond (2013) highlights that consent to participate within a study should be preceded with sufficient relevant information regarding the study. Prior to the start of the study, all potential participants were given information of the nature and purpose of the study, both verbally and also in the form of a Participant Information

Sheet (Appendix 2) as was the requirement of the University and for Faculty Research Ethics Panel (FREP) approval. Recognising the possible coercion to take part as 'my' students, I used a third party to recruit for both stages of the study (Brown, et al., 2007). I did not know until the end of the module (including assessment completion and marking) which students had taken part.

Respondents were given the opportunity to ask questions related to the study and survey, either to me directly, or via the third party. This was considered a crucial step prior to gaining consent in writing or any other form (Moule and Goodman 2009). The Participant Information sheet (PIS) was given to the students a week before the first questionnaire to ensure students had time to seek clarity if required and to consider their participation. It was made clear in the PIS and the consent form (Appendix 3) that there would be no repercussions for non-participation and that, as the researcher, I would not have any access to data linked with their names until completion and marking of the module assessment had taken place.

Completion of the questionnaires was voluntary and return of the completed form together with a completed consent form required for inclusion. The consent form followed the format prescribed by the University and was also approved by the FREP prior to commencement (Appendix 4).

All of the participants in the study were over 18 years of age and none were deemed 'vulnerable' and so this was in line with the legal principle of consent being valid only when freely given by a competent adult (Dimond 2013). This was also considered when undertaking the interviews, all of the interviews being conducted on university property with respondents given the choice of being accompanied either by a friend, a relative, or another member of staff if they wanted. As noted above, two of the students who agreed to interviews were my personal tutees. However, it was made clear that participation was voluntary, and they were under no obligation to take part (This aspect of being personal tutor to some of the students is discussed later in 7.2).

All respondents were informed both in the PIS and consent forms and verbally of their right to withdraw from the study at any time should they wish to. This is an important aspect since the right to withdraw at any point during the study is of paramount importance (Plowright 2011).

Given the sensitive nature of the subject I also sought the advice of the student support services team, and ensured there was a counselling facility for anyone requiring it as a result of issues coming out of the research. Whilst this was offered to all students, none accessed the service.

3.5 Confidentiality and Anonymity

During phase one, the questionnaires used included no data whereby the students could be individually identified. Students were asked to indicate their name if they wished to be included within the second phase of data collection, on the matched (by number) consent form. The inclusion of their names did not compromise anonymity, however, as the matched consent forms were retained and stored in a locked cupboard by the third party recruiter until both sets of questionnaires had been administered and the module completed, including marking of assessments.

In considering the storage and access of personal information, no personal data was stored electronically. All electronic data storage had no reference to the participant's names at all. As an employee of the institution, I undertook training in relation to data protection and applied the principles outlined within the Data Protection Act of 1998 which dictate that all personal data should be protected from access by unauthorised persons (Dimond 2013).

All students selected for phase two were known only by participant number and as such were known only to the researcher, providing protection of identity. Selection of the participants was by data resulting from phase one only, again only identifiable by participant number to all but myself.

All data taken from VLE posts for phase three were anonymised from the outset and collated and used as a single set of data. All reference to names or NHS trusts were removed.

All data gained from interviews, VLE posts and questionnaires were stored, with no reference to names, electronically on a personal password-protected laptop computer. Non-electronic data in the form of the questionnaires, consent forms and

interview notes were stored in a locked cupboard, only accessible by the researcher and initially the third party recruiter, on University property.

3.6 Reliability and Validity

In this study, reliability and validity of the quantitative aspects were assessed during analysis. Reliability of the findings were assessed by testing the reliability of the individual scales used. Cronbach's alpha was applied to establish this and thus consistency of findings was confirmed. Reliability tests were conducted on the data for each of the scales used in Q1 and Q2. Cronbach's alpha was used for this. Field (2005) suggests that a Cronbach's alpha value of .7 - .8 is acceptable, with values lower than this indicating potentially unreliable scales. However, Cortina (1993, in Field, 2005) notes that these 'ideal' figures should be viewed with caution because the value of alpha depends on the number of items in the scale, such that the greater the number of items the higher the value of alpha.

In terms of validity, assessing that I was measuring what I wanted to measure (Field, 2005) was assured by using previously validated scales that measured attitude and empathy.

Even though, when viewed in isolation, the quantitative findings in this study have shown reliability and validity, they are intended to be a very small part of a bound case study, and as such, unlike quantitative findings in purely deductive studies, the overall findings are not strictly considered as generalisable.

3.7 Trustworthiness

Trustworthiness is a term used to describe the rigour of research. It is associated with qualitative research and is equivalent to the concepts of reliability and validity in quantitative research. Whilst some authors believe that qualitative research should be judged by similar principles to quantitative research (Morse et al, 2002), the aim of naturalistic enquiry, as in this case study, is the relevance of findings to a specific

instance (or case), rather than generalisability. Validation in case study is concerned with discovery of truth to the participant and researcher (Riessman, 2008).

Trustworthiness, then, is an alternative criterion developed to judge and evaluate qualitative research and refers to the confidence that the reader can have in the study (Robson, 2011). This study has applied the criteria suggested by Lincoln and Guba (1985) for improving trustworthiness in qualitative research: credibility, transferability (see 3.8), dependability and confirmability.

Credibility deals with the focus of the research and refers to the confidence in how well the data address the intended focus (Polit and Beck, 2014). Because the aim of the study was not to 'control' the data, interpretation can be challenging. To improve credibility, and thus confidence in the truth of the data and its interpretation, verification of the results with my supervisory team was sought throughout the process of data analysis and coding. In addition, participants for phase two (interviews) were invited to confirm the accuracy of their interview transcripts.

Dependability in qualitative research refers to the findings being consistent, and the likelihood of them being able to be repeated. This is often described as closely corresponding to the notion of reliability associated with quantitative research. Given that the cohort of students used in this case were representative of a typical cohort at this institution, the dependability of the results is likely to be reasonably good; the main limitation to this and replication of the study's results would be the social context of attitudes toward drug use at the time of study. However, the steps to undertaking the research and analysis have been explicitly detailed to ensure auditability and thus improve dependability.

Confirmability, which is the degree to which the findings reflect the focus of enquiry (Lincoln and Guba, 1985), has been improved and acknowledged as a limitation in this study, both by the extra confirmation checking stages during data analysis by the supervisory team, and also by researcher reflexivity, acknowledging any influences upon the research process and findings.

3.8 Transferability

Transferability refers to the degree to which the results, or findings of qualitative research, can be applied or transferred beyond the bounds of the given study to other contexts or settings. It is suggested that the researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research, as were clearly laid out in this study. Strictly speaking, the overall findings of case studies are not usually considered generalisable (Thomas, 2011) and so even though in this case there are some deductive aspects, which may usually be generalisable (Gilbert, 2008), as all findings were within the context of the case, statistical generalisations were not expected (as opposed to analytical generalisations as per Yin, 2014 (below)). The case was a snapshot in time of a specific cohort of students and no comparison or analysis was undertaken to establish if the cohort was representative of the wider population of student midwives, nor was this important in designing the study. A thick description of the phenomenon studied (Lincoln and Guba, 1985) was, however, given to allow readers to contemplate whether or not transferability was possible. For example, the demographics of the students in this study were collected at the start using the questionnaires. Not only did this allow for study of any differences in terms of views, but it also gave the opportunity for those reading and interpreting this research to be able to draw parallels to similar cohorts of students where they felt this to be applicable. In addition, detailed description was given concerning the educational intervention, the exact methodology used and the researcher's role. Thus, there may be some degree of transferability of the findings to another setting or similar group (Polit and Beck, 2008).

In line with this concept, whilst the findings are not strictly generalisable, it does not exclude the potential value of the findings of any specific elements of the case being used in the context of other wider research or studies (Flyvbjerg, 2011; Bassey, 1999). The generalisability of case study research has been the centre of varied philosophical and academic debate (Bassey, 2001; Denscombe, 2010) and, of course, any such application would have to be considered with caution, recognising the uniqueness of

the exact set of events and circumstances that *bound* this unique case. Bassey (1999, p12) suggests that fuzzy generalisation might be a means of generalising from a case in terms of how likely, possible, or unlikely that what is found in a single case is to be found in similar situations. Similarly, Stake (1995, p7) suggests that, although case study may not transform understanding, it may instead refine it, emphasising commonality as a powerful element.

Yin (2014) takes the concept a stage further, making the distinction between statistical generalisations (associated with the results of empirical studies) and analytical generalisations, where instead of thinking about the case in terms of a sample, it can be viewed as an opportunity to shed light on theoretical concepts or principles. In this way Yin (2014) suggests that (as may be the case with this study) the findings or lessons learned may go beyond the setting for the specific case that has been studied. In other words, the analytical generalisations may be based upon corroborating, modifying, rejecting or advancing theoretical concepts that were referenced when designing the case study, or new concepts that arose upon completion of the case study (Yin, 2014:41). Yin's suggestion is likely to be of value in this case study where there were strong theoretical concepts already underpinning aspects of the study.

3.9 Chapter Summary

This chapter has detailed the approach taken to conduct the study, including the philosophical concepts underpinning it. A case study approach was used that combined both quantitative and qualitative data collection tools. Statistical analysis was undertaken on the quantitative data using the SPSS software package. Qualitative data was analysed using both conventional content analysis and the framework method. Some of the strengths and limitations of the approaches taken have been outlined in the chapter. Chapters 4 and 5 present the findings of the research; Chapter 4 the quantitative data from questionnaires used in phase one and also the qualitative data from the students VLE posts at the start of the module from

stage three. Chapter 5 presents the qualitative findings of the semi-structured interviews undertaken following the module.

Chapter 4

Findings from Phase One and Three

This chapter follows on from the methodology chapter and presents the study's findings. Due to the volume of data collected the findings have been separated between two chapters. The first, Chapter 4 gives an account of the quantitative findings from phase one of the study which used questionnaires to determine empathy levels before and after the educational intervention (Substance Misusing Parents module). The tables shown include the main results and relevant p values from the tests undertaken, however an example of the raw data results tables from SPSS for MCRS are in Appendix 6. It also presents analysis of the students' VLE posts 'experiences and attitudes' which is a post from the start of the module before they had undertaken the 'educational intervention.' The findings from the interviews conducted following the module are presented in Chapter 5.

The approach to the study is a single case study but using different tools for data collection and therefore, whilst the findings of each of the methods is presented separately in Chapters 4 and 5, the findings are drawn together at the end of Chapter 5 and discussed as a 'whole' case in Chapter 6 (Discussion of Findings).

4.1 Questionnaires (Phase One)

Student Demographics

A total of forty students completed the first questionnaire, prior to the module (educational intervention) and twenty-nine of these students completed the second questionnaire, following the module; the students were from eight different health care trusts. A response rate of over 50% is required to gain representativeness (Moule and Goodman 2009) and thus this criteria was met. Forty-eight students were invited to participate in each of the questionnaires, two students were absent from class on each occasion, leaving forty-six possible participants. Forty agreed to complete the initial questionnaire (87% response) and twenty-nine completed the second

questionnaire (63% response); these twenty-nine students had completed both questionnaires, thus producing a matched group.

All of the students were female and the age range was 20 years – 50 years old, with an average age of 29; this was the same with both participant groups, before and after the module (n=40 and n=29). 34 of the students (85%) reported that they had had exposure to substance misuse prior to the module in a professional capacity (25 reported the same following the module (86%) and 23 personally before (friends, family or themselves) (58%), compared to 19 (66%) following the module. There were five students in total who stated that they had not been exposed to substance misuse at all in the past prior to the module (14%), one student did not answer the question. Following the module 4 of the 29 respondents reported that they had not been exposed to substance misuse at all (14%). Therefore, although there was a slightly greater proportion of the students following the module who reported personal experience with substance misuse of some kind than before, all other data was roughly similar proportionately.

Hypotheses

Given the aims of the study the following hypotheses were generated to be tested by the quantitative data produced by the questionnaires (Q1 and Q2).

1. *'There is a significant positive difference in the general empathy levels shown by students before and after an educational intervention around substance misuse'.*
2. *'There is a significant positive difference in the regard shown by students toward women with reduced fetal movements in pregnancy before and after an educational intervention around substance misuse'.*
3. *'There is a significant positive difference in the regard shown by students toward women who misuse substances during pregnancy before and after an educational intervention around substance misuse'.*

Distribution of Data

The data sets were tested to verify if they represented a normal distribution so that the appropriate test to compare means could be selected. This was assessed using Kolmogorov-Smirnov's (KS) test (Table 4.1). In this test values of significance less than 0.05 demonstrate a non-normal distribution of data. Values greater than 0.05 represent normally distributed data.

Table 4.1. Kolmogorov-Smirnov test of normal distribution

Scale	KS Before Module	KS After Module
JSPE-HP	0.176	0.667
MCRS – Substance Misuse in Pregnancy	0.794	0.847
MCRS – Reduced Fetal Movements	0.196	0.849

Given that all data sets were 'normally' distributed, with p values greater than 0.05, paired t-tests were used to compare the mean values from each of the matched data sets, before and after the educational intervention as noted below. An independent t-test was also used to compare the means of the 'full' data sets from Q1 and Q2, that is the non-matched participant groups where for Q1 n=40 participants and for Q2 n=29 participants.

Reliability of measurement scales

Each of the scales was tested for reliability using Cronbach's Coefficient Alpha. Field (2005) suggests that a Cronbach's alpha value of 0.7 - 0.8, or higher is acceptable, with values lower than this indicating potentially unreliable scales. Applying this criteria, each of the scales used had good reliability (Table 4.2).

Table 4.2 Cronbach's Coefficient Alpha for all three attitude scales

Scale	Cronbach's Alpha
JSPE-HP	0.867
MCRS – Substance Misuse in Pregnancy	0.794
MCRS – Reduced Fetal Movements	0.777

Jefferson Scale of physician empathy (health professional version)

To give an indication of 'general' empathy levels the first psychometric test applied was JSPE (HP). In this participants were required to answer 20 questions (10 of which were negatively worded) using a 7-point Likert scale (Strongly disagree=1 to Strongly agree=7). The negatively worded questions were then reverse-scored for analysis. Scores can range from a minimum of 20, to a maximum of 140. The higher the score, the greater the participant's level of empathy.

The mean empathy scores were compared before and after the educational intervention, questionnaire one, against questionnaire two;

Table 4.3 JSPE Results Pre and Post Test (Matched Participant groups)

	Mean Score	Standard Deviation
Questionnaire One (Before module)	114.03	12.97
Questionnaire Two (After module)	115.27	6.50
Paired t-test (Before and After Module)	Significance (2 tailed) 0.539	

When statistical analysis by way of t-test was performed it showed that there was no significant difference in the students mean scores before and after the intervention; $p > 0.05$ ($p = 0.539$). Thus indicating that their empathy levels did not significantly increase after undertaking the module.

Table 4.4 JSPE Results Pre and Post Test (Independent)

	Mean Score	Standard Deviation
Questionnaire One (Before module)	113.75	12.93
Questionnaire Two (After module)	115.27	6.50
Independent t-test (Before and After Module)	Significance (2 tailed) 0.538	

The results of the independent t-test also demonstrated no significant change in student's general empathy levels, corroborating the finding of the matched t-test and further suggesting that the matched participant group was representative of the larger participant group in Q1.

An analysis of the individual JSPE-HP items before and after the module showed that respondents answered all of the questions in a positive way (with scores of 4 or above), demonstrative of general empathy. When paired t-tests were applied to compare the mean scores for each individual item before and after the module, there were two questions which showed a significant difference from before and after the module. Question 7; '*Midwives should try to think like their patients in order to render better care,*' ($p = 0.017$) and Question 16; '*Because people are different, it is difficult*

to see things from patients' perspectives' ($p = 0.050$). Both of these changes were in a positive direction.

Medical Condition Regard Scale (MCRS)

The MCRS was used in addition to JSPE (HP), to give an indication of the specific regard that students felt when considering substance misuse in pregnancy as a medical condition, as opposed to 'general' empathy levels as measured by JSPE (HP). As the specific focus of the educational intervention is substance misuse, it was deemed that this was important to measure. For the purposes of this study, substance misuse (SM) was compared to reduced fetal movements in pregnancy (FM), a condition not associated with stigma, or considered self-inflicted as discussed (Macdonald, Magill-Cuerden & Mayes, 2011).

The mean scores and standard deviation (SD) were calculated before and after the modules for each MCRS SM and MCRS FM and charted (Table 4.5).

Table 4.5. Data From before and after the module for MCRS SM and FM

Scale	Before Module Mean	Before SD	After Module Mean	After SD
MCRS SM	50.79	7.00	53.55	5.33
MCRS FM	56.41	6.72	57.00	4.79

Paired t-tests were then carried out to compare the results of the matched participant groups MCRS SM and MCRS FM before the module and similarly after the module. MCRS SM and MCRS FM pre module scores were also compared with their respective post module scores to note any changes (Table 4.6). A comparison of mean scores was also tested for the full participant groups before and after the module for SM and also FM using independent t-test (Table 4.7), to determine if the responses and changes in the two groups were similar between the different groups of participants.

Table 4.6 Comparison of matched participant group mean MCRS scores using paired t-test

Mean Scores Compared	Significance Value (p)	Significant Difference
Pre Module MCRS SM and MCRS FM	0.000	Yes
Post Module MCRS SM and MCRS FM	0.009	Yes
Pre Module MCRS SM and Post Module MCRS SM	0.012	Yes
Pre Module MCRS FM and Post Module MCRS FM	0.646	No

Table 4.7 Comparison of mean MCRS scores using Independent t-test

Mean Scores Compared	Significance Value (p)	Significant Difference
Pre Module MCRS SM and Post Module MCRS SM	0.019	Yes
Pre Module MCRS FM and Post Module MCRS FM	0.957	No

As with the result for the JSPE-HP using independent participant group testing, the results with MCRS before and after the module in relation to SM and FM regard

showed a similar statistical significance. The findings for SM of the independent participant groups was significantly more positive following the module and there was no significant difference for FM. Again this is suggestive that the participants in this group who undertook Q2 were representative of the larger group in Q1.

Results from the MCRS's individual items analysis provided more detail as to how students specifically reported their regard for patients with substance abuse and reduced fetal movements and in which areas they showed more, or less regard. Therefore, the mean responses to individual questions were analysed to see if there were any specific questions demonstrating particularly low, or high regard and if these changed significantly before and after the module.

Before and after the module this revealed that in relation to FM, all mean responses were greater than 4, which on a 1-6 scale could be deemed indicative of positive response/regard and when paired t-tests were applied to the data all changes were deemed not significant. When SM was similarly analysed it demonstrated that prior to the module, question 2; *'Insurance should cover patients like this to the same degree that they cover patients with other conditions,'* question 4; *'I feel especially compassionate toward patients like this'* and question 9; *'I can usually find something that helps patients like this feel better.'* All had mean values below 4, (3.47, 3.75 and 3.83 respectively), which may be indicative of areas of negative empathy. Whilst the means scores for questions 4 and 9 increased in value to greater than 4 following the module, the score for question 2 remained below 4 (3.83).

These findings show that the students in this study had less empathy for those women who were substance misusers in pregnancy, than those with reduced fetal movements overall. This was demonstrated both before and after the module (educational intervention). However, whilst empathy remained lower toward substance misusers compared to those with reduced fetal movements following the module, there was a significant positive change (Table 4.5) in their regard for substance misusers after undertaking the educational intervention ($p=0.012$).

Summary of phase one

In summary, the first two hypotheses were found to be false;

1. *'There is a significant positive difference in the general empathy levels shown by students before and after an educational intervention around substance misuse'.*
2. *'There is a significant difference in the regard shown by students toward women with reduced fetal movements in pregnancy before and after an educational intervention around substance misuse'.*

And the third was shown to be true;

3. *'There is a significant difference in the regard shown by students toward women who misuse substances during pregnancy before and after an educational intervention around substance misuse'.*

The findings showed that there was a significant difference in the students regard toward substance misusers in pregnancy before and after the module.

4.2 Conventional Content Analysis of VLE posts (Phase Three)

All of the VLE posts (both posts and replies) that participants had written for the e-activity 'Experiences and Attitudes', were collated, headings removed and then viewed as a single document for analysis using a conventional content analysis approach as described by Elo and Kyngas (2007) and outlined in Chapter 3, Methodology. Due to the way the data was collated for this part of the study, it was not possible to assign participant numbers to the individual quotes used from the VLE posts. Whilst it is acknowledged that this is a limitation of this data set, the quotes used do represent a range of participants who consented to take part.

Preparation and Initial Impressions of the VLE data

As detailed in Chapter 3, the first two stages of the analysis process were carried out by reading, re-reading and making notes on the text, highlighting points and beginning to generate key phrases and words in relation to the study question and

aims; preparing the data. The next stage involved listing initial impressions of the dataset as a whole (figure 4.1).

Figure 4.1 Initial impressions of VLE data
The discussions the students presented, despite being directed to write about their experience and attitude, were representative of their knowledge and experiences. In effect they appeared to equate attitude with knowledge

Views were often led by media, society and family influences. So what the students had seen

Mentors had an effect on students attitudes

Many commented on a 'generational thing'

Many had had a negative practice example/poor practice modelled

There were some examples of good practice, but these were overshadowed by the poor practice

Many mentioned Carbon Monoxide monitoring (an exhalation test used both in pregnancy and by smoking cessation services, to detect levels of carbon monoxide that indicate the person has been smoking), reflecting on the dishonesty they had seen – they commented on midwife-mother relationship

Lots of reflection on practice and self-challenge of views and challenge of practice views. But unable to explain why

Expectations of the module were often expressed

Dichotomy between legal and illegal drugs both professionally and by society

little acknowledgement of the challenges to providing better care expressed

When guidance was mentioned it was only NICE guidance

Students often unsure and hesitant and lacking in passion and real insight regarding reasons for use

Many had had negative experiences with users, personally, or professionally

Some felt society affected the way we felt about users. Especially negatively

Organisation and Abstraction of VLE data

The data was organised to facilitate development of codes to represent the points being made in the data. This had started in the preparation stage by the highlighting of words and text that had relevance to the research question and aims, so words such as 'attitude,' 'opinion,' 'experience,' or anything suggestive of the reasons for

these; 'practice,' and anything relating to this; 'education,' 'knowledge,' 'module' and related terms and phrases. The words and phrases from the data were collated (coding sheet) and then grouped under higher order headings drawing together like terms, with brief explanation of meaning (Table 4.8).

Table 4.8 Charting of terms and early formation of codes and categories in VLE Analysis

Experiential Knowledge	Includes below
Practice experiences (included attitudes, opinions, experiences, practice examples, knowledge based on practical examples)	Negative , for example mentors attitudes, or practice examples. Or women's behaviour, poor behaviour, non-disclosure, sick babies. Positive , mentors attitudes or examples Reflection , students reflected on practice experiences
Personal experiences (included attitudes, opinions, experiences, reasons for use, personal examples, knowledge based on personal experiences and encounters)	Society/media influences on attitudes Family , negative/positive, generational influence Peers , friends positive and negative Professional , from previous employment Anomalies , where expressed judgement but without any obvious attribution to where this arose from
Other knowledge	Includes below
Theoretical (included knowledge from university, from literature/books)	Reflection on self and practice. Based on some degree of theoretical knowledge Module knowledge from previous academic content, or expectations of this module
Guidelines (included knowledge from any type of guidance for practice, national or local, from literature, or from practice experience)	Knowledge gained from guidance on practice

From this coding chart and re-reading of the text, a coding framework (Figure 4.2) emerged which was applied to the VLE document as a whole and text was used to support each of the categories and themes generated, which was then reported.

Figure 4.2 Emergent Coding Themes, Categories from VLE contributions



Reporting of findings from VLE contributions

Whilst many of the views and attitudes expressed through the posts were supported with reference to specific examples from practice, this was not always the case and so on occasion it was not clear where the opinion had originated from. The nature of this part of the research was such that this detail could not be verified. Furthermore, clarification of intended meaning could not be sought for any of the points made in this data analysis of the VLE posts, due to the fact that the analysis took place after

the students had graduated from the university and in addition that the direction of the VLE post task was not written with this research in mind. As such, this analysis whilst adding distinct value to the overall case, has been interpreted and analysed bearing this in mind.

Much of the student posts on the VLE related to their experiences of substance use and misuse, this was not a surprise given that the activity for this post was to discuss their experiences and attitudes of drug use. Further analysis of the content showed that where students discussed attitudes, these were usually in the context of experiences. What the students described implicitly and sometimes explicitly, was their experiences (personal and practice related knowledge) and also other aspects (or knowledge) that influenced their views relating to theory/guidelines. Therefore, in the below description of findings the different aspects are divided into factors, or attitudes that appeared to be related to experience (*Experiential knowledge*), with other factors under the heading, '*Other Knowledge*'. Within each of these headings, the themes that emerged and are detailed in Figure 4.2 are used as sub-headings in order to demark and differentiate the various findings.

Experiential knowledge

Practice

Negative

Most of the students had observed negative experiences being displayed toward substance misusing women in practice. This was both from their midwife mentors, midwives in general and other health care professionals. They made comments such as;

'I ... have witnessed the judgemental attitudes of midwives and other healthcare professionals to these women.'

'many a professional take a dim view ...'

'Recently I went to a case conference with my mentor for a heroin addict and listened to the negative comments from the people involved and I felt this was wrong.'

And,

'it has somewhat shocked me to say the least as to many midwives approaches when dealing with women that are smokers and their attitudes towards them.'

Many discussed how midwives they had worked with had stereotyped drug users and this seemed to be reflected in the way in which they delivered care, such that;

'Midwives adopt a presumptive attitude when caring for teenage mothers that there will be some degree of substance or alcohol misuse.'

'She wasn't referred because "they seem like a nice couple".'

And,

'I feel that teenagers regularly get interrogated about whether they use drugs. I have witnessed one midwife ask "do you smoke funny cigarettes" and on replying "no" she kept repeating the same question, as if she didn't believe her! The young innocent looking teenager looked horrified.'

Furthermore, some students reported that they felt there was an inconsistency shown by midwives toward illicit drugs such as heroin, cocaine and cannabis compared with alcohol and tobacco and this was on occasion the consequence of stereotyping;

'I believe that some midwives do not take smoking as seriously as they do other substances that are misused.'

Or,

'I have had one woman say that she was smoking cannabis a month previous to falling pregnant, and these (concern sheets) are started instantly and then

another lady with exactly the same history where nothing has happened because "they look like a nice couple" and "she won't smoke it now she is pregnant".

One student expressed that she felt this was due to midwives' personal views impacting upon the care they provided;

'Whilst working with a variety of midwives, it has come to light that their own opinions and experiences of substance misuse (be it alcohol, class A drugs or smoking) often transpires when taking the women's history of substance misuse and subsequently giving them advice. You can see it through watching their body language and facial expressions.'

When considering disclosure of some illicit substances students felt that the responses and consequential actions were often disproportionate and unnecessary relative to legal substances;

'I have seen women who admit to having used cannabis once as a teenager being having social concern sheets started on them, despite now being 30 and in a stable home and job.'

And,

'I have ... noticed women being labelled as "drug users" after disclosing one-time cannabis usage more than a decade previously, and think that this really impacted the woman's experience and prevented her from feeling able to trust her health care providers.'

Whilst students felt that midwives were often distrusting of women who had disclosed using illegal substances, they expressed the opposite in relation to the way in which they dealt with alcohol use; observing that on occasion midwives were not even asking about alcohol use. They reported;

'I have often seen midwives take for granted that women have given up alcohol, and complete the booking paperwork adding "0 units per week since pregnant" without actually asking the women.'

Or,

'Some midwives have avoided this question by telling them to fill this section out at home. ... they have told me that that is a personal question that would embarrass them if asked directly.'

Students noted that there was variation in the way in which midwives practised in relation to alcohol and tobacco use. Identifying that many did not practice in accordance with national guidance, for example pertaining to carbon monoxide (CO) monitoring;

'I have found midwives attitudes to carbon monoxide screening vary greatly.'

And,

'midwives attitudes toward this vary, with some being quite judgemental towards the women, insisting that they have the test.'

Many of the students made reference to the way the midwives had spoken, or phrased questions and the impact that they felt this had on the women. These comments were frequently made by the students;

'The lady left looking embarrassed, ashamed and tearful.'

Or,

'(some) midwives who do not word it in such a good way, I think it then makes these women put barriers up.'

And,

'My midwife ... asked her if she knew why it was 'bad' and that she needed to stop. She began to treat this normal woman like a naughty child, and for the rest of the booking seemed dismissive of her ... she had simply scorned her like a child and belittled her.'

Or,

'I have found that talking through the list of risks associated with smoking in pregnancy often feels as though you are lecturing them and I think this only leaves women feeling guilty and ashamed.'

Some noted how this had made them feel too;

'I was on community placement and the woman had a higher CO reading the midwife replied 'oh dear, that's not very good is it?' It still makes me embarrassed thinking about it! ... The midwife was disapproving.'

And,

'these women are spoken about as if they are not real or there and the vibes in the room are awkward and sad.'

For many of the students the negative experiences they had observed in practice, in relation to midwives and other professionals, were further compounded by equally as negative encounters and consequential scepticism of the women themselves. Many had had experiences of women in practice behaving in ways which they perceived to be negative, for example by deliberate, or inadvertent avoidance of the truth. Again these encounters were quite often mentioned by the students;

'I have looked after a couple of women on the postnatal ward who had substance misuse issues and several mothers who smoke ... (they) seem to have an amazing capacity for recovering from C-sections in order to be able to go outside and get some "fresh air".'

And,

'She was extremely charming, and made every effort to distract the midwife and myself from the issue of her alcohol consumption.'

Or,

'... in my first year whilst on a community placement there was one woman that constantly 'DNA' antenatal appointments including all her screening tests.'

And,

'At a booking appointment my mentor asked a woman if she smokes and she replied no and yet we could smell the cigarette smoke on her breath.'

Some students gave explanation for why they felt women were not always honest;

'Many (women) visibly cringe when I have asked them whether they smoke and only admit to smoking 2 or 3 cigarettes a day, when in reality it is probably more ... In my experience they are expecting to be 'judged' by the midwife.'

Or,

'The fear that they will have their children taken away is something I believe is a huge barrier to them being open to healthcare professionals about substance misuse.'

And,

'some women have been honest about their use and others have not maybe because they are ashamed or feel judged, not just by the midwives but also society.'

Students appeared to equate the effects on the infant of maternal drug use, with negative feelings toward the mother.

'The baby was ... very twitchy and a little jaundiced. When we discussed the possible reasons why baby was twitchy and unsettled the mother became very defensive about her smoking.'

When reflecting on a baby withdrawing in NNU, *'I remember thinking, why do mothers do this?'*

'The withdrawal cry is unforgettable and heart wrenching!'

And,

'I found it extremely hard not to be judgemental of their situation and found it deeply saddening watching a helpless baby have daily seizures, dislike being comforted and continuously have a high pitched cry.'

Some described how they found some mothers' attitudes toward their substance use difficult and that the mothers did not always comprehend the implications of their use.

"It's ok, I have cut down a lot as it is I am only now smoking x a day" ... which is wrong.'

Or,

'I find women's attitudes often a little bit blasé regarding consuming alcohol.'

And,

'... the mothers often remark at some stage ... that they wish they hadn't mentioned it, or that it would have been easier to be dishonest for all the stress and upset it causes them. They don't always seem to realise that it is our duty to do what we feel is necessary to protect the safety of the unborn child.'

One student went on to state that she felt the fact that health care professionals were there to support and give advice, but that this was not always appreciated;

'... I do not feel this always translates to the public and they have a very jaded view of healthcare professionals and would rather put themselves through situations like the one mentioned, rather than get safe advice.'

Despite the numerous negative experiences expressed by the students, both in relation to midwifery care and also the behaviour of women, many of them expressed definite empathy toward substance using women;

'I felt gullible for believing the woman, it taught me that although most women feel able to be open some women when they are scared may give you the information they think you want to hear.'

Or,

'Although it is difficult at times to be non-judgemental, I feel many of these women have experienced hardship of some degree in their lives or are from a disadvantaged group that has made them turn to drugs.'

And,

'I couldn't help but feel sorry for her as it had made it seem like we as professionals did not trust her.'

Or,

'I don't know the intimacies of their lives so can't judge them for their choices even though in my heart I don't approve.'

Positive

Whilst distinctly in the minority, there were a few students who gave examples of positive attitudes toward users and good practice. Some of these related specifically to a designated substance misuse midwife;

'She had a very non judgment approach with these women.'

Or when reflecting on the care of women with heroin addiction and working with a substance misuse specialist;

'This was a positive experience as it gave me confidence that with the right attitude and support, addiction can be overcome.'

And,

'She opened my eyes into a world I didn't realise existed. ... We also visited women who were out the other side and over their addictions and onto second pregnancies and this was amazing to see.'

Others made reference to non-specialist midwives (mentors) they had observed, overall however the positive experiences were overshadowed by the negative ones;

'I felt in awe of her (mentor) as I just wanted to leave. When we discussed the visit, I told my mentor how intimidated I had felt and how upset I was for the baby.'

'My mentor went beyond her duty of care and tried on numerous occasions to visit her at home to help in dealing with her addiction.'

And,

'I have experienced occasions when care provided has been non-judgemental and supportive and the woman can feel comfortable and important for her time throughout the childbirth continuum.'

Reflection

Throughout the posts a common theme in the student's posts was their reflection upon the encounters they had in practice, good or bad, making suggestions of where they felt there were concerns.

For example reflecting on women being automatically referred for consultant led care;

'I do feel that this could lead to community midwives becoming deskilled in dealing with vulnerable women.'

Many used the post to reflect and begin to make sense of what they had seen, recognising that care, or their own view had not necessarily been ideal. In the most part however, this was the extent of the reflection.

Reflecting on her own judgements, one student noted;

'I then found myself thinking, is that right? I have no idea what they're like. The midwife then confirmed my thoughts by saying to me, 'oh dear, poor baby'.'

And,

'I know I had judged the woman as I felt repulsed by her on the postnatal visit, where was my empathy?'

Or,

'I instantly found myself feeling slightly judgemental towards these parents ... however, I was also aware that I was making judgement towards someone I knew very little about.'

Some of the students expressed how their experience in practice had challenged their views, or stereotypes;

'I felt my attitude towards substance misuse was challenged by her (mentor) behaviour.'

Or,

'the woman continued a very successful city career and presented herself as a respectable and responsible individual. This made me re-evaluate my stereotypes of alcohol abusers.'

And,

'I found that I was questioning my understanding ... The realisation that I judged this woman, and was saddened at the prospective life of her new born baby, led me to think that perhaps I am not as understanding as I first thought.'

Very few went on to elaborate and consider how they felt in the context of more knowledge, or information; there were one or two that did, but these were in the minority;

'I explained my feelings (of anger and mistrust) to the specialist midwife as I was curious if she ever felt the same. The specialist midwife then went on to tell me that some women are not aware of the dangers due to lack of knowledge and contradicted information they receive from professionals, family members, friends and media. ... This made me realised how important her role was to educate and support women when dealing with substance misuse it completely changed my pre conceived views on these women.'

And,

'however it has to be thought about what has made them turn to drugs and why are they abusing them and also is it that easy to withdraw and stay off the drugs just because they are pregnant? What about women who are on anti-anxiety, sleeping or depression medications. ... I suppose the way that is seen is one set is legal and one set is illegal, but surely for most the social and educational opportunities and experiences have influenced which path the woman may take.'

Personal

In addition to the experiences the students discussed which related to practice, a number of them also made reference to personal experiences that may have

informed their views. These were categorised in origin to, Family, Society/Media, Professional, Peers and Self. In addition where views were expressed but where the origin was not specified, the students 'voice' was categorised under the heading, 'non-specified student judgment'.

Family

Many of the students made reference to their own upbringing and the way in which their parents had viewed substance use. Some distinctly expressing that the acceptance of smoking and alcohol use were definitely a 'generational' thing;

'I do think it's maybe an older generation thing?'

'I think it could be linked to generation too. My Mum smoked through both of her pregnancies, and always tells me we were both good weight babies!'

And,

'It was OK to smoke when I was a kid, pregnant or not. The clay thumb pots we made at school were all destined to become ashtrays.'

Others reflected on their own experiences of parenting and of the experiences they had encountered within their families such as;

'As a mum of teenagers it shocks me how openly my children inform me of how many people they know smoke 'weed' and how readily and easily it is available to them.'

And,

'I cannot judge when I have recently discovered that a close family member has been taking cannabis ... what I do know is that it has changed the person to become a liar and untrustworthy and I dread to think what it could lead to.'

Society

Many of the students discussed what part they felt societal and media views had in influencing opinions around use. For the most part however, it was not clear if this was the view held by the students, or just their opinion of the 'wider view held in society'. Most of what they discussed in relation to this was not written as directly related to themselves; so they did not often use terms such as 'I' and where they did, they did not identify if the view they were expressing related to themselves.

A number highlighted that they felt there was a difference in the societal view of cannabis, alcohol and tobacco, compared to other illicit drugs such as cocaine and heroin;

'using Cannabis as this is deemed to be more socially accepted, and some even seem to have the opinion that cannabis use is "not a big deal."

And,

'I don't think people class cigarettes the same as cocaine, heroin etc because it is a legal drug you can buy over the counter.'

Making the point regarding societal influence on views, one student stated;

'33% of individuals asked regard cannabis as a safe drug.'

And another,

'society seems rather 'blasé' about drugs.'

The influence of the media was expressly described by some students;

'A lot of the education and media around substance misuse in pregnancy focuses on the negative effects it has which although it is true and does educate people of the effects, it often seems like a scare tactic.'

And,

'perhaps our prejudices and judgements are affected by what we see as the norm.'

Or,

'Just recently watching 'Call the Midwife' and seeing the doctor, midwives and mums all smoking freely with not a care in the world demonstrated this. Society has changed over time and research has with it, brought evidence, educating us the risks, however, to some old habits and the norm die hard.'

On a number of occasions the students challenged the societal stereotype and view that they had observed and some supported this with the knowledge they had gained during their training, both practical and theoretical;

'I do have to keep reminding myself the misuse of legal substances (prescription drugs to smoking, alcohol and food) can be just as damaging to the women and child and that it can affect people from all social classes. It just seems society is happier to accept and ignore people of higher social classes who have addictions.'

'Despite its teratogenic effects being more devastating than those of class A drugs, alcohol use, out of and in pregnancy, is more socially acceptable than the use of other teratogens, such as smoking, cocaine, MDMA, heroin or cannabis ... I find this to be a blasé attitude.'

And,

'As a society unfortunately we do judge and point the finger at the lower classes but we must accept that higher class women shouldn't be overlooked.'

Professional

Two of the students discussed their previous professional experiences, in roles before they began their midwifery training and attributed their views now to these experiences;

'my own past experiences probably helped me to have an empathetic and understanding attitude.'

'I believed I had a fairly open attitude towards substance misusing women in my care. I felt I was extremely patient and understanding of their needs and difficulties in dealing with an addiction.'

Some of the group expressed their opinions to substance use and misuse in the context of their peers and experiences they had encountered. Whilst a few went on to state how this affected their views, others merely stated their experience;

'a couple of my friends smoke marijuana and have done for years. Although I do not partake myself, it does not offend me.'

'I only have to go to my local town for a night out and I am confronted by people my age who go out and binge drink or chain smoke.'

And,

'I lived in a very middle class area and recreational cannabis use was prevalent and was certainly as accepted as alcohol or tobacco use amongst my peers.'

Additionally, some of the students described experiences their peers had had with health care professionals and the impact that this had;

'I personally know someone who smoked throughout her pregnancy despite her best efforts to quit. After the birth of her child she saw a doctor who asked her if she was still smoking. The woman explained that she was, but she never smoked in the house or around her baby and that she would continue to try and quit. The doctor then went on to say "I bet she (the baby) appreciates that!" and walked out of the room.'

'(A friend was) told at her booking by the Midwife that it would be more stressful for her to quit smoking than to have the odd cigarette and that it will cause no harm to the baby. The subject then turned to drinking alcohol in pregnancy and two friends went on to say how they were told by their Midwife that the odd alcoholic drink in pregnancy is fine.'

Self

Others identified and reflected on their own personal experiences, or that of a partner who used drugs, noting;

'Looking back at this experience now I see that at that time I could have been considered a vulnerable woman.'

'I continued to smoke throughout my first pregnancy and would always lie to the midwife about my smoking on antenatal visits as she was very judgemental.'

Or,

'I find it very difficult as someone who has never taken recreational drugs, how some women seemingly choose this over their baby.'

And,

'Personally, I have witnessed the destruction addiction can have on a person and their family. Substance misusers often become selfish in their behaviour with drugs becoming the most important thing to them. This often means people lie, steal and break the law to fund their habits.'

Unspecified judgement

Throughout the posts, there were a number of comments made that reflected student attitude, or judgment toward substance use, however the reason for this was not always specified. These discussions were grouped together in this section to

ensure this aspect was not ignored just because there was no identifiable 'cause' for their view;

'it is easy to get angry at these women and judge them.'

'I of course was shocked, as she didn't look like the kind of person to do that, stereotypical of me I know.'

And,

'I feel that sometimes it is very hard not to judge substance misusing women, especially when they lie about not using and then present clearly under the influence.'

Or,

'I have absolutely no right to judge how other people live however, I find it hard to accept that pregnant women are ignoring the health warnings that are widely broadcasted! Surely they must feel guilty?'

Other Knowledge

Guidelines

Many of the students used the discussion board to comment on their perception of current guidance in this area. Some felt that the guidance was inconsistent and clearer guidance was needed stating;

'I think we need some clearer advice on this.' When discussing cannabis use.

Or,

'there is no consistent guidance on alcohol consumption in pregnancy.'

And,

'I have found there to be limited information available to professionals regarding the use of cannabis in pregnancy and the effects to the neonate.'

In the main the students commented as described that they felt there was a lack of guidance, or that it was inconsistent, however very few actually made reference to any specific guidelines by name. Where they did, it was limited to NICE guidance, and specifically to NICE (2010) Complex Social Factors guidelines;

'NICE state "Helping pregnant women who smoke to quit involves communicating in a sensitive, client centred manner, particularly as some pregnant women find it difficult to say that they smoke. Such an approach is important to reduce the likelihood that some of them may miss out on the opportunity to get help".'

In the above example and in others, this was the extent of their discussion of the guideline. There was no assimilation linking them to their own practice examples or comments regarding whether they were useful at all.

Theoretical

Reflection

Whilst much of the discussion in the posts related to the students personal, or practice experiences, there were occasions where the discussion centred around reflection on knowledge they had gained whilst at university, in various modules;

'My IBL presentation in the first year was on alcohol during pregnancy ... I was actually shocked when I looked into the subject in detail. I feel we do not give enough information to women about the teratogenic effect of alcohol.'

And,

'although it must be hard in some circumstances not to judge. 66% of female substance misusers have psychosocial issues and mental health problems.'

Or,

'I had not previously thought all alcoholics were homeless, scruffy and jobless, but I had no idea that someone consuming such high levels of alcohol could function so well in day-to-day life, and be so convincing.'

Module Expectation

Furthermore, a large number expressed a similar expectation of this module; that it would provide them with the required theoretical knowledge to be of use to them when coming across substance misuse in practice;

'I'm hoping this module will give me the knowledge and understanding to help these women feel less stigmatised and make positive change to their lifestyles.'

And,

'I look forward to this module, and gaining an insight into how we alter our role as 'experts in normality' to accommodate for women with more complex social requirements.'

Or,

'I ... feel that I know very little about the effects of any type of drug and am looking forward to being able to have the information to help women and their families in the future.'

In addition, there were two students who reflected on where they felt any new knowledge gained may help them;

'I guess this module is not going to change that for us (negative feelings) but hopefully give us a better understanding of why women are unable to get out of the circle of substance misuse and to offer them advice.'

And,

'I hope this module will give me the knowledge I need to take forward into practice. I would like to gain the tools and skills to be able to deal with women who for their own reasons choose 'substance misuse' to get through their everyday life.'

Some of the students even expressed their expectation that they would be challenged in the module;

'I'm hoping by doing this module it becomes clearer in my mind the different types of substance misuse there are and challenges any stereotypes or prejudices I have.'

And,

'society seems rather 'blasé' about drugs, I am preparing myself to be taught many shocking facts. Hopefully this will give me enough drive to transfer to women in my community in order to reduce the rates of substance misuse.'

Summary of phase three

In summary the qualitative content analysis of the VLE posts explored the knowledge, attitudes and opinions of the students at the start of the module in relation to substance misuse and substance misuse in pregnancy. The findings revealed that there were a range of views held by the students in this regard and that these were influenced or informed by a variety of factors including, personal and practice experiences (experiential knowledge) and to a far lesser extent theoretical knowledge and knowledge of written practice guidance (which is created upon theoretical knowledge).

Whilst the students had begun to make sense of their views and had begun to evaluate the place of these and reflect upon them, they did not appear to go into detail and depth or have the theoretical knowledge to fully evaluate and explore how they felt, or why. It was clear that a strong element of their understanding and views had come from practice; both from mentors' behaviours and expressed views and also from their own encounters. Many of the students expressed their expectations

for the module in giving them this 'missing' knowledge and in providing them with challenge.

4.3 Chapter Summary

This chapter has presented the findings (and to a lesser degree a little of the process) of phases one and three of the study. In phase one it was found that the students' attitudes were positively altered toward substance using pregnant women when comparing their before and after scores from the medical condition regard scale (MCRS), but not their general empathy (as demonstrated by the Jefferson Scale of Physician Empathy JSPE) or their attitudes toward women experiencing reduced fetal movements during pregnancy (as measured by the MCRS). Phase three began to explore the students' attitudes, opinions and experiences toward substance use at the start of the module to give a baseline understanding of their position before the module. The findings of this phase suggested that the attitudes and opinions were largely based upon experiential knowledge that the students had acquired either in their personal lives, or in practice encounters and the students seemed to overall express a lack of theoretical knowledge in the area of substance use in pregnancy.

Chapter 5 presents the findings of phase two of the study which involved in-depth interviews, following the module, with ten of the students. This chapter builds upon the findings of chapter 4 and the exploration of students' attitudes and experiences in relation to having completed an educational intervention (module) around substance misuse.

Chapter 5

Findings from Phase Two Interviews

This chapter follows on from chapter 4 which presented the findings from phase one (quantitative) and phase three (qualitative VLE posts). This chapter presents the findings in relation to the ten semi-structured interviews that were carried out following completion of the module. These were undertaken to explore the student experience of undertaking the module and where they felt they had gained knowledge or there had been any changes to their views, or opinions. Essentially it explores what the students learnt and how they felt the educational intervention (module) had facilitated this. Where the views of the participating students are presented in this chapter, the students participant number is assigned to the student comment (P1, P2 and so on), to demonstrate that the data represents a range of participant's views.

5.1 Framework Analysis (interviews)

As indicated in Chapter 3, ten students were invited to take part in this phase which involved an individual semi structured interview exploring their experiences of undertaking the module, what they felt they had learnt and so on. Framework analysis was chosen as the method for analysing this set of data and the process of this and early stages of the formation of a data matrix are outlined in Chapter 3. The presentation of findings in this chapter follows on from the preliminary 'sorting' of the data that is described in Chapter 3. This included transcription of the interviews, familiarisation with the text through reading and re-reading, initial coding and development of an analytical framework with a set of categories, codes and working definitions of terms, application of this framework to the transcripts and finally charting of the data into a framework matrix.

In this section the data from the matrix (Appendix 7) is explored and generated into ideas to represent what was expressed. Each of the main categories is used as a heading and within it sub headings are used to represent the codes, which where it

was felt applicable and meanings were similar, have been grouped together under a single sub heading. Many of the codes placed under the 'other' category on the original matrix have been moved and integrated into the other sections as was felt appropriate upon re-reading of the grid and transcripts together.

The aim was to represent what the overall data was saying rather than a description of individual participant's views. The participant numbers have been used to show that the views are those of the full range of participants, rather than to attribute who said what.

Memos have been created for each of the main categories, with a brief definition of the category, the codes that relate to it, a summary of the raw data from the matrix, discussion of deviant cases, which were related to the main category but which appeared to be inconsistent with the overall views expressed, or 'bucked the trend.' Further points for consideration or note in later discussions were also outlined for each category as is described in Chapter 3.

The main categories from the matrix (Appendix 7) were;

- Student Attitudes Toward Substance Misuse
- Student Practice Experiences
- Interaction with Peers
- Impact of Knowledge Gain
- Method of Module Delivery

5.2 Attitude of the students toward substance misuse

Definition; Comments and reflections relating to where the students felt their attitudes toward substance misuse came from and what impact the module had upon these.

Codes: Origin (A O), Self-reflection in module (A R), Service user impact (A SU), Experiences (personal/professional) (A E), Student Judgments displayed (A SJ).

Summary of data:

Self-reflection

Without fail all of the students described a journey of self-discovery and reflection through their learning in the module and identified that some aspects of their perceptions had altered;

'It made me feel and think slightly in a different way.'(P1)

'I think yes, it has changed my perceptions of it. I think I am a little bit less judgemental than I was.'(P1)

And,

'Because I went into it being so judgemental with my views towards drug users. I came out of it a really different person.' (P3)

Or,

'(I was) able to reflect on a 'horrible' experience in practice in the module ... I treated this module very much about reflecting upon the scenario that I had encountered because I think it was so problematic for me that I needed to make sense of it.'(P4)

'I've been educated into thinking differently.'(P10)

Students recognised that this change would have a positive impact upon their practice;

'When I've got to care for patients who substance misuse the care that I give them is going to be more beneficial – following the module.'(P3)

And,

'The knowledge gained will change the way I practice.' (P6)

Furthermore they identified that whatever their judgements, this could have an effect upon the women they are caring for;

'I feel like my attitude isn't that bad towards drug use, but then that could mean that I don't give women the help they need. So for example if I feel so optimistic, then I may end up trivialising their problem and saying it's okay, you can get through it. So it was really helpful for me.' (P5)

And,

'I've changed as a person. I've grown in confidence as well and as a midwife ... that's what changed because I didn't realise how much judgement around substance misuse issues can affect women.' (P4)

Reflecting on the journey they had made during the module, some of the students noted that it was an uncomfortable and difficult process challenging your own views;

'I think substance misuse is more controversial and I don't think people always want to deal with it. It's like a moral dilemma and I don't always want to think about it. I don't have the headspace for it. And substance misuse has quite a lot of this. It really challenges you.'(P6);

'it felt really odd challenging your own views and thoughts.'(P6)

And,

'It's awkward there's no doubt about that at but awkward questions have to be asked sometimes.'(P8)

When asked what impact the learning from the substance misuse module would, or has had in the students practice, all reported a gain in confidence in dealing with substance misuse and less fear, than prior to the module;

'when someone comes in from booking, having the confidence to probe and ask questions.'(P1)

Or,

'I'm more confident with asking if I do get a yes answer.'(P2)

And,

'I think that because of this module I can achieve this (6cs). I'm happy to care for these women to give them support and commitment courage, compassion, I have a lot of compassion for them now, I really want to help them now.'(P3)

Others stated that they had begun to write new guidelines and pathways in relation to substance use in pregnancy for their Trust since the module. And a few expressed their passion for this area of practice and their desire to become specialist midwives in the area.

Student judgments

Throughout the interviews students expressed value laden statements regarding substance misuse in pregnancy. These were varied, but included negative statements relating to how they felt, or viewed themselves prior to undertaking the module. Some identified these as being *'human nature' reactions*;

'I think you can't help when someone walks in that's heavily pregnant and they stink of smoke, there's that human instinct that kicks in and thinks, err you stink of smoke, or when you walk into a house with a newborn baby and they are smoking around the baby. It just makes you think, oh, God, they are smoking around that baby.'(P1)

Or,

'you know that shouldn't be judgemental, but we've not really very much knowledge and so you're bound to be a little bit judgemental because that's not your life choice.'(P8)

And,

'I think I was quite judgemental towards the sort of people and found it quite difficult to understand why they would be allowed to keep children and things like that.'(P10)

There were also many positive statements regarding how judgemental they perceived themselves to be;

'I'm pretty open minded'(P2)

'I don't think I ever judged people.'(P4)

And,

'I'm really just not a judgemental person in any aspect, whether that be, religion, culture and what everybody. People are people. Whatever that got going on in their life.'(P9)

Others made reference to the types of people who they believed to be using substances prior to the module;

'The ones that are doing the drugs are the ones who aren't really academic and really haven't any motivation to do anything in life. So you create a stereotyping in your head that the people who take drugs are people who just don't care about anything ... the media reinforce this.'(P3)

Many students then went on to suggest that there were reasons for use and demonstrated a level of empathy toward users;

'I think it's just the people they've been hanging around with and how they got into it.'(P7)

And,

'they come from deprived social backgrounds and you can't always escape those influences.'(P8)

Or,

'These people are vulnerable. It's not just about substance misuses about all the things that go with that.'(P8)

And,

'I think I'm non-judgemental, because I understand that everybody has a history and that led them to where they are today. And everyone can change.'(P9)

When reflecting on how experiences in practice had made them feel, some made comments such as;

'I was so annoyed with her that I judged her on her substance misuse rather than thinking, she really needs help. She's taking this for a reason.'(P4)

And,

'I've never felt so angry at a women before and so upset at the same time.'(P4)

Or,

'I think you need to remain non-judgemental and I definitely judged that woman.' (P5)

One voiced her frustrations in practice of not doing more to support substance using women;

'many of them, although maybe this stereotypical, that I have come across have been from low social economic backgrounds. They've not got jobs, they've got children in care and things like that, a criminal history because of their drug use, it becomes a vicious circle and why are we not helping them more? Because we then see them twice, three times, having children and their circumstances don't improve.'(P4)

Overall, many felt that their attitude had changed from before the module;

'before I took the module I was really judgemental towards substance misusers ... But doing this module I saw their side of the story really and find that I am far less judgemental.'(P3)

And,

'(the) Module has helped me to be less judgemental.'(P10)

Origin of attitudes and personal or professional experiences

When asked about their experiences and where they felt their attitudes toward substance use had come from, the responses were varied and included; Social circle, peers, parents, previous work experiences, media, school, personal use, or sibling use were all cited. Some noted that although they had knowledge it was limited;

'Attitudes came with me from previous experiences and roles. Though ... I think maybe I had quite a narrow view about it.'(P4)

Some students commented on the increasing social awareness of drugs today and the effect of the media in relation to this, one felt that,

'The media reinforce negative stereotyping, with negative connotations which you associate with drugs.'(P3)

And,

'I think media is the most influential.'(P7)

Many of the students stated that they felt their views had also been influenced by their experiences in practice placements before the module. One had had a particularly negative encounter already in practice with a cannabis user and reflected upon the fact that this had influenced her opinion of users;

'(she) was aggressive and physically abusive... I ended up caring for her from afar, from the corner of the room ... It was an awful experience. I think that's the first time I've ever judged someone for substance misuse.'(p4)

Many of the students demonstrated their empathy through accounts of situations they had encountered in practice, reflecting on how the women may have felt;

'she ended up having a BBA (born before arrival of assistance – at home) ... the reason for this was mainly because she knew she wouldn't have to go into hospital ... and thought that by having this baby at home, she wouldn't have to be screened or go into hospital at all.'(P2)

'... just being on the NICU ward you can see why staff get upset. But they (women) aren't doing it on purpose and that's what you have to remember and they have already upset themselves and feel guilty.'(P9)

Or,

'It gives them a lot ... on top of the guilt they already have and probably causes them to continue to use as opposed to thinking, I have support around me and feeling positive about things. You can still make positive comments to them, even though their behaviour may be negative.'(P9)

Impact of service user input

One aspect that was repeatedly iterated by students when referring to aspects of the module that had a particular impact on them was the inclusion of users' stories;

'The Swansea love story was heart breaking and really moving. I found that really, really eye opening and useful ... The reasons behind the drug use were really powerful. And it's such a vicious circle. They just can't get out of.'(P2)

'I saw their side of the story really.'(P3)

And,

'the Swansea love story really change my perspective.'(P3)

And,

'the Swansea love story made me cry, I didn't actually believe people looked like that. I knew the drugs were a problem, and I've travelled quite a lot, but I saw that and really didn't realise that there were people who lived like that ... it was quite an eye-opener for me I guess seeing that and thinking that's in the UK.'(P6)

All of the students valued the service user input into the module and many felt that they would have liked more of this, with the opportunity to meet 'real' users through the module.

Discussion points

Areas for further thought and discussion arising from this section, included what impact does the normalisation of drug use have upon attitudes? Furthermore, if reflection on practice is important what is the best way to encourage reflection on negative practice experiences? Service user input was also a prominent feature of the views expressed in this section, what are the implications of this for educational delivery?

5.3 Student Practice Experience

Definition; the views and examples expressed by the students which related to their perception of clinical practice pertaining to substance misuse in pregnancy.

Codes from matrix: Guidelines/processes (AIP G), Training needs (AIP T), Attitudes and Judgments of staff (AIP A), Knowledge base of staff (AIP K), Avoidance of care by midwives (AIP Av), Different view of licit vs illicit drugs (AIP Dif).

Summary of data:

Practice Guidance

Over half of the students reported that there was a lack of written guidance at trust level in relation to substance misuse in pregnancy;

'I was really surprised that there's no guidelines in my trust for substance misuse.'(P1)

'There were no proper guidelines for me to look at: no policy.'(P3)

A few also expressed that they found the national (NICE) guidance to be equally as inadequate;

'There is a lack of guidance in the area - Trust and NICE.'(P4)

In the case of this participant, this was despite there being a high substance misuse rate and a specialist substance misuse midwife in post in her trust. The students felt that guidance was important and that midwives needed this to enable appropriate support and referral. A few stated that the module had been useful where their trust was lacking:

'The module was good to be able to share guidelines where some trusts were lacking them.'(P5)

Those participants who stated that their trusts did have written guidance in place had mixed views on its usefulness;

'We have guidance and there is a pro forma at the back of the guidance on how to do a referral which I found really useful because I didn't know that before I looked at it.'(P2)

But conversely, others reported that although there was guidance it may not be known about or accessed until required;

'there's lots and lots of information out there on how to deal with it, but ... I don't think anybody would access it. Unless they had the problem arise in the first place.'(P2)

Or that it was limited in its application;

'The guidance that we have for it is only one little guideline and really relates to how we make a referral to the substance misuse midwife. That was it. And it was about six or seven years out of date.'(P3)

Furthermore, many of the participants felt that the guidance that was available wasn't specific enough and recognising the needs of individuals felt that this rendered it less useful;

'Without specialist knowledge in the area ... care pathways are basic and can lump everyone together and that's the difficulty.'(P8);

'All vulnerable women are lumped together but their needs are very different.'(P8)

And,

'the local and national guidelines are very generalised and everybody's situation is quite specific, so they (guidelines) aren't specific to specific substances.'(P10)

Without fail all of the participants recognised the challenges of practice today and commented on organisational factors such as workload, time management and systems;

'Time demands are too great. You are attending a discharge planning meeting for women, you maybe met twice. I don't think that's appropriate. You're there to give a judgement on how that woman has interacted with that baby over the last couple of hours. You may have come on shift three hours ago and have spent two minutes with her. How can you make that judgement? Yet it's so important for her and can be life changing.'(P6)

And,

'I think that the community midwives struggle enough providing continuity of care, the way our system is set up and they might only see that women twice because somebody else has seen her the other times, and so they don't feel confident.'(P8)

Participants also recognised the difficulties presented by organisational cutbacks to services and the effect this had upon midwives trying to signpost and refer, when they didn't have the skills to provide support themselves for women;

'I don't think there's much support for the women if they are just sort of in the medium/light using bracket, because the midwives don't really know what to say. So I think I'm not blaming the midwives for that, but they just don't have enough training and they have very busy jobs'(P1)

Some felt this impacted upon the care that was given;

'Midwives have so much information to give antenatally that they just skirt over drugs.'(P10)

Or,

'There are guidelines to follow. (But) They (midwives) are quite slapdash on how they apply them.'(P8)

And where there was a specialist midwife in post to support vulnerable women, they expressed that the individual demands on these midwives were unrealistic;

'She was being seen by our drug and alcohol midwife, but it didn't seem like she (the midwife) had a lot of help, there just wasn't a proper plan in place or anything.'(P4)

Or,

'we have a specialist midwife but she's too busy.'(P10)

Knowledge base and training needs

Participants almost unanimously concurred that midwives knowledge base around substance use was limited, or poor;

'I think it's pretty rubbish actually in terms of what they know.'(P1)

And,

'I feel personally. They (midwives) have very little (knowledge).'(P2)

The participants elaborated detailing where they felt that knowledge was poor;

'There are guidelines, but I don't feel a lot of people have a lot of knowledge around substance misuse at all.'(P6)

And,

'In my personal experience I feel that there is a distinct lack of understanding of misuse and misusers all the way from smoking up.' (P8)

Additionally they suggested that midwives lacked the skills in assessing women and asking about substance misuse and in relation to what support was available to them locally;

'They (midwives) skirt around the question or they ask it so directly that the women is taken completely off guard and wouldn't tell the truth anyway.' (P4)

One participant reflected on her experiences of home visits with mentors;

'when I've done home visits, many midwives don't take any notice of the things lying around. I've done visits, with mainly smoking appliances laying around and said, "oh, did you see that?" and then the mentor has said "no, I didn't." They just don't seem to be aware of the things around them or don't know what to look for.' (P9)

This lack of knowledge the participants suggested meant that on a practical level the midwives didn't know how to deal with substance use appropriately;

'I think most midwives in practice probably wouldn't have a clue if I'm perfectly honest. And I think that's why they can't deal with it when they have it thrown at them.' (P2)

When considering the problem with having limited knowledge, one participant suggested that some of the midwives she had seen drew on their personal experiences, similarly to the way students had in the substance misusing parent's module. However she importantly noted that;

'although these (personal experience views) are valid. They may not be accurate and may not be informed by evidence.' (P6)

Another reflecting on what the impact of a lack of knowledge could be on how women feel, suggested;

'so if they think you don't really know much, are they questioning the ability of the midwife ... How safe do you feel (with) them looking after you? And so on. And do you want to open up to them (midwives) and let them know that you're finding it difficult looking after your baby? Probably not.'(P6)

And,

'I think we need to talk to them, rather than at them and I think a lack of knowledge sometimes stops us doing this.'(P8)

The general consensus from the participants was that midwives were on the whole genuinely caring and not malicious, but that their lack of knowledge transferred into practice and presented as poor attitude and substandard practice;

'they're getting sub optimal care really and midwives are missing the signs and symptoms that could that could prevent things.'(P10)

The main area that participants felt was lacking, was in relation to understanding the wider picture of substance use;

'I think that midwives don't really understand the full picture of what's going on with that woman.'(P3);

'it was a lack of knowledge, purely just not understanding their side of the story, and being ignorant and not understanding that they do have a tough time.' (P3)

Participants did recognise that there were some midwives with better knowledge around substance use;

'I think the midwives often have the knowledge, but they don't talk about it very much unless their woman discloses that she is using the drug and then it all comes out.'(P5)

However these were very much in the minority, with the general lack of knowledge leading as suggested to poorer care provision and a focus upon completing tasks in practice as opposed to providing individualised care.

All of the participants identified a need for additional training in relation to substance misuse to bridge this knowledge void;

'I think there needs to be more training courses on it.'(P1)

'Training seems a bit hit and miss.'(P5)

And,

'there are midwives that have been out there long time and have had no training at all.' (P2)

The participants suggested that training would be beneficial on many levels;

'they would access the different websites and guidelines because they would have to and then they would be aware of what was out there.'(P2)

'Training just helps people to be able to interact with these people better and not be so judgemental.' (P7)

And,

'with knowledge and training you are more empathetic to them and more aware of the underlying needs.'(P8)

One participant made the point that it was not just midwives who needed training, it was all professionals that the women may come into contact with;

'training (is needed), not just staff but also people like receptionists and people who were front-line so as not to be judgemental, so it would enable people to feel more at ease with coming forward with an issue in the problem.' (P2)

In regard to the specific elements that the participants explored as a part of the substance misusing parents' module, they identified brief interventions, recognition of use, reasons for use and ways of asking as being areas that they felt midwives in practice could particularly benefit from training on. Participants suggested that training should be mandatory for substance misuse, as with safeguarding and domestic abuse, although none knew of any trust where this position had been implemented thus far.

Concluding, one participant discussed the success of training in this area to improve confidence in broaching the subject, by reflecting on training following the introduction of carbon monoxide monitors in pregnancy to discuss and monitor smoking; initially met with hostility and opposition, but now an accepted part of antenatal practice.

Staff Attitudes and Avoidance of Care

Some participants reported that they had witnessed positive attitudes displayed toward substance using pregnant women in practice;

'I don't think I've seen much in terms of judgement. I haven't really seen anything different to how they interact with other women.' (P5)

And,

'They feel empathy for the woman. The woman is very much the focus and the first concern.' (P6)

In fitting with the comments made regarding knowledge, one participant described that staff attitudes were;

'Positive, but knowledge is what is lacking and this leads to poor care. I think are very supportive of the woman. I've not heard of bad attitudes.'(P6)

Whilst these views were of course reassuring to hear, on the contrary most of the participants had seen poor attitudes displayed in practice and gave a plethora of examples of their experiences of this;

'I see a lot of midwives look down their nose at people who smoke during pregnancy and someone that drinks.'(P1)

'Midwives are 'quite negative in the way they deal with them. It may not be while they are in the room with the women, but outside of it. Then everybody's got an opinion of it.' (P10)

And,

'I remember my mentor being totally and utterly gobsmacked that she had said that yes, she smoked weed ... she was totally and utterly shocked by it ... it was just horrific, like someone just told that they had killed her mother! There was a look of horror on her face in front of the woman.' (P2)

Or,

'... there were midwives who were being judgemental looking after her saying things like, silly girl. She's only 16 what's she doing? ... they were really slagging her off.'(P3)

One participant similarly made reference to care they had seen whilst working in non-midwifery placements and attitudes of staff they had witnessed there;

'I saw in the neonatal unit with neo-natal nurses and how they are with the women, they aren't looking after the women, but the babies so they are often very judgemental. Like this is what she's just done to this baby!' (P7)

And,

'(neonatal unit staff) they were very rude to her, they just came in and brought the baby to her and didn't even speak to her.' (P7)

Some of the participants expressed that they felt that negative attitudes by midwives were often expressed as avoidance of care;

'I know that the midwives I have been out with try to avoid it.' (P2)

Or,

'Midwives don't talk about it unless a woman discloses. They seem reluctant.'
(P5)

And,

'There's a lot of avoidance. They carry out the care that they need to carry out according to guidelines in terms of making sure that mums monitored babies monitored etc, but there's no emotional support and they become task orientated.' (P9)

They felt that midwives did this again because they were unsure and lacked confidence in dealing with it;

'midwives shy away from trying to help because they don't know how to don't know what they're supposed to do.' (P7)

Other reasons that the participants suggested for more negative attitudes were the normalised view in society of drug use;

'If it's normal to you as a midwife or you use yourself, you may see nothing wrong with it. Or hypocritical challenging it.' (P6)

And negative past experiences of dealing with substance use;

'If they've had bad experiences every time they've looked after a substance misusing parent they may always feel like that.'(P3)

Regardless of the reasons for the negative attitudes, or avoidance of care, the participants felt that such behaviour impacted upon the care received and how women were made to feel. Reflecting on a scenario from practice one participant stated;

'I asked her "what did the midwife say to you about cutting down?" She said, "She looked down on me." The woman looked really upset by it and it really upset me to think the midwives judgement was going on the woman ... And then she won't disclose anything else, for fear of judgement. It's sad.'(P5)

Around half of the participants made comment regarding the age, or length of midwifery experience and the level of judgement shown; linking this to training, or practice experience. There was however no consensus on which was worse;

'midwives who go into those houses don't see it, because they're quite set in their ways, many of them and have been there a long time.'(P4);

'I would say it's uncomfortable, and in my experience, a lot of my mentors have been of a certain age, where perhaps they feel it's not that important.'(P8)

And,

'I think the older midwives have more of an opinion than the younger newly qualified midwives, but I think maybe they didn't have too much of the training when they trained.'(P10)

They generally felt though that midwives with greater training were less judgemental and less task focussed.

Differentiation of legal and illegal drug use

Many of the participants expressed a difference in the way that midwives in practice viewed legal and illegal drugs when women disclosed use and that this had a direct correlation to the midwives willingness to engage with support for the women. All of those who discussed this aspect made reference to midwives viewing the legal substances as 'OK' and illegal ones as not. For example;

'it's no different saying I've smoked cannabis in my pregnancy than I've had the odd glass of wine in my pregnancy but the reaction of the midwife is entirely different.'(P6)

And,

'I think a lot of guidance are for substance misuse and so when people look at the guidelines they think oh well, she is only a heavy smoker and it's not the same as injecting heroin. So they are reluctant then to do anything.'(P8)

Some participants also inferred that because midwives felt legal substances were OK, they felt confident in enquiring about these such that;

'We ask about do you drink alcohol do you smoke cigarettes, but we don't ask about illegal substances so much.'(P4)

This often meant their responses and questioning was often disproportionate, so for example;

'midwives just take the answer and leave it at that ... e.g. alcohol ... "not now I'm pregnant," but actually that's not really a great answer is it? Because we don't know what she drunk beforehand and when she found out she was pregnant.'(P8)

Or,

'if someone says they used to use heroin or cannabis. It's like, ooo ... red flag, we need to watch them. When the reality is they probably don't need as much watching because they're probably already receiving help or have.' (P8)

Deviant cases

Some good examples of care were also given, it was not all negative. Overall the students were quite 'loyal' to practice and their mentors suggesting the system was at fault in many cases rather than the individual midwives. Students also suggested that on the whole they felt that the mentor's attitudes were born out of a lack of knowledge rather than a lack of empathy.

Discussion points

Within this section some of the areas that arose to consider when discussing the findings were, what impact does mentorship have? Over 50% of student midwives training is spent in practice, under direct supervision of mentors and so this is likely to have an impact upon them. Additionally, do the views expressed here by students relating to practice, represent an organisational culture? If so what is the impact of this then when considering change.

The implications for practice in this section are that strong guidance is needed to provide adequate and clear support for midwives when needed. However, where does this fit in the current academic hierarchy, or climate. For example, is there sufficient addressing and coverage of the issues of substance use in journals aimed at midwives? This raises the issue of dissemination of literature and research addressing the stigma and profile of users. One student commented;

'A lot of the journal's focus on clinical skills and a clinical improvements to practice, but I guess this subject challenges opinions. Do people really want to read things which are a little bit challenging?'(P6)

This comment itself highlighting the possible difficulties of dissemination of research findings in this area.

5.4 Interaction with peers

Definition: Students dialogue relating to interactions with peers through the module discussion boards and the impact upon learning

Codes: Shared resources (DB R), Sharing of experiences (DB SE), Critical discussion skills (DB D), Challenge of views (DB C), Protection of discussion board (O DB).

Summary of data:

Sharing of learning resources

All of the students recognised the value of the discussion boards as a learning tool. Many described how they had gained valuable resources through others sharing on the discussion boards and this had then enhanced their own opportunity for further study;

'It allowed me to not only have a different perspective put across but also to have the references to go and find it read about it myself from others.' (P1)

'it was really interesting to read the other posts ... because people chose different subjects.' (P8)

And,

'some of the services they found, other references they might find were different to the ones that I found and that all helped with my learning.' (P9)

Sharing of experiences – learning from each other

In addition to the sharing of resources, all of the students made comment regarding learning from the experiences of others on the discussion boards, both personal and professional. Discussing some of the posts they had felt were useful, one student stated;

'one was her personal experience and personal view and then other people talked about difficulties they had had in placement with heroin users and staff, and with difficult families and family members because of it. It was good to get both sides.'(P3)

And,

'there was learning from others different trusts and choices of substance and also sharing of others views.'(P4)

Though some students did see the limitations of this;

'It was good to learn from what other people wrote about their different experiences ... but you have to read with caution as it's a personal view, I think you've got to read that with caution because it's going to be subjective and usually its third hand.'(P6)

And,

'everybody works in a different area and people see things from different perspectives when their writing their posts. They're writing it from their thoughts and feelings.'(P9)

One student reflected on the protection that the discussion board offered when referring to a peer who had shared a very personal account;

'so I guess because it was online, it meant people felt able to share these sorts of things. Whereas face-to-face may be more embarrassing or you may feel that you were being judged. So that's the flipside to doing online and not face-to-face. I mean, it is a bit of a taboo subject, isn't it, not everybody will be open

and honest will they. Not everybody feels comfortable discussing it like that.'(P2)

Challenge of views by peers and critical discussion skills

Students were able to identify that their own critical discussion and writing skills had improved through the use of discussion boards. There were a few reasons highlighted for this; firstly some felt that through critical feedback and interaction with peers it had challenged and made them consider their own arguments better. Describing a reply to her own post one noted;

'So it was really good to get that alternative point of view.'(P3)

And,

'It made you ensure that it was balanced and well considered. It makes you step up your game a bit more because other people are going to be doing to your work, what you're doing to theirs, which is critiquing it.'(P6)

Secondly due to the 'exposure' of the discussion boards and the limited word allocations for reply, it had helped them develop their own critical discussion skills;

'with the online discussion boards, you've got to have thought about it before you post it and reference it.'(P8)

Or,

'you get the opportunity to read your peers work and to get them read yours and where your names attached to the post you put up you want your peers to think well of you. It helped improve writing skills.' (P6)

And,

'when you're going to write a post you were able to think about it, consider it and think about what you're going to write. Whereas when you're in class just

talking, you can often get a bit confused about where the discussion's going or go off on a tangent.'(P8)

And lastly because some students suggested that it had helped because when they read others posts they saw examples of good writing style and critical discussion and it also provided ideas and resources to develop their own arguments further. So good critical discussion had been modelled for them;

'Other peoples posts gave insight to aspects not considered.'(P5);

'Others posts put ideas in your head and made you think.'(P10)

Deviant cases

All of the students enjoyed the discussion boards and really engaged with learning through them. The only aspect expressed negatively was that they would have liked the time to be able to engage with more of the posts and thus more discussion. Many reported that they would have liked to have read all of the discussions posted by peers and been able to respond, however, with other modules and practice running alongside they were limited by time. One student suggested the use of an 'open' discussion board on the module virtual learning environment to have additional discussions for those who wanted it.

Discussion points

The main points for thought in later discussion raised here were in relation to the students expressing a degree of challenge in their views via the discussion boards. It is important to consider if it was this challenge that enabled and encouraged self-reflection regarding attitudes amongst the students, i.e. was the discussion board the vehicle for change? And if so why?

5.5 Impact of Knowledge gain

Definition; Students reference to gaining knowledge, theoretical and practical within the module, that they felt impacted upon their attitudes, or practice skills.

Codes: Practical (KG P), Theoretical (KG T), Reasons for use (KG R), Bridge of theory-practice divide (O TP), Comparison to other conditions (O sim)

Summary of data:

Practical and theoretical knowledge gain

Students noted how they had gained knowledge throughout the module relating both to the theoretical aspects of substance use and also knowledge regarding skills in practice. Some made reference to how the theory had given them skills in recognising drug use in placement;

'it will definitely benefit my practice and when looking at safeguarding issues and stuff. Running around people's houses and stuff, you see papers etc on the side, so you might think they're taking joints, tinfoil and so on, and it gets your mind thinking.'(P1);

Or had improved their knowledge of the variation of drugs that are around;

'... I was absolutely amazed at how many there are out there.' (P2)

And,

'my knowledge has grown especially around the different types of substances that people use and how it affects them and how it could affect their baby.'(P4)

Two students made reference to the revelation they had regarding the difference between legal and illegal drugs in the module and how this had challenged the way they dealt with this in practice;

'When you read the definition of what alcohol does to the body and then what its long-term effects were, it sounded a lot worse than many of the other drugs did and I was really shocked by that.'(P6)

And,

'I never really thought about people who smoked during pregnancy as substance misusing but obviously it is I've just never considered it before.'(P7)

Many felt that undertaking the module had also given them knowledge in the area of support and guidance for users and that they would be able to apply this to their practice in the future;

'If I do come across it. I will be able to access the guidelines and know how to refer someone now.' (P2);

'I know about appropriate websites appropriate agencies and guidelines etc on what there is.'(P5)

Interestingly, some reflected that it was not their attitude that had changed, but their knowledge;

'What changed was not attitude, but knowledge of how to care for women. For example for particular drugs, knowing what to do.'(P5);

'I didn't know enough about it to make an informed judgement ...I just didn't know enough about it. I didn't know enough about them.' (P6)

Whilst in contrast, others suggested that it was the knowledge gain that had changed their attitude;

'The knowledge gain has shifted attitude.'(P6);

'Exploring the substances made me change my attitude.'(P5)

And

'(my) Attitude has changed because I know more.'(P7)

Amongst the elements that they felt they could directly put in to practice students found the questioning techniques such as motivational interviewing particularly beneficial;

'motivational interviewing was really interesting because that encouraged us and taught us a way of asking open questions, so I found that really rewarding and helpful on how to deal with it if I come across it.'(P2);

'it's (the module) given me more skills. Like the motivational interviewing.'(P7)

Nonetheless, a few of the students identified that the knowledge they gained whilst doing the module had driven them to find out even more about drug use and pregnancy, with some undertaking further voluntary training days, such as the National Organisation for Fetal Alcohol Syndrome (NOFAS), alcohol in pregnancy study day. Whilst others sought out specialist placements in practice to gain more practical experience and knowledge, either with a substance misuse specialist midwife, or with their local community drug and alcohol service (CDAT).

Knowledge gain relating to reasons for use

In addition to the skills regarding questioning techniques and recognition of drug use that students mentioned specifically, an area that resonated with all of the students was that around reasons for use. When reflecting on their perceived change in attitudes and why this may have occurred, all of the students recognised an impact

of knowledge relating to this aspect, with many demonstrating empathy in their narratives;

'There's lots of reasons why people do substance misuse and it was very informative.'(P1)

'I think it was when looking at other aspects like why people take substances and there were all sorts of mental health issues involved. Like there are people with bipolar or had depression and so they started doing alcohol.'(P3)

And,

'After doing the module I've got more of an understanding, I think I'm probably less prejudice if that makes sense and I think I am more understanding of the contributing factors and the reasons behind drug use as to why they behave the way they do.'(P6)

Or,

'(I have a) Better understanding of where they are coming from.'(P7)

And,

'Women are still people. Usually that have got substance misusing issues because of underlying issues. Either depression or other health conditions. Or just inequalities or really bad luck, so I don't think it's something that anybody would just choose to do.'(P9)

Theory-Practice Gap

Students described how the module had helped them to bridge the gap between theory and practice, suggesting that they were able to apply the theory learnt to practice;

'(it) made me realise how much my own practice needs to change.'(P5)

And that this in turn would help them to give better care;

'I'm perhaps better informed about how to provide care for them (women who use).' (P6)

Or,

'The theoretical knowledge helped me to know what to expect in practice.'
(P4)

And,

'because of where I work, I got that experience and practice of being around substance misusing women alongside the module, so for me, there was the theory side of it and practice side of it and I don't think it could get better than that.'(P9)

Conversely, whilst recognising the shift in knowledge and the potential benefits of this, one student noted that without experience she couldn't be confident it would help her in practice;

'motivational interviewing and brief interventions ... (were) really good. But I think I would feel really uncomfortable if I had to ask a woman any of those questions. I think because I've not had to experience it.'(P3)

Some of the students could identify how this gain in knowledge and transferring of theory into practice would benefit the care they were able to provide;

'I'm perhaps better informed about how to provide care for them because I understand where they're coming from.'(P6)

'It allowed you to look back at the things you'd done in practice and relate them to the theory.'(P6)

And,

'The module reaffirmed what I knew to be so from practice.'(P6)

Additionally, whilst students were reflecting during the interviews on how they felt about substance misusing women and the knowledge and confidence they had gained during the module, many of them drew parallels to other stigmatised areas of practice, for example obesity and mental health;

'... if you see a woman with a BMI 40 coming to give birth... You think oh she's lazy. She must be a bit of slob. She must be this, she must be that. But the fact is you don't know what's behind the obesity because you could class substance misuse as food ... with mental health as well.'(P1)

Or Domestic Abuse,

'like around domestic abuse, mental health, anything that there's a stigma around. It's made me realise that if you don't ask the question, then you aren't going to be able to find out and help the family.'(P7)

The students were then able to recognise the skills they had gained in this module and transpose them to these other areas of care;

'It also taught me to look at my attitude around things and challenge my views not just in relation to substance misuse. It's given me like a model for way of dealing with things appropriately when I come across something I don't know about all that makes me feel a little bit uncomfortable.'(P6)

Deviant cases

Many of the students reflected upon the fact that they had limited experiences of caring for people who were substance misusing and this they felt had an impact upon what they gained from the module;

'I struggled as a lot of the module asked us to draw on experiences and I didn't have much. So I needed practical too, to gain confidence.'(P3)

Or,

'In order to improve the module ... I think it would have been good to get experience. But you can't get someone experience really!'(P3)

And,

'To gain greater knowledge it would be good to have a placement alongside to facilitate learning.'(P7)

Discussion points

Some of the areas for discussion later arising from this section were relating to the place of practical experience in learning, such as, is practical experience necessary to reinforce the learning? And can learning still occur when students have not physically experienced situations for themselves? Furthermore, even when attitudes have changed, do these translate into changes in practice? Is this measurable?

5.6 Module Delivery Method

Definition: Comments and Insights made by the students which directly related to the method of delivery, i.e. distance learning.

Codes: Flexibility of completion (DL F), Community of learning (DL C), Scope of learning (DL S), Gained researching/wider learning tools (DL R).

Summary of data:

Flexibility and scope of distance learning

The students' views regarding the distance learning method of delivery of the module were varied, with most preferring this method of delivery and recognising many benefits including, the flexibility of completing at convenient times, at their own pace and without the distraction of the classroom setting;

'being online was really good ... because it meant you could do it whenever you wanted. It was much more flexible. So for me when my husband was at work and the children at school ... and to do it at my own speed.'(P3)

'I personally feel I got more from it at home because I think you're easily distracted in the classroom.' (P3)

And,

'you could just go home and do it and, read it in your own time.'(P5); *'You got to explore and do slots or small snippets of work.'*(P6)

Conversely there were some students who found working from home equally as difficult due to distractions and used the university library instead as a place to complete their work;

'I found it quite hard to do any online stuff at home because of having a family and the distractions that go on ... I ended up coming into the library to do my work.'(P2)

There were also comments made relating to the difficulty of being physically isolated from each other all day to work;

'It was quite difficult to motivate myself at home studying alone.' (P10)

One participant further suggested that she had found it difficult to be looking at a computer screen all day.

In a positive light participants valued being able to revisit areas of learning when they were unsure, or at later dates when they perhaps came across the subjects in practice;

'I really enjoyed doing this online and the setup of it ... it worked really well and you could go back and look at things again if you didn't understand it or

you needed to read up on it again. All of the links and things are there for you to go back and look at whenever you want.' (P1)

And,

'online is really good because you can do it in your own time, at your own pace and anything you don't understand you can go through as many times as you want or need to. Not having to feel conscious that someone else is getting fed up with you.'(P3)

Additionally, students identified that they appreciated the scope of learning that the module delivery style offered, whereby they could research and explore different subjects and follow links that opened out the learning opportunities when compared to the classroom setting. They liked;

'Flexibility in self learning. You could take it as far as you wanted.'(P4)

'It was very much about you deciding what parts were going to be more useful to you and being efficient with your time.'(P4)

'I liked that you could follow whatever links you want to, online, that you wouldn't be able to do in the classroom.'(P5)

And,

'The fact that you could go where you wanted as an individual was really important.'(P6)

Wider research skills from delivery method.

Students noted that they felt this method of learning equipped them with wider researching skills and tools that they could then apply to other areas of learning;

'it's given me the tools to go and find out information if I don't know it. So in knowing where to look when I go online.'(P1)

'it teaches you a different way of doing things ... if I came across something I would be better prepared to deal with it and I would know where to look ... rather than just googling it. I have gained Independent learning skills.' (P6)

And,

'you're learning to do it yourself. So it helps with your research skills. So in a classroom, you might be given those links to go and have a look at yourself when you get home, but very few people do that. Whereas online, you're more likely to.' (P5)

Interestingly many of the students recognised and referred to their need to become adult learners and take responsibility for their learning;

'(We are) ...adult learners ... but I think you get out of it what you put in. That's one of the learning skills with a degree. It's up to you how much you take from it.' (P6)

And I have learnt, *'how to research properly and how to write a reasoned evidence-based argument concisely.'*(P6)

Reflecting on the difference between this experience of distance learning and classroom based learning, one student suggested;

'I think the learning isn't as deep in class as you haven't had to do this (research and critically form an opinion). I think when it's in the class. It's more of what you know, rather than what you've learnt because you fall back on what you feel you know and are not perhaps as confident with the new things that you've learned.' (P8)

Online community of learning

The students described throughout the interviews a sense of belonging to a community of learning, where they each mutually gave and received;

'it made you feel that that it was a module that you were taking part of. Part of the community rather than on your own and also that your questions were important.' (P1)

And,

'As a group we were supportive and respectful of each other.' (P8)

They also acknowledged that part of this sense of community came from the support provided by the tutor.

Deviant cases

Whilst all of the students, even those who were unable to work at home, acknowledged the benefits of distance learning with its scope and flexibility, almost all made comment that they would have liked some face to face contact as well; a blended learning approach. However, when prompted they all suggested this would be purely for discussion and not for the learning materials;

'I would have liked to have had lectures too, in-class to have an open discussion, because online, you can't really get into a debate.' (P2)

And,

'if you're having an open debate in the classroom and there's 30 of you in that room, 30 if you get involved with it, whereas I found that you may only get two or three people commenting on one status online.'(P2)

Furthermore, although there was a definite sense of community online, there was equally some frustration expressed regarding the slow speed at which some students

completed the work and posted on the discussion boards. Students recognised that with a small cohort this could potentially limit learning opportunities, though for this large cohort felt it did not;

'timing ... relies on others completing so you can read their posts. So it worked because we are a big cohort. I think our cohort was quite big and so there were quite a few who were in their already doing it.' (P2)

Discussion points

Points for discussion were raised pertaining to the question of whether the method of delivery is important in success of altering attitude. So in this research, was the learning deeper and more successful because of the use of a distance learning approach? If the approach to delivery was important, where did the learning take place? In the discussion boards? Or from the content sections? And why was this so?

In addition, was the perception of the students that they were able to bounce ideas off of each other dependant on the size of the cohort? Would it be as effective in a smaller cohort?

5.7 Summary of Phase Two

This chapter has presented the findings from the qualitative data produced from in-depth individual interviews with a selection of students following the module. The main categories under which the headings were presented were;

- Student Attitudes Toward Substance Misuse
- Student Practice Experiences
- Interaction with Peers
- Impact of Knowledge Gain

- Method of Module Delivery

The findings overall indicate that the students found the module beneficial in terms of not only improving their knowledge base of substance use in relation to effects and reasons for use, but also challenged their thinking and attitudes toward substance use and users. Furthermore they stated that they had also gained skills to give them confidence in practice when encountering women who were substance users.

In addition to the specific changes that the students noted in reference to drug use, they also commented on the type of delivery of the module. They stated that aspects of this approach enhanced the depth of their learning, such as distance learning delivery and the sense of community they felt learning alongside peers in this way. They stated that the 'learning skills' they had acquired were transferable to other areas of learning and practice.

5.8 Summary of Combined findings from Chapters 4 and 5.

Chapters 4 and 5 give a picture of the overall findings from the study for each of the three phases, however the aims and purpose of the study was to explore the effect of the educational intervention as a whole case; phases one, two and three were the products of this. To discuss the overall findings of the study in the context of the literature available and practice implications the findings have been drawn together to represent an overall picture (Chapter 6, Discussion of Findings). In a similar way to the quantitative element of the module being a before and after exploration, the qualitative aspects (VLE posts and interviews) can also be viewed this way. So for each, before and after the module, there was a range of data from different methods to represent and explore the students views, opinions and experiences. The findings of the VLE posts and the interviews were drawn into like categories, or themes based upon their content using the conceptual map (VLE posts) and framework matrix (interviews). These categories and higher order themes were then rechecked against the original data to confirm they were representative and formed the basis of the headings (or themes) to be used for the discussion chapter. The quantitative findings

were considered to be supportive of many of the emergent themes and so have been discussed in Chapter 6 as and when relevant.

The main themes that emerged from the review of the findings of the overall case study are detailed in Table 5.1.

Table 5.1 Themes emerging from combined data

Theme	Includes
Attitudes toward Substance Misuse	Personal Attitudes Attitudes seen in Practice
Knowledge of Substance Misuse	Experiential Knowledge – Practice and personal Theoretical Knowledge
Change	Reflection Theory-Practice Divide
Mode of Delivery	Method of Delivery Community of Learning – Reflection and Challenge

These themes form the basis of the next chapter; Chapter 6, Discussion of Findings. Chapter 6 draws together all of the findings of the study and discusses them in the context of previous studies and literature in the relevant areas to identify the new perspectives emerging from this study with some discussion of their implications for practice where relevant.

Chapter 6

Discussion of Findings

This chapter provides detailed discussion of the findings from the study presented in the previous chapters. It makes suggestions of where the findings are congruent or conflicting with previous research and theoretical concepts, and highlights the novel findings that emerged. This chapter assimilates the overall findings from the different aspects of the case that were explored, including phases one, two and three together. The examples used in this chapter represent a range of the participants views as outlined in chapters 4 and 5, however the individual students are not identified in this chapter and the 'case' is discussed as a whole.

The purpose of this study was to answer the research question; 'What place does drug and alcohol education have in relation to attitudes of student midwives toward pregnant drug users?' The main focus of the research was to explore, using case study, the role of an educational intervention (module) 'Substance Misusing Parents,' which I am module leader for. Within this case, a variety of issues or aims were considered; the attitudes of a group of student midwives toward substance use during pregnancy, measurement of these and an exploration of any effect the educational intervention had on altering attitude toward pregnant drug users.

The findings from the questionnaires used in phase one of the study demonstrated that there was a significant difference ($p < 0.05$) in the students' attitude toward substance misuse in pregnancy before and after the educational intervention (MCRS SM $p = 0.012$), but not their general empathy levels (JSPE-HP $p = 0.539$), or their attitude toward reduced fetal movements in pregnancy (MCRS FM $p = 0.646$) as discussed later in the chapter. Thus it is reasonable in part at least to attribute the noted changes before and after the module in relation to substance misuse attitude, to the undertaking of the module. It should be remembered however that attitude development and change is an extremely complex phenomenon, as discussed both in chapter 2 and in this chapter and as such simplistic cause and effect is not likely and will not be claimed to be so.

The findings of the other aspects researched including the VLE posts and interviews, were used to gain deeper insight into anything that may account for such change. The VLE posts and semi-structured interviews gave depth regarding what may have been different before and after the module and an indication of what had influenced this difference. Whilst there was a lot of overlap in what the students expressed before and after the module in relation to attitudes shown and practice and personal experiences, there was a definite change seen and expressed, which was also demonstrated by the questionnaires, mostly by way of reflection on new knowledge. There were also definitive comments made in relation to the mode of delivery of the intervention and the potential usefulness of this. Thus as described in the findings chapter summary, the focus of this chapter will be to discuss the main themes arising from the overall case in more detail;

1. Attitude and practice around substance misuse in pregnancy
2. Knowledge around substance misuse
3. Change
4. Mode of delivery

6.1 Attitude and practice around substance misuse in pregnancy

Throughout the study negative judgments and opinions were expressed regarding pregnant drug users by the students. This was verified by the findings of phase one where although the students' attitude mean scores toward substance misuse improved following the module, they were still significantly different (negatively so) compared with their attitudes toward pregnant women with reduced fetal movements both before and after the module ($p = 0.000$ before, $p = 0.009$ after). The comments they expressed about pregnant drug users ranged from an inability to understand the lifestyle choices of users, including in relation to parenting, to a dislike of the effects of drug use upon the user, their families and society. For example;

'I found it extremely hard not to be judgemental of their situation and found it deeply saddening watching a helpless baby have daily seizures, dislike being comforted and continuously have a high pitched cry.'

And when discussing a family members drug use;

'... I... know it has changed the person to become a liar and untrustworthy and I dread to think what it could lead to.'

Many of the students expressed finding it difficult to understand why women continued use during pregnancy, alluding to the fact that women had choice regarding whether to stop or not. These findings are aligned with those of Radcliffe (2010), Deville and Kopelman (1998) and McLaughlin and Long (1996), all of whom noted that pregnant drug users were subject to particular stigmatisation and also the UKDPC (2010b) who made similar remarks regarding parents who were substance misusers. Some of the participants described how they had found mothers' attitude toward their substance use difficult and that the mothers did not always comprehend the implications of their use;

'I have absolutely no right to judge how other people live, however I find it hard to accept that pregnant women are ignoring the health warnings that are widely broadcasted! Surely they must feel guilty?'

This is a concept that is also supported in literature whereby substance use is considered a moral, rather than health disorder by society (Radcliffe & Stevens, 2008). As such the general consensus is that those with this condition are responsible for it, it is self-inflicted (UKDPC, 2010a). Consequently there is a reluctance both on the part of society (and indeed health care professionals) and also drug users to engage with each other in support of the condition (Corrigan, 2000). The individual question responses to the MCRS SM support this view; question 2; *'Insurance should cover patients like this to the same degree that they cover patients with other conditions,'* received a negative mean response before and after the module which may indicate a view in line with that held by society regarding the culpability of drug users for their condition.

Livingston et al (2011, p40) highlight that due to this notion of self-inflicted condition, perceived as 'moral deficit', interventions designed to reduce stigma are likely to be adversely affected, which may explain why negative and stereotypical comments

about substance users were still present following the educational intervention and similarly noted in the findings of the MCRS (SM compared to FM before and after). Such judgments were however far fewer following the intervention and were usually expressed in relation to how the participants had reflected upon such views held prior to the module, demonstrating what they felt was a change in their perceptions.

It is considered that students have a range of pre-existing knowledge both from formal learning and life experience before they begin their studies (Walklin, 1990; Rogers, 2004). Students' prior educational and life experience will therefore affect the way they learn. Lovell (1984) suggests that the most important factor influencing adult learning and behaviour is what has already been learned and organised in conceptual structures; that is students are effected by their previous experiences and understanding and their 'subjective norms' (Ajzen, 2001). Before and after the module, students expressed value laden statements about pregnant substance misusers. These were negative in nature overall as highlighted. These views were often led by media, society and family influences, i.e. what the students had seen or experienced in the past, or their subjective 'norms';

'The ones that are doing the drugs are the ones who aren't really academic and really haven't any motivation to do anything in life. So you create a stereotyping in your head that the people who take drugs are people who just don't care about anything ... the media reinforce this.'

Some justified these by suggesting it was 'human nature' to stigmatise, or stereotype such individuals;

'I think you can't help when someone walks in that's heavily pregnant and they stink of smoke, there's that human instinct that kicks in and thinks, err you stink of smoke, or when you walk into a house with a newborn baby and they are smoking around the baby. It just makes you think, oh, God, they are smoking around that baby.'

These opinions expressed by the students were generally similar to those expressed by society (Room, 2005; Schomerus et al., 2011; Taplin & Mattick, 2011; Radcliffe,

2010). Selleck and Redding (1998) observed in their study that having personal experience, or experience through a family history of substance use explained only around 4% variance in knowledge of substance use and thus it is likely that the influence of media and society is the largest extraneous factor to consider. Which is in line with attitude formation theories such as CAB (Cognitive, affective, behavioural) (Maio & Haddock, 2015) and Theory of Planned Behaviour (TPB) (Ajzen, 2001), both of which link the formation of attitude with past experiences and exposures.

Demonstrating this effect, all students in the study recognised the effect that society and media had on the opinions toward users, particularly when viewing substance misusers in a negative manner;

'A lot of the education and media around substance misuse in pregnancy focuses on the negative effects it has which although it is true and does educate people of the effects, it often seems like a scare tactic.'

Students were articulate in recognising the negative influence for example of the media on views and how this creates 'stereotyping' following the module;

'The media reinforce negative stereotyping, with negative connotations which you associate with drugs.'

Interestingly however, none of the students made reference to the effect of society, or media upon their own view prior to the module, instead only making reference to its effects on other third parties: they didn't often use terms such as 'I' and where they did, they didn't identify if the view they were expressing related to themselves. This, despite the fact that they were clearly demonstrating such views. This was a particularly interesting concept as it seemed to suggest that the students in the study, were unable to transfer their observations of influence onto themselves and their behaviour and perhaps did not relate to such stereotyping in themselves. Goffman (1963), suggests that there is an initial unconscious element to forming judgment, which is not recognised until we are actively questioned, or in the case of the module directed to evaluate and consider it. This appeared to be what was represented in the students writing and critical 'thinking' through the VLE posts and thus may be an

important consideration in attitude change in practice. Following the module, there was a shift in this aspect with students referring to their own recognition of judgements before the module;

'Because I went into it (the module) being so judgemental with my views towards drug users. I came out of it a really different person.'

Following the module, most of the students were able to recognise some negative attitudes, or behaviours in themselves and reflect that this was not appropriate in practice;

'I was so annoyed with her that I judged her on her substance misuse rather than thinking, she really needs help. She's taking this for a reason.'

Many commented on negative attitudes being a 'generational thing.' Interestingly many students also used this term when discussing poor attitudes in practice displayed by mentors, before and after the module, indicating an alignment with what they expressed regarding the views of society. This association with age does not appear to be substantiated in the literature but was apparent before and after the module. Although following the module the students in part at least equated this with a lack of knowledge due to deficits in training;

'I think the older midwives have more of an opinion than the younger newly qualified midwives, but I think maybe they didn't have too much of the training when they trained.'

Many also made reference to a change in their own attitude from before the module, seeing that there had been a positive shift;

'before I took the module I was really judgemental towards substance misusers ... But doing this module I saw their side of the story really and find that I am far less judgemental.'

This was verified by the findings from phase one where there was a significant increase in mean scores for the MCRS for substance misuse. However again, the students did not express these observations of themselves and their attitudes at the start of the module; they could not at that stage recognise their own stereotyping and judgments in fitting with Goffman's (1963) observations of an unconscious forming of attitude initially. This also demonstrating the effect of the module on changing this aspect of self-awareness too.

One of the main areas that was specified in relation to what the students felt had changed for them was the dichotomy between legal and illegal drugs. Prior to and following the module the students discussed the general view that there was a difference in the way these were accepted. However, following the module many commented that they could see that this view had come from the normalising of drugs in our culture with some reflecting on the harms of both legal and illegal substances;

'I never really thought about people who smoked during pregnancy as substance misusing but obviously it is, I've just never considered it before; that's what society makes you think.'

This is in line with the society view that illegal drugs are more harmful and thus viewed more negatively (Room, 2005; Cunningham et al, 1994; Ahern, Stuber & Galea, 2007), however this notion arguably further perpetuates the stigmatisation of an already marginalised group and recent estimates suggest that the costs associated with legal drugs outweigh those that are illegal (Nazari & Raistrick, 2014).

Before the module many of the students views of women in practice were led by their mentors behaviours in practice and if they agreed or disagreed with these. With no other knowledge or experience to draw on for some, the students may have felt uncomfortable with their mentors' views, but couldn't reconcile exactly why, or challenge them with alternative evidence. They also gave examples of what they deemed poor practice in terms of the midwife-mother relationship, where they mentioned for example carbon monoxide (CO) monitoring, reflecting on the dishonesty they had seen on both sides (mentors and mothers) and on how midwives sometimes spoke to or referred to women;

'One of the experiences I have had was a woman informing me during her booking that she no longer smokes, but on offering her carbon monoxide screening she then told me that she does smoke.'

And,

'My midwife ... asked her if she knew why it was 'bad' and that she needed to stop. She began to treat this normal woman like a naughty child, and for the rest of the booking seemed dismissive of her ... she had simply scorned her like a child and belittled her.'

These findings were similar to previous studies in this field (Deville & Kopelman, 1998; Klee et al 2002; Neale et al, 2008). These experiences had affected not only the students views of the mentors but also of the women, and the views the students were expressing appeared to have begun to mirror those of their mentors in practice;

'I felt gullible for believing the woman, it taught me that although most women feel able to be open some women when they are scared may give you the information they think you want to hear.'

Additionally, they described other personal examples and stories of substance misusing women in practice being deceitful, dangerous or manipulative; these exacerbating their negative views.

Some of the students seemed to be basing their negativity upon concerns or fear of substance users, emulating what may have been modelled or suggested in practice as indicated by research (McLaughlin & Long, 1996; Wright & Baril, 2011; Ford, 2011), or the views of society (AIVL, 2011). Conversely it is reported that the actual proportion (and therefore numbers) of substance users who do represent such 'danger' is minimal (AIVL, 2011) and therefore such views are unjustified. When considering this concept in relation to attitude formation amongst the students, Castelli and Carraro's (2011) observations of what is in effect amplified response to negative experiences when compared to positive ones, may offer some explanation. Following the module however there seemed a definite shift in this aspect. Whilst the students still recounted the negative experiences, they had used the module to reflect on the experiences and begun to gain some understanding of why these

events may have occurred as they did. The students following the module talked about the reasons for use and the value of service user input into the module in relation to giving them insight and some understanding of the lives of users. Reflecting specifically on an input called 'Swansea Love Story' (Swansea Love Story, 2009), the students commented;

'The Swansea love story was heart breaking and really moving. I found that really, really eye opening and useful ... The reasons behind the drug use were really powerful. And it's such a vicious circle, they just can't get out of.'

There was a tangible shift in empathy toward users seen. This finding concurs with Livingston et al., (2011) systematic review of interventions, which concluded that an effective strategy to reduce social stigma was communicating stories of those with substance use disorders. Livingston et al., (2011), suggest however that these 'stories' should be positive in nature, which was not always the case in this module delivery, where positive and negative accounts both appeared to be of value to the students' understanding. This notion of understanding the position of substance users as having a role in attitude change, appears to be grounded in attitude change theory (specifically attributional approach, Cacioppo, Petty & Crites, 1994) which suggests that attitude is formed in part by a person's inferences regarding the cause of the behaviour. As such interventions designed to offer service user perspectives, as was the case in this module, provide an opportunity at least to 'demystify' perceptions of the motivation and influences behind drug use and in doing so potentially help to alleviate fears.

When considering the findings from the JSPE-HP, whilst the overall general empathy levels seen before and after the module did not significantly change, two of the individual items in the scale did show significant positive changes in empathy. Question 7; *'Midwives should try to think like their patients in order to render better care,'* ($p = 0.017$) and Question 16; *'Because people are different, it is difficult to see things from patients' perspectives'* ($p = 0.050$). Both of these questions are indicative of understanding the situation from the patient's perspective and so may be

reflective of the change in understanding of drug user's position and predicament that was expressed in interviews.

A change in empathy was verified by the MCRS SM findings which demonstrated significantly greater empathy toward substance misusers following the module as indicated earlier. Similarly to the JSPE individual item scores, question 4 on the MCRS SM; '*I feel especially compassionate toward patients like this*' although did not show a significant change from before to after the module, did go from being a negative scoring question (mean < 4), to a positive scoring question (mean > 4) following the module and so may be representative of the students improved understanding of the circumstances of substance users. Equally, there was empathy shown before the module toward the situation of users by a few in their VLE posts, however, this was limited in depth in terms of what they wrote in their posts, but following the module this aspect was frequently expressed.

Most of the students felt that there was a lack of written guidance to help in practice, this was both at a local and national level. Prior to the module they only discussed one specific national guideline; Care of the women with complex social factors (NICE, 2010) and they gave no real opinion of it. Following the module however, they mentioned this and other national guidance designed to support care in practice. Whilst they did not always feel this guidance was useful, they were able to discuss its merits in the context of care, or potential care, demonstrating a greater understanding of both care planning and also policy making.

Prior to the module none of the students made reference to local Trust guidelines at all, although this may not mean they were not aware of them. Part of the module is around local and national guidance and critically appraising these and thus it was not a surprise that many of the students were able to discuss guidance in the interviews following the module. The students' comments in interview suggested that guidance was lacking in many Trusts, or was not detailed and specific enough and this they felt rendered it unhelpful. Many of them commented that this activity in the module was useful as it gave them an opportunity to see what guidance was available in other Trusts and source guidance they had not previously known existed;

'The module was good to be able to share guidelines where some trusts were lacking them.'

This notion of lacking guidance may be representative of what Livingston et al. (2011) refer to as structural stigma, whereby the rules, policies, procedures and thus guidance from organisations restrict the rights and opportunities of the stigmatised groups (p40); or the organisational culture and customs. The implications for practice of this are vast and beyond the scope of this study, however it is clear from this study that strong guidance is needed to provide adequate and clear support for midwives when needed and this needs to be specific to the needs of individuals. A systematic review by Livingston et al (2011) suggests that institutions, such as the National Health Service (NHS) could address this issue with suitable guidance, contact-based training and education programmes and that these would improve the confidence that professionals feel in dealing with stigmatised groups including substance users. Mirroring the findings of a practice based study by Lee, Haynes & Garrod, (2010) before and after the module, students suggested the need for suitable guidance and training for all midwives in practice.

It was interesting that following the module all of the students were able to recognise the challenges faced in practice, whereas prior to the module many were not able to do so. They made reference to a lack of guidance, as suggested, but also to other organisational constraints such as time, workload pressures and financial cutbacks all of which they felt impacted upon the standard of care that was provided and all of which raise implications for changes needed in practice;

'Time demands are too great. You are attending a discharge planning meeting for women, you may be met twice. I don't think that's appropriate. You're there to give a judgement on how that woman has interacted with that baby over the last couple of hours. You may have come on shift three hours ago and have spent two minutes with her. How can you make that judgement? Yet it's so important for her and can be life changing.'

This mirrors the findings of previous studies looking at the challenges in care in the area of substance use (Lee, Haynes & Garrod, 2010; Jenkins, 2013). Of note was that the students even felt this to be the case where there were specialist substance misuse specialists employed, which is contrary to some previous research (Leggate, 2008);

'She was being seen by our drug and alcohol midwife, but it didn't seem like she (the midwife) had a lot of help, there just wasn't a proper plan in place or anything.'

And,

'we have a specialist midwife but she's too busy.'

Leggate (2008) suggests that where there are specialists in post, such as substance misuse midwives, women substance users feel that the care they receive is improved. Conversely, the findings of this study and some others, such as Rassool (2009), indicate that whilst women may feel better, non-specialist midwives in general feel less confident to provide care, instead deferring to the specialist; in effect, de-skilling themselves. Rassool and Rawaf (2007), suggests that this may be due to the education that is delivered to professionals which reinforces the view that dealing with substance misuse is the job of a specialist. Another possibility is that it is reflective again of the organisational culture and customs in practice and is indicative of the general apathy observed in a 'pushed to the limits' NHS (Campbell, 2013). In terms of the implications for midwifery education, this raises concern regarding the extent to which students' exposure to culture, custom and practice impacts upon their own behaviours and attitudes in care giving. Perhaps, beyond the remit of this study again, however, when we consider that midwifery students spend over half of their training under the direct supervision of their mentors in the NHS environment, it certainly needs to be considered. Whilst it may not have been the intention of the study, the findings do appear to be suggestive of some alignment between the views expressed by participants prior to the module and those represented in studies of midwives in practice, indicating some correlation may exist between the two.

There were some examples of good attitude displayed in practice toward substance misusing women, confirming the findings for example of Jenkins (2013), however these were very much in the minority. This did not change before and after the module, however, this was not a surprise given that for many of the students there was no further midwifery placements during the module, therefore what they reported was often representative of examples before the module began. These positive attitudes however, were all attributed to better knowledge, either through role (for specialist substance misuse midwives), or experience (for other mentors), in line with previous research (Lee, Haynes & Garrod, 2010). When discussing spending time with a substance misuse specialist midwife, one student wrote;

'She opened my eyes into a world I didn't realise existed. ... We also visited women who were out the other side and over their addictions and onto second pregnancies and this was amazing to see.'

Before and after the module, students noted conversely, that there were poor examples of care and attitude represented in practice and all had witnessed this first hand, verifying the experiences reported by substance misusing women in previous research (Radcliffe & Stevens, 2008; Ahern, Stuber & Galea, 2007). They described the attitudes as affecting the care received by substance misusing women and recognised the unfairness of this and the detrimental impact upon women;

'they're (women) getting sub optimal care really and midwives are missing the signs and symptoms that could that could prevent things.'

Giving a specific example of where they had observed this one student relayed her experience in practice;

'I remember my mentor being totally and utterly gobsmacked that she had said that yes, she smoked weed ... she was totally and utterly shocked by it ... it was just horrific, like someone just told that they had killed her mother! There was a look of horror on her face in front of the woman.'

These sentiments were still present following the module, although for the most part students were defensive of their mentors and the poor examples they had seen, stating that they felt it was due to constraints as highlighted, or a lack of knowledge, which is also represented in previous research (Lee, Haynes & Garrod, 2010).

Again fitting with the observations of Livingston et al., (2011), many of the students felt this lack of knowledge was specifically in relation to reasons for use and the 'voice' of the service user;

'I think that midwives don't really understand the full picture of what's going on with that woman.'

These observations by the students are the same as those discussed by Lloyd (2010a) as being held by society which demonstrate a lack of understanding of the nature of addiction and indicate a need to improve knowledge.

Some students went on to reflect on this and, in a similar way to their own knowledge base prior to the module, made the observation that this meant the mentors (midwives) were drawing on their own personal experiences and that this meant the care was not necessarily evidence based;

'Whilst working with a variety of midwives, it has come to light that their own opinions and experiences of substance misuse (be it alcohol, class A drugs or smoking) often transpires when taking the women's history of substance misuse and subsequently giving them advice. You can see it through watching their body language and facial expressions.'

Similarly but taking it further following the module, one student commented;

'although these (personal experience views) are valid. They may not be accurate and may not be informed by evidence.'

This represents single-loop learning on the part of the midwives, where the emphasis is on 'techniques and making techniques more efficient' (Usher and Bryant: 1989 p87) as opposed to critically thinking about and exploring the situations faced in light of other variables and information, for example evidenced based information. The

findings of this study suggest that this may be what is happening and being modelled to varying degrees in practice; staff tend toward being 'task' or 'process' focussed, rather than looking at the underlying concepts underpinning the care;

'They carry out the care that they need to carry out according to guidelines in terms of making sure that mums monitored, babies monitored etc, but there's no emotional support and they become task orientated.'

Essentially the students equated poor knowledge with poor care;

'midwives shy away from trying to help because they don't know how to, or don't know what they're supposed to do.'

It was not until after the module that they were able to do this however, where their own knowledge base was greater and they could see which aspects were lacking, making changes to their own thought processes were necessary and making sense of the situations that they had witnessed. Argyris and Schon (1978) describe this as 'double-loop' learning, where individuals draw upon their 'learnt' or 'inbuilt' systems as a first line response (single-loop) but an alternative, or next level response (double-loop) is to question the governing variables themselves, to subject them to critical scrutiny. Furthermore, this represents the cognitive element of attitude formation described by Katz (1960), whereby learned behaviours (attitudes) are subject to cognitive scrutiny. This is what education and arguably this educational intervention has encouraged and facilitated. The students were able to consider critically the actions they had seen in practice, in light of their new learning, to challenge their previous knowledge.

One aspect of negative attitude and the impact on care that the students described following the module was that of avoidance. They discussed examples of where they felt midwives were avoiding care in the area of substance misuse, both in relation to legal and illegal drugs. They felt this was often because the midwives lacked knowledge of what to do;

'Midwives don't talk about it unless a woman discloses. They seem reluctant.'

And,

'I know that the midwives I have been out with try to avoid it.'

These findings correlate with the literature in the area. Lloyd (2010a) proffering that one of the functions of stigmatisation is to identify and avoid potentially dangerous people, which is grounded in the work of Katz (1960) who suggested that attitudes serve an ego-defensive function. Furthermore, Goffman (1963 p24) suggests that the societal response to the stigmatised is avoidance of contact with each other as a way of dealing with the anticipated uncomfortableness. It is likely that given the view discussed earlier regarding fear and threat perceived by substance users that a part of this avoidance was related to similar fear on the part of midwives in practice, although the students did not explicitly express this as the reason and so it cannot be confirmed.

Prior to the module, almost all of the students had had a negative practice example, and poor practice modelled. Many acknowledged however that this was wrong and care should not be this way;

'Recently I went to a case conference with my mentor for a heroin addict and listened to the negative comments from the people involved and I felt this was wrong.'

Whilst, there were some good examples of practice, these were overshadowed by the poor practice as highlighted. This situation emulates the findings of studies exploring women's experiences of maternity services, whereby there were some good examples of individual care, however the overwhelming situation reported was fuelled by negative care (Leggate, 2008; Radcliffe, 2010). This study did not explore individuals' responses as it was the entire 'case' that was explored, however, it could have been that those with the higher pre module scores in the MCRS were the same students who expressed positive examples in practice, in a similar way to Livingston et al (2011) the suggestion was that positive examples of substance users are associated with more positive attitudes in professionals. It was beyond the remit of this study due to the way the data was collected and anonymised, however it would have been really interesting to have matched the students who gave positive

examples of practice with their scores in the MCRS (SM) tests to see if there was any correlation.

In a similar way to the views expressed by the students of themselves and society prior to the module discussed previously, many participants felt that midwives (mentors) differentiated between illegal and legal drugs when practising and this affected their willingness to engage with women. The students felt that in light of their learning in the module, their mentors' reactions were often disproportionate, or blasé. Whilst evidence suggests this is often the societal view (Room, 2005; Ahern, Stuber & Galea, 2007), on a professional level there is a range of research to the contrary, which suggests the harms associated with, for example, alcohol and tobacco are at least as great (often greater) than illegal drugs such as cocaine and cannabis (McCambridge, McAlaney & Rowe, 2010). It is however suggestive that without the input of accurate evidence, individuals including health care professionals revert to their pre-existing views of substance use, fuelled by the societal and media 'normalisation' of legal drugs and as indicated earlier regarding the students prior perceptions, the legal versus illegal drugs dichotomy.

Furthermore, Ahern, Stuber & Galea (2007), suggest that the criminalisation of certain substances (for example heroin) deemed morally abhorrent, whilst serving some purpose, in fact exacerbates the associated stigma and marginalisation of people using them. This ultimately informs institutional and social processes designed to 'deal' with use and thus in a health care setting, it is likely that policies and guidelines are written (where present) to reflect such views. This may in part account for the students' observations of the lack of adequate guidance in practice around drug and alcohol use and also the behaviour and attitudes of staff toward legal and illegal substances. The students inferred that the midwives they worked with deemed legal drugs to be 'OK' and this was represented in the advice they gave;

'I think a lot of guidance are for substance misuse (in general) and so when people look at the guidelines they think oh well, she is only a heavy smoker and it's not the same as injecting heroin. So they are reluctant then to do anything.'

As already highlighted, when midwifery students spend at least half of their three years of training in clinical placement, the influence of their mentors and the environment they work in upon their learning cannot be underestimated. Ramirez-Cacho et al (2007) make a similar observation of medical students in their research stating that; 'Medical students are taught compassion and empathy in classrooms but may see a different approach in the clinical setting.' (p 86.e1). This aligns with attitude formation theory discussed by Maio and Haddock (2015) which suggests that the beliefs underpinning our attitudes are formed by direct observation, acceptance of 'norms' and making sense of these in the context of prior knowledge; without sufficient prior knowledge, the attitudes are only based upon observation and acceptance of the 'norm.'

6.2 Knowledge of Substance Misuse in practice

In general students felt that before and after the module, knowledge of substance misuse was lacking in practice and hence attitudes were seemingly unfair and often judgmental as indicated. This is consistent with the views of midwives in practice (Lee, Haynes & Garrod, 2010). This included reference to the differences seen in attitude toward legal versus illegal drugs as stated. Before the module however, the students had very little to compare what they were seeing to; they could identify that it was 'wrong', but could not give a critical discussion using evidence to pinpoint why, or to offer alternatives. One aspect which emerged from the study findings was related to knowledge and how this affected attitudes and practice, which is what will be discussed in this section.

At the start of the module, the discussions the students presented, despite being directed to write about their experience and attitude, were representative of their knowledge and experiences. Attitudes were discussed but this was always in the context of either an experiential example or their knowledge base and in summing up what they gained from the module, they again made the connection between attitude and knowledge;

'The knowledge gain has shifted attitude.'

And,

'(my) Attitude has changed because I know more.'

So in effect they appeared to equate attitude with knowledge. This is concurrent with the work of Katz (1960) who proposed that attitude serves a knowledge function, such that attitudes are formed in the process of managing knowledge. Interestingly following the module some students expressed that it was not their attitudes that had changed, but their knowledge;

'What changed was not attitude, but knowledge of how to care for women.'

Throughout the VLE posts the students described knowledge coming from reflection in practice, rather than reflection based upon the theoretical knowledge they had; i.e. the practice event had sparked reflection and provided new knowledge which helped them to make sense of their preconceived ideas. Many of their statements began, *'I have noticed ...', 'I have seen ...', 'some midwives have ...', 'in practice ...'* and so on. Thus most of the views were from experiential knowledge not evaluation of literary, or theoretical evidence base. They had formed their views based upon what they had experienced, not upon what they knew or had necessarily learnt from a theoretical perspective. This is supported in literature whereby we create new beliefs based upon what we already know and make sense of this in the context of observations and acceptance of 'norms' (Maio & Haddock, 2015; Eagly & Chaiken, 1993). This observation may have been because the students had not previously had any theoretical knowledge regarding substance use in pregnancy; however the consequence of this then is that their views were not necessarily evidence based, or accurate. In fact, following the module, the participants recognised the limitations of this aspect themselves in evaluating the material in each-others posts;

'everybody works in a different area and people see things from different perspectives when they are writing their posts. They're writing it from their thoughts and feelings.'

A common observation of the VLE posts was that depth of discussion and evidence base was lacking, both in relation to challenges in practice, of guidance, of discussion ability and so on. The students appeared to lack the knowledge to form an evidence based view and thus argument. Views and opinions expressed in a critical evidence driven way were scanty and limited in depth before the module; so as highlighted previously, the students were for example able to indicate that what they had seen in practice was inadequate, however, they could not offer any alternative view, or suggestion, or discuss why it was not adequate. This observation may be based in their inadequate theoretical knowledge prior to beginning the module, alternatively, it may actually be indicative of them expressing the views that they felt they were supposed to as a result of undertaking an academic assessment and presenting their views to peers. Considering the theory of behaviour intention (Ajzen, 2001) whereby it is suggested that behaviour is influenced in part by underlying attitude, but also by subjective norms and the relative perceived importance of these, it is entirely possible that what the students expressed at the start of the module was not their true attitudes but what they felt it was permissible to present, or express as their attitudes to the rest of the learning community. Given that similar views were presented by almost all of the 40 participants using a range of different rationales for them, it is likely that overall a picture of the students' pre intervention attitudes and experiences was reliably ascertained however.

Conversely, some students did demonstrate knowledge that related to theory, or the ability to make sense of practice in light of theory before the module, however these students were very much in the minority. Those that did try to reflect in this manner appeared hesitant and unsure; they seemed to lack confidence in their knowledge, for example;

'it has to be thought about what has made them turn to drugs and why are they abusing them and also is it that easy to withdraw and stay off the drugs just because they are pregnant? What about women who are on anti-anxiety, sleeping or depression medications. ... I suppose the way that is seen is one set is legal and one set is illegal ...'

Following the module however this was not the case and all of the students were able to discuss examples of practice in their discussions, where they had reflected in light of the new knowledge and evidence base they had;

'with knowledge and training you are more empathetic to them and more aware of the underlying needs. You're not just like, what are they doing smoking a joint? But you're more intriguingly think why are they doing that? You're thinking about it rather than just saying that's wrong.'

This fits with self-persuasion attitude change theory (Cacioppo, Petty & Crites, 1994) where the suggestion is that attitude change comes not from the new knowledge per se, but from the cognitive processing of this and the new ideas and arguments which this process generates. This is what the education delivered as part of this research was able to facilitate. This meant that following the module, their confidence with the subject had improved;

'I'm more confident with asking if I do get a yes answer.'

And,

'... I've grown in confidence.'

This was also supported by the individual item mean scores for question 9 of the MCRS SM: *'I can usually find something that helps patients like this feel better.'* Whilst there was not a significant change in this mean score pre and post module, there was a positive increase in the mean from scoring negatively (below 4), to positive (above 4), suggesting that overall students felt unable to help before the module, but following the module they felt more able to do so. One of the reasons for this may have been that their confidence had improved. Of course this confidence may not translate into clinical competence, although Petty and Cacioppo (1986) suggest that by scrutinising the relative strengths and weaknesses of an argument, which the new knowledge and module process will have facilitated in this study, the resultant attitude is likely to be 'persistent, resistant to counter-persuasion and more predicative of behaviour' (p266).

Furthermore, the extent of the new knowledge and skills gained appeared to extend further than the remit of the module. Many drew parallels between substance misusers and other stigmatised groups and used the knowledge gained in this module to reflect on care for these other groups too for example those with obesity, domestic abuse, or mental health problems;

'like around domestic abuse, mental health, anything that there's a stigma around. It's made me realise that if you don't ask the question, then you aren't going to be able to find out and help the family.'

Although some students expressed a view regarding the complexity of why people used, this was often unsure and hesitant and lacking in passion and real insight during the VLE posts prior to the module. Whereas many of the students following the module expressed greater empathy toward users through enhanced understanding of the reasons for their use, and highlighted this as a particularly fundamental aspect of their learning that had changed. As already noted this was verified by the individual item mean score changes for the questions 7: *'Midwives should try to think like their patients in order to render better care,'* ($p = 0.017$) and Question 16: *'Because people are different, it is difficult to see things from patients' perspectives'* ($p = 0.050$) on the JSPE where these two items showed an increased score and thus regard.

Again, the participants referred to the service user input in the module and how much they had gained from this aspect. This approach of service user input, experience and users' stories to provide insight is recognised by Albright et al (2012) as being beneficial to students comfort when working with this group in practice and so this finding seems to offer promise for the transfer into practice. Furthermore, as indicated earlier, in terms of attitude change theory (attributional approach, Cacioppo, Petty & Crites, 1994), understanding the cause of the behaviour may have a positive effect on attitude.

Following on from this notion of understanding and exposure to service users, a study by Ramirez-Cacho et al (2007), concluded that medical students who had experience in a specialist prenatal clinic for women with drinking problems, showed an increased

awareness of the complexities faced, improved their empathy toward the women and consequently improved their confidence in talking to the women about their drinking. Similarly, Albright et al (2012), concluded the same in their study of medical students attending a rehabilitation residence for pregnant women with substance use disorders. Despite the fact that the students were not on placements in 'clinics' or exposed physically to substance using women during the module, the 'virtual' exposure through users' stories and peers experiences appeared to provide a simulated version of this experience which the students could learn from, which adds to previous research.

Prior to the module, many students expressed an expectation of learning for practice from the module, arguably indicating that they lacked confidence and knowledge and needed or wanted to gain more. Whereas following the module students felt that the knowledge they had gained would enable them to practice in a more effective way. They specifically referred to the areas of motivational interviewing, drugs and their effects, guidance and recognition of drug use as being practical skills that they could use in their own practice.

This was pertinent given that many of the students had reported being previously unaware of any guidance in the area, or strategies to manage substance users. What the students described here was a bridge of the theory-practice divide, discussed in Section 6.3. The new theoretical knowledge they had acquired had helped them to make sense of and learn from past practice;

'The module reaffirmed what I knew to be so from practice.'

They had often already identified that what they were seeing was not right, however, they lacked the knowledge to amend and address these deficits at the start of the module. Following the module however they appeared to flip this and not only discussed making sense of practice in light of the theoretical knowledge they had gained, but furthermore discussed the theoretical knowledge they had gained and how this would equip them for practice;

'The theoretical knowledge helped me to know what to expect in practice.'

Even though the students showed a significant change in regard for substance misuse in pregnancy (through the MCRS) before and after the module and they described this shift personally, like many of their colleagues in practice, this may not translate into their behaviour in the clinical setting. One student made reference to this fear in interview when discussing how useful the new skills she had obtained may be;

'motivational interviewing and brief interventions ... (were) really good. But I think I would feel really uncomfortable if I had to ask a woman any of those questions. I think because I've not had to experience it.'

Concurring with this point, Rasool and Rawaf (2008) suggests in relation to substance misuse education that what is important is not only the skills, or knowledge acquisition, or even the change in attitude, but the *'transfer of learning in(to) clinical practice for the delivery of quality care to those with substance misuse problems'* (p291). In the clinical setting, studies evaluating confidence and skills acquisition following substance use education indicate that these aspects *are* transferred into practice (Perry, 1999; Gerace et al, 1995), for example resulting in more screening taking place and an increased confidence in practice expressed. Furthermore, Petty and Cacioppo (1986) suggest that when considering attitude change as a predictor of behaviour, an individual's ability to engage with the message is of importance and so in the case of this study the fact that the intervention is designed with a strong focus on student engagement is positive. This transference of behaviour into practice, was of course not explored in this study though and so cannot be confirmed or refuted, however, it would make an interesting follow up study.

Additionally, Stuart (2007), suggests that it is important that the student is able to integrate what they have learnt in the university with what they see and do in practice. The design of this module however, with its practice based reflection approach may have been key to the students feeling a sense of confidence related to aspects of practice in this area as highlighted before and so whilst the application of their learning in practice has not been assessed, it is likely as indicated by Perry (1999), Gerace et al (1995) and Petty and Cacioppo (1986), that at least some of what they have learnt will have been integrated into practice. This is congruent with a study by Applin et al (2011), where it was found that although there was no difference in the entry-to-practice competence, graduate nurses who had undertaken a

programme which used problem-based learning (PBL), in contrast to their counterparts who had not been taught using PBL, identified this approach as instrumental in their preparation for practice.

6.3 Change

The MCRS scores for substance misuse (SM) attitude showed a significant change before and after the module ($p = 0.012$), but the students' scores for general empathy (JSPE-HP) were consistent before and after ($p = 0.539$). In fact when compared to other studies using this same scale ((Boyle et al., 2010) where the mean female score was 109.78), the level of empathy shown by the students in this study prior to the module (Mean 113.75) was greater. Similarly, when compared to Boyle et al (2010), measuring regard toward substance misusers, the pre module scores in this study were again higher (Boyle et al., 2010 mean MCRS SM score 46.37, compared with 50.39 in this study pre module). Arguably, it could be suggested that this renders the findings of this study as more robust; the students already appeared to be an empathetic group, both in general and toward substance users and so relatively speaking, such positive changes may be less expected in this study. However, given that this is a different study to those carried out before, caution needs to be taken in making such claims. It does highlight the potential however for further study looking at different professional groups undertaking educational intervention to understand if the changes seen in this study are linked to the type of student, or profession.

Similarly, the fact that participants in this study all chose to undertake the module, as opposed to one looking at antenatal and newborn screening, may suggest that they had a predisposed empathy toward substance use and this in turn may have affected the degree of empathy change seen. It would be interesting to explore this supposition by carrying out the questionnaires on the students from the same cohort, who chose to undertake the antenatal screening module. Interestingly, a study by Anderson et al., (2004) which looked at the effectiveness of education and support for GPs in screening and brief interventions for alcohol use, found that rates of screening and interventions only increased in those who already felt secure and committed to working with the client group prior to the intervention. Whilst this was

a completely different study and looks at a different aspect of behaviour, it does suggest that prior understanding and attitude may have an extraneous effect on findings.

There was a definite change in attitude, or opinion, expressed by many of the students as a result of what they described as a range of things including exposure in practice (before and after the module) and new knowledge gained (after the module). What was overtly apparent however, was that all of the students interviewed following the module described a journey of self-reflection, or discovery and recognised a shift in their views, or attitudes toward substance misuse, which was conferred by the MCRS SM findings;

'I've changed as a person. I've grown in confidence as well and as a midwife ... that's what changed because I didn't realise how much judgement around substance misuse issues can affect women.'

And,

'There was a journey of knowledge that expanded towards the end (of the module).'

They all reflected on the knowledge they had gained, the way in which they had been able to make sense of practice experiences (usually negative) and had been challenged in their thinking through the process of undertaking the module. It appeared from what the students discussed that this was aligned with the process of attitude change known as cognitive dissonance theory (CDT) (Festinger, 1957). CDT refers to a process whereby individuals become aware of inconsistent beliefs, or anomalies which they are then motivated to address. It is likely that the process of undertaking the module and the way in which students were directed to think, reflect and challenge both practice and theory created such inconsistent beliefs and as a result changes in attitude. The module had facilitated them to make sense of their views, opinions and experiences of drug use;

'(I was) able to reflect on a 'horrible' experience in practice in the module ... I treated this module very much about reflecting upon the scenario that I had

encountered because I think it was so problematic for me that I needed to make sense of it.'

The educational intervention (module) provided a bridge between theory and practice, facilitated by the vast array of activities and interactions that essentially directed individuals to reflect on practice and challenge their own perceptions;

'It certainly made me think a lot more than just, "oh, that was an interesting topic." It really challenged my views and thoughts.'

What the students described before the module was akin to reflection-in-action and following the module reflection-on-action, as described by Schon (1987). Reflection-in-action being what occurs at the time of the experience, or interaction, involving analysis of observations. Reflection-in-action tends therefore to be quite intuitive (Smith, 2011) as was evident and expressed by the students in their VLE posts. They had begun to reflect in practice, on an intuitive level, however this was not necessarily evidence based, or linked to the theory as noted previously.

Reflection-on-action on the other hand refers to stepping back from the situation, sometime after it has occurred (Schon, 1987). Reflection-on-action requires a time commitment, which in practice is often a challenge, however the module allowed and facilitated this type of learning;

'It allowed you to look back at the things you'd done in practice and relate them to the theory.'

This correlates with the observations of Donaghy and Morss (2000), who discuss the place of reflection in practice and suggest that; *'Routine treatments, based on implicit theories, may have the advantage of being easy to operate in practice ... However, they may be based on assumptions, ideas and beliefs regarding practice that have gone unchallenged and as such, demonstrate a lack of clinical competence ... There is a need to make professional and personal knowledge accessible for reflection, testing and dissemination.'* (p7)

Through the activities and discussion boards in the module, unlike Dewey's, Lewin's or Kolb's learning cycle, where reflection primarily take place based on mistakes, the

students were enabled to learn by simply reflecting critically upon each-others observations, experiences and in the absence of these, the theoretical concepts that the learning introduced. This gave students a repertoire of ideas, examples and actions that they could draw upon; a concept Donald Schon (1987), saw as central to reflective thought. It was interesting to note that the students reflected not only upon their own learning experiences but also those of others, often when their own were absent; in effect the students were able to 'borrow' the experiences of others and transpose themselves into them to an extent. This was perhaps an example of the students being able to engage with the messages presented as a way of stimulating thought and challenge as described as being important by Petty and Cacioppo (1986) in attitude change, despite these messages not being based on their own practice. At the start of the module, the lack of their own experiences with substance misusers was a worry of some of the students, who felt this hindered their knowledge and practice;

'I ... feel that I know very little about the effects of any type of drug and am looking forward to being able to have the information to help women and their families in the future.'

In contrast, the findings of the study after the module suggest that the students were able to learn from the experiences that others shared and that they found this to be a valuable asset of the module approach;

'we were able to interact with each other and find out about each other's experience.'

The students commented that although being challenged is not always a comfortable experience, in line with the literature discussed earlier around the social avoidance and roots of stigmatisation (Goffman, 1963; UKDPC, 2010a; Lloyd, 2010a; AIVL, 2011), it is a necessary and valuable one, which they also recognised as being important in forming their views and opinions. This challenge and development of the basis of their views had led overwhelmingly to a greater confidence as suggested earlier, which they hoped they would be able to take back to practice with them.

6.4 Mode of Educational Delivery

The design of the module, 'Substance Misusing Parents' was essentially a problem based learning approach. The students were directed throughout to reflect on practice or personal examples and by working together with peers (through peer review and feedback) actively learn together. The essence of the module design was very much along the principles that; *'Learning takes place through the active behaviour of the student: it is what he does that he learns, not what the teacher does.'* Tyler 1949 (in Biggs & Tang, 2011).

The findings suggest that the goals of problem-based learning were achieved in this delivery; developing effective reasoning skills, self-directed learning, increased motivation for learning and effective teamwork (Biggs & Tang, 2011). Some of which will be discussed in this section. The students reported that they recognised this collaborative approach to their learning in the module;

'there was learning from others, different Trusts and choices of substance and also sharing of others views.'

This is in line with Vygotsky's (1986) observation that meaning is generated through social interaction and that collaborative learning becomes internalised within the individual. Haythornthwaite and Andrews (2011) reiterate this point, suggesting that the dialogic exploration of learning, interpretation of old knowledge and creation of new, usually involves more than one person (p33). That is that learning is the effect of community (Rogoff, 1990).

Furthermore, Haythornthwaite and Andrew (2011) propose that learning involves a process of transformation, framing and re-framing (p43). Similarly, Biggs (1989) in Ramsden (2003) states that; *'A quantitative change in knowledge does not in itself change understanding. Rote learning scientific formulae may be one of the things scientists do, but it is not the way that scientists think.'* In the case of this research, this was apparent; knowledge giving was not the only aspect required by the students. The students thoughts, or learnt processing in relation to substance use needed to be reframed and this led to a change in outward actions; or at least the students perception of outward action as suggested. This concept supports the

findings of Gerace, Hughes & Spunt (1995), who found that an interactive and clinically orientated education programme had a positive effect on student nurses' clinical confidence. Furthermore, Cacioppo, Petty and Crites (1994) suggest that for material (educational) to affect attitudes the message needs to be delivered in a rhetorical, rather than a declarative way to encourage thought and response and this was the design and process of the module throughout. Much of the success in changing attitudes toward pregnant substance users in this module was attributed to the module's design and delivery which is what is outlined in this section.

The module delivered for this study was an e-learning (or distance learning module), delivered entirely online. The concept of e-learning itself is complex and there are views that suggest there is something distinctive and different about this type of learning (Haythornthwaite & Andrews, 2011). Having undertaken this study, I would have to agree; there was definitely something different about the way the students learnt compared to the conventional classroom. There was a depth and almost tangible development of academic skills through the course of the module that I have not witnessed in a classroom approach. A term coined by Phil Race (2007), I could 'feel the learning!' Whilst it was not the intended focus of the study, the type of delivery (as opposed to only the content/knowledge delivered) had a much greater impact than was anticipated at the start. Haythornthwaite and Andrews (2011 p 47) confirm my experience stating that *'e-learning constitutes more than a specific environment or site for learning ... something happens to the nature of learning.'*

The module was designed for a multi-disciplinary audience and whilst all students undertaking the module on this occasion were midwifery students, the design was for an interdisciplinary approach, or shared learning. This is in contrast to the findings of Holloway and Webster (2013), who found that most universities (83%) did not facilitate such an approach for delivery of alcohol and drug content. The benefits of shared learning were apparent in this study despite all being midwives in this delivery, the students commented on the benefits of learning from each other's experiences.

This concept is important in curriculum design within nursing and midwifery, where there is much debate around the merits of incorporating more opportunities for

shared and interdisciplinary learning (Sheets-Cook & Rogers, 2002; Public Health England, 2013). Pedagogically the aim of collaborative learning is to engage learners in active construction of knowledge through exploration of varying ideas in peer-peer dialogue (Miyake, 2007). The learners become co-constructors of the new knowledge (Haythornthwaite & Andrews, 2011), which is what the students described in this study.

The students further appreciated the fact that they could share resources that they were not aware of previously. This together with the peer feedback helped them to reflect on situations they had encountered in practice and make sense of these;

'It allowed me to not only have a different perspective put across, but also to have the references to go and find it and read about it myself from others.'

This sharing seemed to widen the student's knowledge base and gave them access to a range of views. They were then able to evaluate these as a part of forming and potentially altering their attitudes, as described by Petty and Cacioppo (1986) who assert that attitude change occurs following careful and considered thoughts regarding the merits of the information presented to support the view. Considering the thoughts, views and evidence base of their peer's contributions helped the students form their own. Exchange of resources along with the dialogic exchange and active (or passive) participation are suggested to provide the fabric of learning in an e-learning approach (Haythornthwaite & Andrews, 2011); they propose there is a shift to a co-learning pedagogy with e-learning.

The act of writing their thoughts down appeared to help the students to externalise them and thus together with their peers, this created a learning process whereby they could make sense of situations. This is supported by the work of Mason et al (2003) who state that an invaluable benefit of group work is that it facilitates lots of informal learning. Haythornthwaite and Andrews (2011) suggest that this internalisation, followed by externalisation becomes the fabric that is the learning community. Whilst the activities were not strictly completed in groups, the peer review process and requirement to read and review each other's contributions enabled each person to expand their learning by learning from each other in the

process and encounter different perspectives that were on occasion a challenge to their own understanding.

The findings of the study as suggested were that students found the peer feedback aspects really beneficial. This aspect facilitated the opportunity for challenge and to learn along the way and as such make changes to their work (and attitude) in line with peer and tutor feedback, ultimately culminating in greater learning.

One aspect in particular that was reported as a benefit of this was that it enabled the students to self-monitor their progress, identify their learning needs and equip them with the skills of recognising what quality work is and what it might look like, by reference to others work. They were able to see by example different approaches and ways of constructing their own writing.

Similarly, the feedback and responses they received from peers were equally as valuable in shaping not only their content and thoughts, but also their critical discussion skills and critical writing style;

'It made you ensure that it was balanced and well considered. It makes you step up your game a bit more because other people are going to be doing to your work, what you're doing to theirs, which is critiquing it.'

This concurs with Haythornthwaite and Andrews (2011), who note that with e-learning the fact that the learner is often isolated (geographically) from the others, they have to make an extra effort to contribute and engage with the learning community.

The students reported that they liked the flexibility that doing the module online afforded them whilst continuing with their other studies, family life and practice placement. It meant they could undertake the module at a time that suited them. Furthermore, one of the aspects the students found particularly helpful to their learning was that because the content was online, they could revisit it as many times as they wanted and could work through it at a pace that suited their learning style;

'online is really good because you can do it in your own time, at your own pace and anything you don't understand you can go through as many times as you

want or need to. Not having to feel conscious that someone else is getting fed up with you.'

This supports the work of Boyle et al (2010) who suggested that the most important aspect of university education was that it incorporated a variety of teaching and learning methods to suit a range of learners and their styles of learning. A definite advantage of a distance learning approach is this ability for the students to go at their own pace (Concannon, Flynn & Campbell, 2005; Childs et al, 2005).

In addition, the students reported that they enjoyed the fact that apart from the general direction of each section there was some flexibility in the scope of learning. This meant they could research whichever areas they felt were most beneficial to them and their practice and also could spend longer and look deeper into areas of particular interest;

'I liked that you could follow whatever links you want to, online, that you wouldn't be able to do in the classroom.'

The findings of this study concur with Holloway and Webster's (2013) that internet based study and case studies were very helpful methods of teaching alcohol and drug education.

The scope and extent of learning that was facilitated by the online environment was also reported to give wider researching skills that the students felt were transferable to other areas of learning. One student commented that they were 'adult learners' and as such this module design gave them the skills to self-learn;

'(we are) adult learners ... but I think you get out of it what you put in. That's one of the learning skills with a degree. It's up to you how much you take from it.'

This of course is aligned to the findings of the Burgess report (Universities UK, 2007), where the primary focus of higher education should be student learning and the thoughts of Burns (1995) who states that: *'By adulthood people are self-directing. This is the concept that lies at the heart of andragogy... andragogy is therefore student-centred, experience-based, problem-oriented and collaborative very much in*

the spirit of the humanist approach to learning and education... the whole educational activity turns on the student'.(p223)

Furthermore, in higher education the ultimate goal is to produce autonomous, critical thinkers; likewise this is the desired professional graduate entering into the NHS. In line with this what the students reported in this study was learning beyond the module, not in terms of content, but of critical thinking and writing skills. Within the module the students demonstrated these appraisal skills and were able to recognise the benefits and limitations of learning from each other's experiences and posts in regard to the evidence based value of these;

'It was good to learn from what other people wrote about their different experiences ... but you have to read with caution as it's a personal view, I think you've got to read that with caution because it's going to be subjective and usually its third hand.'

But beyond this they reflected upon their development of writing and appraising skills for lifelong learning;

'(I have learnt) how to research properly and how to write a reasoned evidence-based argument concisely.'

This fits with Rogers (2004) who suggests that a student centred approach to learning encourages not only deeper learning, but also teaches the student how to learn, standing them in good stead for the future.

On the whole the students appeared to enjoy the sense of belonging to an online community where they could share and learn from each other's experiences;

'it made you feel that that it was a module that you were taking part of. Part of the community rather than on your own and also that your questions were important.'

This student sense of community and belonging may also have been in part due the fact that they already knew each other and in addition knew me, as a tutor. Cacioppo, Petty & Crites (1994) found that where the source giver was trustworthy and deemed

knowledgeable the message was more likely to be received positively, thus there may have been an element of this both in the students perceptions of me and of each other. There were of course exceptions to this positivity, although even in these cases the students enjoyed the online learning, they just missed the face to face discussions.

There were additional anomalies and further disadvantages expressed, which related to concerns regarding the reliance on other members of the cohort to complete work in a timely fashion;

'timing ... relies on others completing so you can read their posts. So it worked because we are a big cohort. I think our cohort was quite big and so there were quite a few who were in their already doing it.'

This concept is in line with what Race (2007) refers to as 'passenger behaviour', or non-participation. Although, the students expressing these views did also comment that due to the numbers in the cohort, it had not posed too much of an issue on this occasion. Haythornthwaite and Andrews (2011) furthermore note that an advantage of e-learning and what they term 'parasitic' learners (p53) is that whilst some learners may contribute little, they still feed off the contributions of others and as such there is some engagement and consequential benefit.

The sense of community and belonging in the group was apparent by the openness of sharing that took place, in relation to a range of personal experiences that were shared by the students. A large element of this may have been due to the fact that the cohort of students all knew each other and had done so for at least two years before undertaking the module and thus there was an understanding of confidentiality and respect for one another. This is supported by Knowles (1990) who suggests that adults learn best in a psychologically comfortable environment where there is mutual trust and respect and of course also aligns with Cacioppo, Petty and Crites (1994) observations highlighted earlier. Furthermore Haythornthwaite and Andrews (2011 p116-117) offer the explanation that where there are strong ties between individuals in a learning community, the result is frequent engagement and exchange of both instrumental and emotional content, with a higher level of intimacy and self-disclosure and this seemed to be apparent in these findings.

6.5 Limitations of the Research and Findings

Chapter 3 identifies many of the limitations of the study's design, this section adds to this and furthermore gives other limitations of the study and the implications of these to its findings.

Variables

Within the findings there was mention of extraneous variables such as previous education and experiences which may have had some effect on both the students' attitudes toward drug users and also their experience of the module. These were however not specifically assessed, but may have influenced the findings. Participants were not specifically questioned about any prior courses they may have undertaken around substance misuse; they were asked about previous experience in phase one, however this was the extent of the questions and there was not opportunity to enquire as to the nature of these experiences including whether the experiences were positive or negative. Given the findings of Anderson et al. (2004) and Livingston et al. (2011) the nature of these experiences may have provided greater insight and may have had an impact on the individuals' pre-test scores. The pre and post-test design of phase one was open to other extraneous variables as discussed, this could be previous experiences or education, or furthermore the maturity of the students, on the premise that the older an individual, the greater the likelihood of more life experiences.

Self-selection and report

Furthermore, the fact that this was a self-selected module option may have influenced the findings of the study. There may have been greater motivation to work with and have empathy for substance misusers compared to other students who did not choose to undertake the module, which could have been explored by also asking the students who chose the alternative option module to complete the questionnaires for comparison. In addition, in the cohort who participated in the study, all of the students were female and so results may be different with males.

Given the findings of Boyle et al., (2010) who found females to have significantly higher mean empathy scores than males (with both JSPE-HP and MCRS), this would need to be considered when viewing the results of this study in the context of other cohorts with males in the group.

There may also be an element of 'learned effect' from testing and then retesting with the same questionnaire, as the students had already completed the questionnaire once. Again these aspects could have been limited by the use of a control group who did not undertake the module, however time and resource constraints did not allow for this to happen.

Additionally, as well as being a self-selected module the methods used to collect data were self-report. Self-report by human nature has a tendency to inflate responses that are socially acceptable and students may be reluctant to comment in a negative way about things in the evaluation of the education (Rasool & Rawaf, 2008), especially given I was their tutor (discussed below). In addition, the views expressed during interview around the attitude and behaviours in relation for example to practice were the perceptions of the students; they represent what the students felt and so their voice, however, this may or may not equate with the picture in clinical practice. Following on from this point, whilst there has been suggestion that what the students have expressed and phase one has measured as change in attitude may transfer into the clinical setting, because this aspect was not explored we cannot assume that this will be the case.

Furthermore there has been discussion regarding the depth of the learning that took place in the module, however this was not assessed, or measured. The students expressed learning experiences and this appeared to have depth, but caution needs to be taken in viewing the findings as a confirmation of the depth of learning that took place.

Known Researcher Impact

An inevitable limitation of interviews is that it is not possible to guarantee participants will truthfully answer questions (Rees, 2011). There is a great deal written about the researcher/researched relationship particularly within qualitative

research using methods such as interviews and focus groups. Much of the discussion is around whether or not the researcher is insider, or outsider in relation to the research topic, participants and so on and how this then impacts upon the responses of those being researched, or on the researcher's interpretation of the research findings. Anything which potentially influences the responses given by participants, meaning they may not represent their views can threaten the validity of the data and this of course should be acknowledged and where possible mitigated against. Furthermore, in this study the fact that I was the researcher, and the participants my students, could be argued to compound this risk, and presented important ethical considerations.

Brown (2010) highlights that teacher research is fundamentally unethical because using one's own students in research is highly likely to involve some form of coercion and that such research blurs the boundaries between teacher as teacher and teacher as researcher, and student as student and student as research participant. In their study, Regan, Baldwin and Peters (2012), further identified that often there is a lack of clarity by the researcher about what students must participate in as part of the programme of study, versus what they can choose to participate in and that the dual role of researcher/tutor can exacerbate this problem. Regan, Baldwin and Peters (2012) also however, highlight that although researching one's own students has the potential for ethical concerns, the important issue is to recognise this and ensure informed consent and that the students' educational needs are placed above those of the project.

Throughout this study, these ethical aspects were taken into consideration when planning the study as discussed in Chapter 3, in terms both of recruitment, consent and the timing of the interviews and second questionnaire. In addition, by acknowledging the dilemma I faced in being the researcher and tutor, I attempted to mitigate against this by employing strategies such as sharing my opinions on the data with my supervisors and asking them to review my interpretation. This was particularly to identify any overbearing biases I may have had in making sense of the data. I also made sure that from the outset I was conscious of my positionality in regard to the research and as such constantly challenged my own potential biases and expectations for the research outcomes. However, whilst attempts were made

to lessen the impact of my being known to the participants and the potential power relation I held, my being the primary researcher is a distinct limitation of this study.

Conversely, DiCicco-Bloom and Crabtree (2006) suggest that a pre-existing relationship between researcher and participants can be beneficial because there is already a rapport there ensuring interviewees are comfortable to truthfully express their attitudes. Young (2004), similarly suggests that researchers who do not share categories (so commonalities, such as gender, interest in the subject, occupation and so on) with their participants work find it more difficult to gain their participant's trust. Thus, although I was tutor for the module being studied and personal tutor to two of the interview participants, I did also share many commonalities with the participants, such as gender, being a midwife and having an interest in substance misuse and these aspects may have enhanced and resulted in more developed and honest responses from the participants.

Generalisability

Generalisations from the study have already been discussed in Chapter 3 along with the methodological limitations. The aim from the outset of this study design was not to be able to generalise, but to produce an in-depth insight into the case. However, the relatively small sample size and the use of self-reported instruments would limit statistical generalisation from the study. One of the main considerations in determining the sample size needed for a study, is so that the researcher can confidently generalise their results. Generally speaking a (statistical) power calculation is undertaken which gives a probability of being able to reject the null hypothesis. The power calculation is used to determine the sample size required to reliably give the effect required (for this research probability of 0.05 or greater). In this research however, a power calculation was not performed, because the purpose of the study as suggested was not to generalise from the findings.

The specific nature of the case, module content and delivery also restrict the generalisability of findings as discussed in Chapter 3. It is suggested that the concepts of transferability, or of analytical generalisations (Yin, 2014) are more relevant to the findings of this study.

When discussing the findings, these concepts were drawn upon, although this was at times problematic given the paucity of studies on attitude of undergraduate midwives towards substance misuse in pregnancy in the UK which made it difficult to make valid comparison during discussion. Robson (2011) suggests however that this can be lessened by similar findings from different data collection methods and that these can increase the confidence in the validity of the results; a benefit of a case study design that was apparent in this study. Furthermore Stake (1995 p7) notes that whilst case study is not chosen to produce generalisations, valid modification of generalisations can occur. As detailed in Chapter 3, there is likely to be elements of this research which are transferable to other situations and circumstances.

6.6 Chapter Summary

The overall findings of this study indicate that it is possible to bring about change in attitudes toward pregnant substance users through educational intervention. In this study attitudes quantifiably improved after the education when compared to beforehand.

The study indicated that mentors in practice had a part to play in forming the students attitudes toward substance users, which was highlighted by the fact that what the students expressed prior to the module appeared to mirror what research suggests is the situation in practice and hence what they may have observed and been exposed to. Following the educational intervention the students' views appeared to be much more secure and independent. The students appeared to attribute their changes in attitude to the educational intervention; both the content and the method of delivery and this was supported by the study's quantitative findings.

The findings indicate that this change has been facilitated through consideration and challenge of views, position, thoughts and reflections on practice and personal situations encountered. The dialogue with peers was particularly useful in this, as was the involvement of service users. The students described a journey of self-discovery through the module.

In terms of educational intervention to bring about change in attitudes, the study has highlighted the need for such education and that this education needs to entail an element of 'reality' for the students in order that they can relate to the concepts. Furthermore, education needs to provide opportunity for interaction with peers and to provide opportunity for challenge through reflection and a rhetorical rather than didactic teaching approach. The study has also highlighted the many benefits of e-learning as a pedagogical approach in this area.

This Chapter has also outlined some further limitations of the study (in addition to those outlined in Chapter 3). Chapter 7 is the final chapter, providing an overview of the findings and conclusions arising from the study and making suggestions of recommendations for change. There is also consideration of the areas for future research that have arisen from the research.

Chapter 7

Recommendations and Conclusion

The findings of this case study provide insight into the effect and place of a tailored education intervention in improving student midwives attitudes toward pregnant drug users. Through a combination of questionnaires, VLE post analysis and semi-structured interviews the effect of and exploration of the educational impact took place. Whilst there was overlap in what the students expressed before and after the module, in the VLE posts and interviews, there was a definite change in attitude expressed, which was confirmed by the questionnaires. Further to the anticipated outcomes relating to attitude change in relation to the module content, there were also definitive comments made pertaining to the mode of delivery of the educational intervention and the potential usefulness of this.

This chapter concludes the study, summarising the research process, findings and implications, making recommendations for practice and culminating in areas arising for future research. Summary of the main findings are outlined in turn, leading to specific recommendations both for education, clinical practice and wider society (7.1) and making explicit the implications and recommendations referred to in the previous chapter. The limitations of the study highlighted at the end of Chapter 6 should also be considered, because many of these provide the rationale for future research and study in the area, highlighted in 7.2. The chapter concludes with a personal reflection on the research journey (7.3).

7.1 Recommendations and Conclusions

Clinical practice

This study did not set out to explicitly assess the situation in practice regarding views, attitudes and behaviour toward substance users and therefore the recommendations

for clinical practice are limited. However, the students' accounts of practice were strong and provided some useful insights.

Training for Midwives

The study added to the body of knowledge regarding students' perceptions of care provision in the clinical setting relating to substance use and what they feel impacts upon this. The students particularly identified poor care provision in some instances and substandard, stereotypical views being expressed by other health care professionals and the adverse impact of this upon substance using women. In particular, the study suggests that organisational improvements to practice are required, especially in relation to policy, guidance and training and that these aspects may then help to improve attitudes of professionals to these vulnerable individuals.

Prior to the education delivery, the findings confirmed that the views and opinions held by student midwives were largely representative of those shown by health care professionals in previous studies. The students' views particularly resonated with those found to be held by midwives which raises questions in relation to the training of student midwives and in fact many health care professionals who spend a significant proportion of their training in the clinical setting. Whilst this study did not evaluate the impact of the practice setting views that the students were exposed to, the findings suggest that these had some impact on the way the students framed substance using pregnant women themselves.

Thus the influence of mentors in practice upon the students' behaviours in relation to drug using women is an area that came through the research findings. Whilst this aspect was not specifically measured and there were many other variables (as discussed in chapter 6) that also account for the students' attitudes and behaviours, the implications of this does raise some concern given the 50:50 split between theory and practice. This may also have implications for other areas of practice too. When mentors are practicing in an evidence based, non-judgmental way this does not pose any concern and in fact is likely to be beneficial to learning, however when they are not (which was often indicated in this research) the implications to development of students could be vast. Therefore, this study recommends further research into the impact of mentors attitudes and views on their mentees in practice.

A recommendation as part of addressing the structural and individual stigma that the students described as being present, is through the implementation of training for all midwives (with some suggestion that this should be extended to all who come into contact with users, including receptionists, etc.). The general consensus from the study was that training should be mandatory and yearly, in line with current safeguarding training requirements. Whilst this study did not ascertain what the specific nature of this training might entail, the recommendation is that it should definitely have focus in the areas of; recognition of drug use, reasons for drug use and practical strategies to support practice such as motivational interviewing techniques. All of these were aspects that the students identified as lacking in practice. Whilst demands in the NHS upon time and resources are currently quite pushed, there is still a requirement for midwives to undertake yearly update training in a variety of skills and thus this would be an ideal opportunity for the inclusion of content pertaining to drug and alcohol use; the effectiveness of such education would of course need to be assessed. Given the popularity of e-learning and the flexibility and educational benefits (from this study) that it offers it may be that development of an e-learning training package would be useful and effective for those in practice.

Improved Clinical guidance

The students in the study concurred with the findings of previous research that there was a need for strong clinical guidance in the area of drug use in pregnancy. This is needed to provide adequate and clear support for midwives when they encounter women in practice and furthermore for students whilst they are undertaking their training. Literature suggests that where suitable guidance, contact-based training and education programmes are available, the confidence that professionals feel in dealing with situations is improved (Livingston et al., 2011). The recommendation of this study is that this guidance should be detailed and specific to the various types of drugs used, including alcohol, rather than a 'blanket' drug use in pregnancy guideline, recognising that the effect and response should be proportionate to the drug used, its harms and so on, as per this study's findings. This guidance should also include reference to appropriate intervention and referral options. Where there were clear care pathways in place the students noted that this was particularly helpful in practice.

Education

This study demonstrated that specific substance misuse education can improve regard toward drug and alcohol users in pregnancy. Specifically, the research demonstrated that education improved the students' perceptions of confidence in this area, improved their theoretical knowledge and understanding and further equipped them with practical skills for clinical encounters. In the study attitudes quantifiably improved after the education compared with before. Confirming this, the students attributed their changed perceptions to the educational intervention; both the content and the method of delivery. Additionally, their reflections on the delivery method were unexpected, yet offer valuable suggestions for educational delivery design in the field of substance use.

Inclusion in Undergraduate Midwifery Curricula

The research findings suggest that not only is education around drug use successful in improving attitudes and confidence for practice, but that there is a need for education into alcohol and drug use in midwifery undergraduate curricula. With the lack of knowledge, confidence and judgmental attitudes reported in practice, a recommendation of this study is to ensure there is adequate training pre-qualification. The provision of drug and alcohol education should form a part of the NMC standards for pre-registration midwifery education, especially given the links as noted to many other areas of care and the wider impact of drug use (financial, health, social, economic and so on).

The design (or nature) of the education delivered in this study was successful in changing attitudes toward pregnant drug users and ideally the recommendation would be to adopt a similar approach across all undergraduate training programmes in the UK. However, with the theory-practice split already outlined there are already competing demands on time and space in curricula and so it may be a little too ambitious to have a whole 30 credit module designated to drug and alcohol education alone. Notwithstanding this, it is possible to incorporate drug and alcohol

education of the type delivered in this study within a broader module encompassing safeguarding, domestic abuse and mental health for example as I have designed for a new undergraduate midwifery curriculum within my academic institution.

Model of Content for Substance Misuse Education

The study findings provided insight into which aspects were important for drug and alcohol education designed to reduce stigma and as such provided recommendations for a model of content required. These include, in addition to knowledge of drugs and their effects:

- Challenge of societal norms and attitudes
- Reflection on experiences
- Service user Input

Challenge of societal norms and attitudes

The views demonstrated by students and identified as being present in practitioners were generally in line with the attitudes expressed by society prior to the module. One may expect a level of professionalism and a different expression of these views as behaviour toward users in practice, however the literature around attitude formation and the findings of the study indicate that this is in reality difficult to achieve. Attitude and consequential behaviour is deeply ingrained and yet education in this study was shown to have a significant impact upon the attitudes expressed. Therefore, it is recommended that education should encompass an aspect of challenge of societal norms and values and recognition of these.

An interesting aspect of this study which adds a unique element to the research base was the concept of students being able to identify with, or own the negative stereotypical views that they held. The study indicated in line with the work of Goffman (1963) that the identity demands placed on substance using pregnant women (and consequential stigmatisation) were initially unconscious by the students. The students did not appear to be able to identify with the views they were expressing until directly challenged to critically consider them. Worthy of further investigation is the suggestion that there may be a reluctance (or denial) in identifying

with stereotypical views in oneself until actively asked to reflect and consider them. If this is found to be the case, the implications for research in this field and for the findings of previous studies which have sought individuals to self-report/assess their attitudes is important. In terms of the role and format of education in addressing such behaviours, this may also be a crucial aspect to take into account. Thus, it is recommended that content which students can relate to themselves and which they are then directed to identify and challenge the stereotypes they may hold should be included.

Reflection on experiences

The primary driver for students reporting a change in their confidence and knowledge in this study was the opportunity to reflect, both on practice examples, or by challenge of their own views and opinions. The education appeared to bridge the gap between theory and practice and there was a journey of self-reflection, or discovery by the students. Interestingly, this bridging was achieved regardless of whether the theory, or the practice was undertaken first. Both the theory and the practice examples together were what increased the depth of learning and so it is this combination that appears to be required to maximise attitude change. Of note and particular importance for future education development, was that the experiences (both personal and professional) did not need to be the students' own experiences; second, or third hand accounts were similarly noted to be of value and this is likely to have merit when designing education with this purpose. Thus, the recommendation is for a problem based learning approach, using case studies, either anonymised from the students own practice or simulated examples and further, an approach which directly facilitates reflection of practice in light of theory and theory in light of practice. In this way theory and practice can be bridged.

Service User Input

The role of service user input and stories was an important aspect of this substance use education and unlike previous studies, this study suggested that there was benefit in both positive and negative service user experiences being expressed. A definite theme that arose was an improvement in the understanding of Users' lives, reasons for drug use and the complexity of these, before and after the module and

this was important in improving empathy. In a similar way to the students sharing of reflections and practice experiences, the students gained as much from second hand accounts as those directly from service users themselves and spoke equally highly of both. Therefore, the recommendation is that education content is designed to challenge individuals' thinking by including exposure to service user experiences in order to facilitate a 'demystifying' of the motivation and influences behind drug use.

It is important to note as outlined by Cacioppo, Petty and Crites (1994) however, that with all content included the message needs to be delivered in a rhetorical, rather than a declarative way to encourage thought, response and critical thinking. These were, as outlined key aspects in recognising, challenging and changing attitudes. This approach is therefore recommended to be deliberate in any delivery for this type of education.

Method of education delivery

In terms of the method, or pedagogical approach that education should take, the key aspects regarding the quality and depth of learning were the opportunity to reflect through sharing of experiences. This reflection was facilitated through a collaborative, or 'shared community' approach and this learning led to change in the students' empathy toward substance using women. Therefore it is a recommendation of this study that a similar approach is followed in education design of this type. This approach creates a sense of community and belonging amongst students, potentially improving satisfaction with learning. Moreover, it also provides an opportunity for interdisciplinary learning to take place which is of great importance in healthcare education and delivery.

Furthermore, this study adopted an e-learning approach, which may have added a further depth. As an educator with experience of delivering both e-learning and face to face education, I am aware of the differing nature of the two approaches. The engagement of students in e-learning, both with each other and with learning tasks is distinct. With this e-learning, there appeared to be a greater reliance on each other in terms of the learning, as opposed to a more didactic approach with greater reliance on tutor input and this represented a shift to a co-learning pedagogy.

With the rise of social media and norm of social interactions and communities online, it makes sense that e-learning forms a part of undergraduate curricula and in the area of drugs and alcohol education (as shown in this study and others), this approach is particularly successful and therefore the recommendation from this study would be to strongly consider the use of e-learning. The success of the e-learning aspect of this module also has potential wider implications for educational practice and module design in general given the depth of learning and wide range of skills for learning that were reported to be acquired by the students during this study, independent of subject.

For example, the delivery approach also helped develop critical writing and research skills amongst the students which they deemed to be important for life-long learning. This again offers suggestion of the potential benefits of this type of learning, not only in terms of the subject content but in the learning skills that the students are able to develop.

Whilst e-learning versus face to face delivery may be important, this aspect was not tested in the study however and so the differences in these two approaches would need to be tested before categorically suggesting that one approach has more 'value' than the other when designing education to improve attitudes toward drug users. Nonetheless, in the current austere working climate, the benefits as suggested in this study of an e-learning approach do seem to offer a more creative solution to education delivery; providing the cost saving benefits afforded by flexibility and freedom. This approach holds potential value, not just for education around drug use, but to other areas which are known to be subject to stigmatising attitudes such as obesity, mental health and domestic abuse. The students drew parallels between their learning and the challenge to their views and opinions in this module and these other areas. They recognised the transferability in terms of the knowledge and skills they gained. As such, the recommendation is that a similar model of education delivery used in this module is considered when designing any education to address and challenge stigmatising attitudes.

Society

Campaigns to address social stigmatisation

The study has further contributed to the existing body of knowledge by providing an insight into the attitudes and knowledge of student midwives in relation to substance misuse. The study has shown that as with a section of society and the findings of studies looking at other health care professionals attitudes, student midwives hold generally negative opinions and attitudes toward pregnant substance users prior to undertaking an educational intervention.

The findings of this study, like many others indicate the need for a shift in the views of society toward the management of drug users in order to address the social stigmatisation that exists. Furthermore, the study suggests that there may also be a degree of structural stigmatisation of drug users by large organisations such as the NHS and that there needs to be a culture shift in this practice too. A change in view and focus at Trust board level could impact upon policy making at management level and consequently filter down to individuals (and society). Similarly, a change in views in society, could also affect this process. Recommendations for ways of addressing aspects of practice that may improve attitudes amongst practitioners have already been made, however, there still needs to be work with society at large.

There has been a great deal of similar work of this nature for other marginalised groups such as Lesbian, Gay, Bi and Transsexuals and also in relation to other stigmatised conditions such as mental ill health. Findings of surveys looking at attitudes and treatment of these groups has shown an improvement overall (although some degree of stigmatisation is still apparent). An example reported by the findings of the 'Time to Change programme,' designed to improve attitudes toward mental illness suggest there had been a significant improvement, with more positive attitude over the years 2003-2013 (Evans-Lacko et al., 2014). This study recommends similar work and public health media campaigns aimed at reducing stigma and improving understanding of substance misuse as a health condition.

Summary

Overall, this is an important study which identifies that educational intervention can positively impact on student midwives' views of pregnant drug users. The study has provided new insights into, the position of student midwives in the UK in terms of their attitudes toward pregnant drug users and where this comes from, the required nature of education aimed at altering attitude toward drug use, the importance of critical reflection in substance use education and that e-learning is an effective model for education design in the field of substance use and attitude change. It has furthermore, confirmed the work of other researchers in showing that, the origin of attitudes relating to drug use are wide and varied, stigmatisation of drug users occurs in practice and negatively effects the care of pregnant drug users, service user input is an important aspect of education delivery and that educational intervention can improve confidence in caring for individuals with substance misuse problems.

7.2 Future Research

Many of the implications for practice, both clinical and educational, which are implicit throughout the findings and explicit in this chapter intimate recommendations for practice and opportunities for further research. This section gives a brief overview of some of the potential studies that this study paves the way for.

Research developments for practice

1. To explore the concept of the culture in the NHS and potential influence of this upon attitudes toward pregnant drug users, it would be interesting to conduct similar research using groups of qualified midwives at differing periods post-qualification. This could also explore and compare the efficacy of the education upon post qualified midwives.
2. The studies which look at the effectiveness of interventions to effect change in practice only evaluate short term impact and so further research is needed to assess whether the education still has the same effect at periods of time further away from the intervention. This could be explored potentially using

the same group of students (now qualified midwives) at one year, three years and five years post qualification.

3. This results of this study definitely highlight the need for exploration of the impact of mentors upon their mentees in the clinical setting. This research could involve just looking in relation to attitudes toward drug use and the impact upon students attitudes, but perhaps a more valuable study would be to gain an insight into the experience of being mentored in general.

Research developments for education

1. This study provides some useful findings in relation to the role that specific education can have upon attitudes toward pregnant drug users, however there is a need for further research like this to evaluate what the education should entail and also to assess what its effects in practice are.
2. Variations following the same study design would also provide greater insight into this area, including using; a larger sample size; different universities; different types of education delivery; different professional groups; exploration of prior knowledge and experience on findings; positive versus negative experiences and their effect.
3. To further explore the impact of the e-learning delivery approach for this study, a follow up study would be to deliver the same content via face to face delivery.
4. Given the commonalities with other marginalised groups (for example mental health) an interesting follow up study would be to explore the same type of delivery for these areas to see if there is a similar effect.

This is of course not intended to be an exclusive list, there are many possibilities for further research building upon the findings in this study.

7.3 Personal Reflection – Another Brick in the Wall

A reflexive relationship is bidirectional with both the cause and the effect affecting one another in a situation. Within the context of my research, it refers to my capacity to recognise the various forces of socialisation and accordingly reflect this in any design or analysis. It crucially requires me to undergo a process of self-conscious inquiry. Within the course of this research I have reflected greatly. I have considered my current role as midwife lecturer and also my place as a researcher within the midwifery profession and this has ultimately shaped the process and development of my research.

Sociologist William Thomas (Thomas, Znaniecki 1919) was one of the first to enunciate the principle of reflexivity, stating that; *'the situations that men define as true, become true for them'* (p21). In the context of my research I was as such aware that there was a risk, that what I either wanted to be so, or what I believed at the outset to be so, was what I would find to be the case. The consequence of this was the time it took me to analyse my data and my insistence on checking it through, 'just one more time,' despite my supervision team also checking over and confirming my findings at each stage.

Another significant challenge for me in conducting this research has been in establishing 'who I am,' midwife, researcher, or academic. I am currently employed in the UK, as a full-time university lecturer in midwifery. I am however, first and foremost a registered midwife (RM), registered with my governing body, the Nursing and Midwifery Council (NMC). To hold my role as a midwife teacher, I am required to be a registered midwife and renew this yearly following successful completion of my supervisory review in which I have to demonstrate my continuing professional development and also that I have completed the required hours for re-registration. Interestingly, the completion of these hours does not have to be in the clinical setting, thus my role at the university is sufficient to meet this. I say interestingly as this I feel is where many of the conflicts arise in practice regarding midwife-academics (of which most midwife-researchers emerge from), in essence part of the so called 'theory-practice divide'. Anecdotally, from discussion with my practice based

colleagues, I find that many clinical midwives feel that midwife-academics are 'not in touch with the realities of clinical practice' and as such this creates difficulties in their working relationships and of course, could be to the detriment of conducting and more importantly disseminating research in this field. Similarly, I have observed this dichotomy between practitioners and academics, whereby clinical experience and expertise is not always recognised and valued in the academic setting in the same way as a more 'traditional' academic career.

Over the last century the occupation of midwifery has become recognised and achieved a certain status, some would argue, as a semi-profession (Hearn 1982; Etzioni 1969). However, with the characteristics of semi-professions being defined as placing an emphasis on practical as opposed to theoretical knowledge, and, '*staffed mainly by women, managed mainly by men*' (Hearn 1982 p197); midwives are seen as serving to support the traditional patriarchal professions, such as obstetrics, rather than achieving occupational autonomy in its own right (Witz 1992). In relation to my own research this was an important factor, both as discussed in relation to dissemination and valuing of my findings, and furthermore in terms of how midwife-researchers are viewed within the field, both by fellow midwives, obstetricians and academics.

In order to be effective as either a researcher or a midwife, I needed from the outset to consider the impact and dissemination of my work. I was already aware of the political and structural constraints on knowledge production and dissemination, the power relationships that have an impact upon how new knowledge is valued and accordingly the challenges in how to get my voice heard in the learning environment. In terms of practice dissemination of my research, it was crucial to be aware of the power relationships that exists within obstetrics and in particular, the 'cultural clash' of obstetric and midwifery knowledge (MacKenzie, 2004). Furthermore, I was beginning to see the challenges in being a practitioner-academic. From the outset I could see that there was very little published in midwifery journals related to challenging views around substance misuse in practice. Interestingly, one of the students in the study observed that, '*A lot of the journal's focus on clinical skills and on clinical improvements to practice, but I guess this subject challenges opinions. Do*

people really want to read things which are a little bit challenging?' Whilst my primary motivation for conducting this research was to improve the situation in clinical practice for substance using women, wearing my 'academic' hat, I wanted to evaluate the effectiveness of the education I was delivering in facilitating this. I very quickly realised that the potential audience and impact could be far wider reaching than midwifery alone. Driven by my primary desire to impact upon practice, my first publication from this research was in a practitioner based midwifery journal. However, I have since widened my remit and submitted abstracts to present at a specialist substance misuse conference for General Practitioners and also to present the education specifically focussed findings at the Higher Education Academy conference.

Undertaking this research and reflecting myself on the journey along the way has enabled me to see the influence of research output in a more reflective manner. I have appreciated better the difficulties, but necessity of breaching the void into the obstetric dominated arena for any midwifery research to achieve its greatest impact in challenging the norms and creating a collaboration in advancing knowledge and ultimately improving practice, both clinical and educational.

To look at where I have come from in my research journey, at the outset I wrote in my research journal, '... as a researcher, I am new, vulnerable and inexperienced and am under no illusion that I am *'competent, skilful or assured'* in the field.' Whilst I would not now profess to have conquered all of these aspects, I would say that I have grown and am proud and confident to call myself a professional researcher. Nixon (2001) suggests that the essence of professionalism is the capacity to be outward-looking, inclusive and morally courageous, and this, I feel I have fulfilled. I have conducted my research with integrity, morality and professionalism. I have produced a piece of research which has not only equipped me with the skills to conduct research, but has contributed to a greater body of knowledge by placing 'another brick in the wall.'

References

Abdel-Latif, M.E., Bajuk, B., Lui, K., Dei, J., 2007. Short term outcomes of infants of substance-using mothers admitted to neonatal intensive care units in New South Wales and the Australian Capital Territory. *Journal of Paediatrics and Child Health*, 43(3), pp. 127-133.

ACMD, Advisory Council on the Misuse of Drugs, 2003. *Hidden Harm*. [pdf] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf [Accessed 12 June 2016].

Adams, M.W., 2008. Comorbidity of mental health and substance misuse problems: a review of workers' reported attitudes and perceptions. *Journal of Psychiatric and Mental Health Nursing*, 15(2), p. 1.

Adam, F., 2014. *Measuring National Innovation Performance: The Innovation Union Scoreboard Revisited*. Chapter 2. Berlin Heidelberg: Springer-Verlag.

Ahern, J., Stuber, J., Galea, S., 2007. Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*. 88 (2-3), pp. 188-196.

AIVL, Australian Injecting and Illicit Drug Users League, 2011. *'Why wouldn't I discriminate against all of them?' A report on stigma and discrimination towards the injecting drug user community*. [pdf] p. 46 Available at: http://www.aivl.org.au/wp-content/uploads/Why_wouldnt_i_discriminate_against_all_of_them_Stigma_discrimination_report.pdf. [Accessed 11 February 2016].

Ajzen, I., 2001. Nature and operations of attitudes. *Annual Review of Psychology*. 52, pp. 27-58.

Ajzen, I., 2005. *Attitudes, personality and behaviour*. 2nd ed. New York: Open University Press.

Albright, B., Skipper, B., Riley, S., Wilhelm, P., Rayburn, W.F., 2012. Medical students' comfort with pregnant women with substance use disorders: A randomised Educational Study. *Academic Psychiatry*. 36(6), pp. 457-460.

Alvesson, M., 2001. Knowledge work. Ambiguity, image and identity. *Human Relations*. 54 (7), pp 863-886.

Anderson, P., Kaner, E., Wutzke, S., Funk, M., 2004. Attitudes and managing alcohol problems in general practice: an interaction analysis based on findings from a WHO collaborative study. *Alcoholism: International journal of the Medical Council on Alcoholism*. 139(4), pp. 351-356.

Applin, H., Williams, B., Day, R., Buro, K., 2011. A comparison of competencies between learning and non-problem based graduate graduates. *Nurse Education Today*. 31 pp 129–134.

Argyris, C., Schon, D., 1978. *Organisational Learning: A theory of action perspective*. Massachusetts: Addison-Wesley.

Arthur, D., 2001. The effects of the problem-based alcohol intervention education package on the knowledge of students of nursing. *Journal of Nursing Education*, 40(2), pp. 63-72.

Atkins, S., Murphy, K., 1995. Reflective Practice. *Nursing Standard*, 9(45), pp. 31-37.

Balbach, E.D., 1999. Using Case Studies to do Program Evaluation [PDF]. [Online] <http://case.edu/affil/healthpromotion/ProgramEvaluation.pdf> Accessed April 2017.

Barnard, M., 2005. *Drugs in the family: The impact on parents and siblings*. York: Joseph Rowntree Foundation.

Bartu, A., Sharp, J., Ludlow, J., Doherty, D., 2006. Postnatal home visiting for illicit drug-using mothers and their infants: A randomised controlled trial. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 46(5), pp. 419-426.

Bassey, M., 1999. *Case Study Research in Educational Settings*. Buckingham: Open University Press.

Bassey, M., 2001. A solution to the problem of generalisation in educational research: fuzzy prediction. *Oxford Review of Education*, 27(1), pp. 5-22.

Bates, B., 2016. *Learning Theories Simplified*. London: Sage.

Bayer, R., 2008. Stigma and the ethics of public health: Not can we but should we. *Social Science and Medicine*, (67), pp. 463-472.

BERA, British Educational Research Association, 2011. *Ethical guidelines for educational research*. [pdf] Available at: <http://www.bera.ac.uk/files/2011/08/BERA-Ethical-Guidelines-2011.pdf> [Accessed 15 December 2012].

Berger, P. L., Luckmann, T., 1966. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Garden City, New York: Anchor Books

Biggs, J. B., 2003. *Teaching for Quality Learning at University*, 2nd ed. Buckingham: Open University Press.

Biggs, J. B. Tang, 2011. *Teaching For Quality Learning At University (Society for Research Into Higher Education)* 4th Edition. Buckingham: Open University Press.

Black, P. and Williams, D., 1998. Assessment and Classroom learning. *Assessment in Education*, 1, pp. 7 -74.

Bland, E. Oppenheimer, L. Brisson-Carroll, G. Morel, C. Holmes, P., Gruslin, A., 2001. Influence of an educational program on medical students' attitudes to substance use disorders in pregnancy. *American Journal of Drug and Alcohol Abuse*, 27(3), pp. 483-90.

Bloxham, S. Boyd, P., 2007. *Developing Effective Assessment in Higher Education: A Practical Guide*. Berkshire: Open University Press.

Boyd, N., 2015. *Substance Use, Abuse and Dependence: Definition and Causes of Substance Disorders*. [online] Available at: <http://study.com/academy/lesson/substance-use-abuse-and-dependence-definition-and-causes-of-substance-disorders.html> [Accessed 1 March 2016].

Boyle, M. et al., 2012. An assessment of undergraduate paramedic student's empathy levels. *International journal of Medical Education*, 3, pp. 98-102.

Boyle, M. Williams, B. Brown, T. Molloy, A. McKenna, L. Molloy, E. Lewis, B., 2010. Attitudes of undergraduate health science students towards patients with intellectual disability, substance abuse and acute mental illness: A cross-sectional study. *BMC Medical Education*, 10(1), article no. 1.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), pp. 77-101.

Breckler, J. S. and Wiggins, E. C., 1989. On defining attitude and attitude theory: Once more with feeling. In Pratkanis, A. Breckler, J. & Greenwald, A., (Eds.), *Attitude structure and function*, pp. 407- 425. New Jersey, Lawrence Erlbaum Associates, Inc.

Brown, J. Ryland, I. Howard, J. Shaw, N., 2007. Views of National Health Service (NHS) Ethics committee members on how education research should be reviewed. *Medical Teacher*, 29, pp. 225-230.

Brown, P. 2010. Teacher research and university Institutional Review Boards. *Journal of Early Childhood Teacher Education* 31: 276-283

Burns, R., 1995. *The adult learner at work*. Sydney: Business and Professional Publishing.

Burns, L. Mattick, R.P. and Cook, M. 2006. The use of record linkage to examine illicit drug use in pregnancy. *Addiction*, 101(6), pp. 873-882.

Byrne, D., Ragin, Charles, C., 2009. *The SAGE handbook of case-based methods*. London: Sage.

Cacioppo, J. T. Petty, R. E. and Crites, S. L., 1994. Attitude Change. *Encyclopaedia of Human Behaviour*, 1, pp. 261-270.

Cambridge Dictionary Online, 2016. *Stereotype*. [online] Available at: <http://dictionary.cambridge.org/dictionary/english/stereotype>. [Accessed 1 March 2016]

Campbell, D., 2013. *Pushed to the limit: 24 hours with the busiest midwives in Europe*. The Guardian News [online] Available at: <http://www.theguardian.com/society/2013/dec/05/24-hours-europe-busiest-midwives-liverpool-hospital-nhs> [Accessed 25 February 2016].

Cape, G. Hannah, A. Sellman, D., 2006. A longitudinal evaluation of medical students knowledge, skills and attitudes to alcohol and drugs. *Addiction*, 101, pp 841-849.

Carolan, M., 2011. The good midwife: commencing students' views. *Midwifery*, 27 (4), pp. 503–508.

CASP, 2013. Critical Appraisal Skills Programme. Making Sense of Evidence. [Online] <http://www.casp-uk.net/casp-tools-checklists> [Accessed 8th July 2016]

Casper, T. Arbour, M.A., 2013. Identification of the Pregnant Woman Who Is Using Drugs: Implications for Perinatal and Neonatal Care. *Journal of Midwifery and Womens Health*, 58, pp. 697–70.

Castelli, L. Carraro, L., 2011. Ideology is related to basic cognitive processes involved in attitude formation. *Journal of Experimental Social Psychology*, 47, pp. 1013–1016

Chappel, J., Schnoll, S.H., 1997. Physician attitudes: effect on the treatment of chemically dependent patients. *JAMA*, 237, pp. 2318-2319.

Chappel, J., Veach, T., Krug, R., 1985. The Substance Abuse attitude survey: an instrument for measuring attitudes. *Journal of Studies on Alcohol*, 46(10), pp. 48-52.

Childs, S. Blenkinsopp, E. Hall, A. Walton, G., 2005. Effective e-learning for health professionals and students—barriers and their solutions. A systematic review of the literature—findings from the HeXL project. *Health Information and Libraries Journal*, 22(2), pp.20–32.

Christison, G. Haviland, M. Riggs M., 2002. The Medical Condition Regard Scale: Measuring reactions to diagnoses, *Academic Medicine*, 77(3), pp. 257-62.

Christison, G. Haviland, M., 2003. Requiring a One-Week Addiction Treatment Experience in a Six-Week Psychiatry Clerkship: Effects on Attitudes toward Substance-Abusing Patients. *Teaching and Learning in Medicine*, 15(2), pp. 93-97.

Cleaver, H. Unell, I. Aldgate, J., 1999. *Children's Needs: Parenting Capacity*. London: The Stationary Office.

Cohen, L., Manion, L., Morrison, K., 2011. *Research Methods in Education*. 7th Edition. Routledge: London

Cohen, L., Manion, L., Morrison, K., 2007. *Research Methods in Education*. USA, Routledge.

Cole, F. L., 1988. Content analysis: process and application. *Clinical Nurse Specialist*, 2(1), pp. 53-57.

Concannon, F. Flynn, A. Campbell, M., 2005. What campus-based students think about the quality and benefits of e-learning. *British Journal of Educational Technology*, 36(3), pp. 501–512.

Connors, G. J. Donovan, D. M. and DiClemente, C. C., 2001. *Substance Abuse and the stages of change*. New York: The Guilford Press.

Cooper, C.M., 2008. Tell me – show me: using combined focus groups and photo voice methods to gain understanding of health issues. *Qualitative Health Issues*, 20(5), pp. 644-507.

Corrigan, P., 2000. Mental health stigma as social attribution: implications for research methods and attitude change. *Clinical Psychology, Science and Practice*, 7, pp. 48-67.

Corse, S. J. and Smith, M., (1998). Reducing substance abuse during pregnancy discriminating among levels of response in a prenatal setting. *Journal of Substance Abuse Treatment*, 15(5), pp. 457-467.

Coyler, C. J., 2015. W.I. Thomas and the Forgotten Four Wishes: A Case Study in the Sociology of Ideas. *The American Sociologist*, 46 (2), pp 248-268

Cresswell, J.W. Plano Clark, V.L., 2011. *Designing and conducting mixed methods research*. 2nd ed. London: Sage.

Crome, I.B. and Kumar, K., 2007. Epidemiology of drug and alcohol use in young women. *Seminars in Fetal Neonatal Med*, 12(2), pp. 98-105.

Cunningham, J.A. Sobell, L.C. Freedman, J.L. Sobell, M.B., 1994. Beliefs about the causes of substance abuse: a comparison of three drugs. *Journal of Substance Abuse*, 6, pp. 219-226.

Cund, A., 2013. Alcohol education revisited: Exploring how much time we devote to alcohol education in the nursing curriculum. *Nurse Education in Practice*, 13, pp. 35-39.

Data Protection Act, 1998. United Kingdom: HMSO.

Day, E. George, S., 2005. Management of drug misuse in pregnancy. *Advances in Psychiatric Treatment*. 11, 253-261. [online] Available at: <http://apt.rcpsych.org/> [Accessed 1 January 2012]

Dearing, K. S. Steadman, S., 2008. Challenging Stereotyping and Bias: A Voice Simulation Study. *Journal of Nurse Education*, 47(2), pp. 59-65.

Denscombe, M., 2010. *The Good research guide for small scale research projects*. Berkshire: Open University Press.

Denzin, N. K., Lincoln, Y. S., 2011. *The SAGE Handbook of Qualitative Research*. 4th Edition. London: Sage.

Department for Education, 2010. *Building on the learning from Serious Case Reviews: a two-year analysis of child protection database notifications 2007-2009*. United Kingdom: HMSO.

Department of Health (England) (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive. [pdf] Available at: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf [Accessed 4 July 2016]

DeVilje, K. and Kopelman, L., 1998. Moral and social issues regarding pregnant women who use and abuse drugs. *Obstetrics and Gynaecology Clinics*, 25(1), pp. 237-254.

Dhital, R. Whittlesea, C. M. Milligan, P. Khan, N. S. Norman, I. J., 2012. The impact of training and delivering alcohol brief intervention on the knowledge and attitudes of community pharmacists: A before and after study. *Drug and Alcohol Review*, 32(2), pp.147-56

DiCicco-Bloom, B., Crabtree, B. F., 2006. The qualitative research interview. *Medical Education*, 40 (4), pp 314-321.

Dimond, B., 2013. *Legal Aspects of Midwifery*. 4th Edition. London: Quay Books.

Donaghy M. E. Morss, K. T. I., 2000. Guided reflection: A framework to facilitate and assess reflective practice within the discipline of physiotherapy. *Physiotherapy Theory and Practice*, 16(1), pp. 3-14.

Drugscope, 2005. *Substance Misuse in Pregnancy: A resource book for professionals*. UK: Drugscope.

Eagley, A. H. Chaiken, S., 1993. *The psychology of attitudes*. California: Harcourt, Brace and Jovanovich.

Eagley, A. H. Chaiken, S., 2007. The advantages of an inclusive definition of attitude. *Social Cognition*, 25, pp. 582-602.

Edward, K., 1990. The Interplay of affect and cognition in attitude formation and change. *Journal of Personality and Social Psychology*, 59(2), pp. 202-216.

Elo, S. Kyngas, H., 2007. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), pp. 107-115.

Etzioni, A., 1969. *The Semi-Professions and Their Organisations*. New York: Free Press.

Evans-Lacko, S. Corker, L. Williams, P. Henderson, C. ThRogersornicroft, G., 2014. Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: an analysis of survey data. *Lancet Psychiatry*, 1, pp. 121–28.

Fazio, R. H., 2007. Attitudes as object-evaluation associations of varying strength. *Social Cognition*, 25, pp. 603-637.

Festinger, L., 1957. *A Theory of Cognitive Dissonance*. Stanford California: Stanford University Press.

Field, A., 2005. *Discovering Statistics using SPSS*. 2nd ed. London: Sage.

Flyvbjerg, B., 2001. *Making Social Science matter: why social inquiry fails and how it can succeed again*. Cambridge: Cambridge University Press.

Flyvbjerg, B., 2011. Case Study. In Denzin, N.K., and Lincoln, Y.S., (Eds) *The Sage Handbook of Qualitative Research*. 4th ed. London: Sage.

Ford, R., 2011. Interpersonal challenges as a constraint on care: the experience of nurses' care of patients who use illicit drugs. *Contemporary Nurse*, 37(2), pp. 241-252.

Foucault, M., 2005. *Madness and Civilization: A History of Insanity in the Age of Reason*. 7th edition of French translation. London and New York: Routledge.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., Redwood, S., 2013. The Framework Method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*. 13: 117.

Gerace, L.M. Hughes, T.L. Spunt, J., 1995. Improving nurses' responses toward substance misusing patients: a clinical evaluation project. *Archive of Psychiatric Nursing*, 9, pp. 286-294.

Gergen, K.J., 1993. *Toward Transformation in Social Knowledge*. 2nd edition. London: Sage.

Gergen, K.J., 2002. *Social Construction in context*. London: Sage.

Gergen, K.J., 2015. *An Invitation to Social Construction*. 3rd Edition. London: Sage.

Ghaye, T. Lillyman, S., 2010. *Reflection: Principles and practices for healthcare professionals*. 2nd ed. Dulwich London, MA Healthcare Ltd: Quay Books Division.

Giddings, L. S., 2006. Mixed-methods research. Positivism dressed in drag? *Journal of Research in Nursing*, 11 (3), pp 195-203.

Gilbert, N., 2008. *Researching Social Life*. 3rd ed. London: Sage.

Gillham, B., 2000. *Case study research methods*. London: Continuum

Gilligan, C., 1982. *In a Different Voice: Psychological Theory and Women's Development*. Harvard University Press: Cambridge and London

Gleeson, M., 2011. *The Bad, The Sad and the Redeemed*. [online] Available at: <http://injectingadvice.com/articles/guestwrite/260-mattgleeson2> [Accessed November 2011]

Goffman, E., 1963. *Stigma: Notes on the management of spoiled Identity*. Englewood Cliffs, New Jersey: Prentice-Hall.

Graham, J. Haidt, J. Nosek, B. A., 2009. Liberals and conservatives rely on different sets of moral foundations. *Journal of Personality and Social Psychology*, 96, pp. 1029–1046.

Graham, J. Nosek, B. A. Haidt, J. Iyer, R. Koleva, S. Ditto, P. H., 2011. Mapping the Moral Domain. *Journal of Personality and Social Psychology*, 101(2), pp. 366-385.

Greene, J. C., 2000. Understanding social programs through evaluation. In Denzin, N.K. and Lincoln, Y.S., (Eds) 2011. *The Sage Handbook of Qualitative Research*. 4th ed. London: Sage.

Guba, E. G., 1990. *The Paradigm Dialog*. London: Sage.

Hagemaster, J., Handley, S., Plumlee, A., Sullivan, E., Stanley, S., 1993. Developing educational programmes for nurses that meet today's addiction challenges. *Nurse Education Today*, 13, pp. 421-425.

Hall, J. L. Van Teijlingen, E.R., 2006. A qualitative study of an integrated maternity, drugs and social care service for drug-using women. *BMC (Biomed Central) Pregnancy and Childbirth*, 6(19).

Hamilton, L., 2011. *Case studies in educational research, British Educational Research* [pdf] Available at: www.bera.ac.uk/wp-

content/uploads/2014/03/Case-studies-in-educational-research.pdf [Accessed 1 July 2015}

Hammersley, M., 2007. *Ethnography: Principles in Practice*. 3rd ed. London: Routledge.

Hansen, J. T., 2004. Thoughts on knowing: Epistemic implications of counselling practice. *Journal of Counselling & Development*, 82, pp. 131– 138.

Hanson, G. R. Venturelli, P. J. and Fleckenstein, A. E., 2002. *Drugs and society*. Sudbury (MA): Jones and Bartlett Publishers.

Haythornthwaite, C. Andrews, R., 2011. *E-Learning; Theory and Practice*. London: Sage.

Hearn, J., 1982. Notes on patriarchy, professionalization and the semi-professions. *Sociology* 16, pp184-202.

Hepburn, M., 2004. Substance abuse in pregnancy. *Current Obstetrics & Gynaecology*, 14(6), pp. 419-425.

Hesse-Biber, S. N., 2012. *Feminist Research: Exploring, Interrogating, and Transforming the Interconnections of Epistemology, Methodology, and Method*, in S. Hesse-Biber. 2012. *The Handbook of Feminist Research: Theory and Praxis*. 2nd ed. Chapter 1. Thousand Oaks, California: Sage

Hojat et al, 2001. The Jefferson scale of physician empathy: Development and preliminary psychometric data. *Educational Psychology Measures*, 61, pp. 349-365.

Hojat, M. Gonnella, J. Nasca, T. Mangione, S. Vergare, M. Magee, M. 2002. Physician empathy: Definition, components, measurement, and relationship to gender and specialty. *American Journal of Psychiatry*, 159(9), pp. 1563-9.

Hojat, M. Gonnella, J. Mangione, S. Nasca, T. Magee, M., 2003. Physician empathy in medical education and practice: Experience with the Jefferson scale of physician empathy. *Seminars in Integrative Medicine*, 1(1), pp. 25-41.

Hojat, M. Gonnella, J. Mangione, S. Nasca, T. Veloski, J. Erdmann, J., 2002. Empathy in medical students as related to academic performance, clinical competence and gender. *Medical Education*, 36(6), pp. 522-7.

Holloway, A.S. Webster, B.J., 2013. Alcohol education and training in pre-registration nursing: A national survey to determine curriculum content in the United Kingdom. *Nurse Education Today*, 33, pp. 992-997.

Home Office, 2014. *Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales*. [online] Available at: <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales#extent-and-trends-in-illicit-drug-use-among-adults> [Accessed 1 March 2016]

Hooks, C., 2015. Paranoid or persecuted? The stigmatisation of pregnant drug users: a literature review. *Practising Midwife*, January, pp 14-18.

Hopwood, M., 2007. Stigma and health, Paper presented at NCHSR Consortium workshop, 19 May, Sydney. In *Australian Injecting and Illicit Drug Users League (AIVL) 2011, 'Why wouldn't I discriminate against all of them?' A report on stigma and discrimination towards the injecting drug user community*. Canberra, Australia [pdf] Available at: http://www.aivl.org.au/wp-content/uploads/Why_wouldnt_i_discriminate_against_all_of_them_Stigma_discrimination_report.pdf [Accessed 26 June 2016].

Hovland, C. L. Janis, I. L. Kelley, H. H., 1953. *Communication and Persuasion: psychological studies of opinion change*. New Haven, Connecticut: Yale University Press.

Howatson-Jones, L., 2013. *Reflective Practice in Nursing*. 2nd ed. London: Sage.

Howe, K. R., 1988. Against the quantitative–qualitative incompatibility thesis or dogmas die hard. *Educational Researcher*, 17: 10–16.

Hsieh, H-F., Shannon, S. E., 2005. Three approaches to qualitative content analysis. *Qualitative Health Research*, 15 (9), pp 1277-1288.

Huestis, M. A. Choo, R. E., 2002. Drug abuse's smallest victims: in utero drug exposure. *Forensic Science International*, 128, pp. 20-30.

Jackson, E., 2013. Choosing a Methodology: Philosophical Underpinning, *Practitioner Research in Higher Education Journal*, 7(1), [online] Available at: <http://194.81.189.19/ojs/index.php/prhe> [Accessed 20 May 2015]

Janis, I.L., Kaye, D., Kirschner, P., 1965. Facilitating effects of 'eating while reading' on responsiveness to persuasive communications. *Journal of Personality and Social Psychology*, 1, pp. 181-186.

Jasper. M., 2003. *Beginning Reflective Practice*. Cheltenham: Nelson Thornes.

Jenainati, C. and Groves, J., 2010. *Introducing Feminism, a Graphic Guide*. London: Icon books.

Jenkins, L., 2013. A survey of midwives' attitudes towards illicit drug use in pregnancy. *Evidence Based Midwifery*, 11(1), pp. 10-15

Johns, C., 2010. *Guided Reflection: A narrative approach to advancing professional practice*. 2nd ed. Chichester: Wiley-Blackwell.

Johns, C. Freshwater, D., (eds) 2005. *Transforming Nursing through Reflective Practice*. 2nd ed. Oxford: Blackwell.

Jones, E. Farina, A. Hastorf, A. Markus, H. Miller, D. Scott, R., 1984. *Social Stigma: The psychology of Marked Relationships*. New York: Freeman.

Jos, P. Perlmutter, M. Marshall, M., 2003. Substance abuse during pregnancy: Clinical and public health approaches. *Journal of Law, Medicine and Ethics*, 31(3), pp. 340-350.

Katz, D., 1960. The functional approach to the study of attitudes. *American Association for public opinion research*, 24(2), pp. 163-204.

Kelleher, S., 2007. Health care professionals' knowledge and attitudes regarding substance use and substance. *Accident and Emergency Nursing*, 15(3), pp. 161–165.

Kelleher, S. Cotter, P., 2009. A descriptive study on emergency department doctors' and nurses' knowledge and attitudes concerning substance use and substance users. *International Emergency Nursing*, 17, pp. 3-14.

King, D.L. Kalucy, R.S. de Crespigny, C.F. Stuhlmilller, C.M. Thomas, L.J., 2004. Mental Health and alcohol and other drug training for emergency department workers: one solution to help manage increasing demand. *Emergency Medicine Australia*, 16(2), pp. 155-160.

Klee, H., 1998. Drug-using parents: analysing the stereotypes. *International Journal of Drug Policy*, 9(6), pp. 437-448

Klee, H., Jackson, M., Lewis, S., 2002. *Drug Misuse and Motherhood*. London: Routledge.

Knight, M. Tuffnell, D. Kenyon, S. Shakespeare, J. Gray, R., Kurinczuk, J.J., (eds) on behalf of MBRACE-UK, 2015. *Saving Lives, Improving Mothers' Care – Surveillance of maternal deaths in the UK 2011-13 and lessons to inform maternity care from UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015.

Knowles, M.S., 1990. *The adult learner: a neglected species*. 4th edition. Houston: Gulf Publishing Company.

Kohlbacher, F., 2006. The use of Qualitative Content Analysis in Case Study Research. *Qualitative Social Research Forum*, 7(1), article 21.

Korzilius, H., 2012. Statistics, Use of in Case Study. In *Encyclopedia of Case Study Research*. Ed. Mills, A.J., Durepos, G., Wiebe., E., 2012. Sage: Thousand Oaks.

Kuhn, T., 1970. *The structure of scientific revolutions*. Chicago: University of Chicago press.

Kumar, R., 1999. *Research Methodology. A step by step guide for beginners*. London: Sage.

La Piere, 1934. In Watson, H. Maclaren, W. Shaw, F. Nolan, A., 2003. *Measuring staff attitudes to people with drug problems: The development of a tool*. Effective Interventions Unit, Scottish Executive Drug Misuse Research Programme.

Lavender, T. Bennett, N. Blundell, J. Malpass, L., 2001. Midwives' views on redefining midwifery 1: Health promotion. *Journal of Midwifery*, 9(11) pp. 666-70.

Lee, D, Haynes, C. Garrod, D., 2010. *Exploring health promotion practice within maternity services: Final Report*. Stockport NHS Trust.

Leggate, J., 2008. Improving pregnancy outcomes: mothers and substance misuse. *British Journal of Midwifery*, 16(3), pp. 161-165

Levy, L., 2013. Review of the Literature. In Blessing, J. D., Forister, J. G., (Eds) 2013. *Introduction to research and medical literature for healthcare professionals*. 3rd Edition. Jones and Bartlett, MA.

Lewin, K., 1951. *Field theory in social science; selected theoretical papers*. D. Cartwright (ed.). New York: Harper & Row.

Lewis, G. Ed., 2007. The Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005*. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH.

Lincoln, Y. S. Guba, E. G., 2000. Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. 2nd ed. pp. 163–188. Thousand Oaks, California: Sage.

Lincoln, Y. S. Guba, E.G., 1985. *Naturalistic Enquiry*. Beverley Hills: Sage.

Link, B. G. Struening, E. L. Rahav, M. Phelan, J. C. Nuttbrock, L., 1997. On Stigma and its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse. *Journal of Health and Social Behaviour*, 38(2), pp. 177-90.

Livingston, J.D. Milne, T. Fang, M.L. Amari, E., 2011. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, 107, pp. 39-50.

Lloyd, C., 2010a. *Sinning and the Sinned Against: The Stigmatisation of Problem Drug Users*. UK Drug Policy Commission, London. [online] Available at: www.ukdpc.org.uk/reports.shtml [Accessed 28 August 2015].

Lloyd, C., 2010b. *Drug addicts are not to blame for their plight*. [online] Available at: <http://www.theguardian.com/society/joepublic/2010/aug/24/drug-users-stigma-addiction-blame> [Accessed 30 August 2010].

Lovell, B. R., 1984. *Adult Learning: New patterns of learning*. London: Croom Helm.

Lyons, A., 2002. *An exploration of the effects of societal ideas of 'mother' on the mother's sense of self and her mothering practices of women with drug and/or alcohol issues*. Unpublished Masters Thesis. [pdf] Available at: <http://pandora.nla.gov.au/pan/42706/20040617-0000/www.community.nsw.gov.au/documents/accan/papers/353D-3.pdf> [Assessed 14 June 2009]

Macdonald, S. Magill-Cuerden, J. Mayes, M., 2011. *Mayes' Midwifery: A Textbook for Midwives*. 14th ed. London: Balliere Tindall.

MacKenzie, C., 2004. The Politics of representation: a personal reflection on the problematic positioning of the midwifery educator. *Studies in Continuing Education*. 26 (1) pp117-127.

Macrory, F., 2006. *Meeting Multiple Needs: Pregnancy, Parenting and Dual Diagnosis*. In *Dual Diagnosis Nursing* Edited by: Rassool, P., Oxford, Wiley-Blackwell Ltd.

Maddux, J. E. Rogers, R. W., 1980. Effects of source expertness, physical attractiveness, and supporting arguments on persuasion: A case of brains over beauty. *Journal of Personality and Social Psychology*, 39, pp. 235-244.

Maio, G. R. Haddock, G., 2015. *The Psychology of Attitudes and Attitude Change*. 2nd ed. London: Sage.

Manning, V. Best, D. W. Faulkner, N. Titherington, E., 2009. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health*, 9, p. 377

Marmot, M. Allen, J. Goldblatt, P. Boyce, T. McNeish, D. Grady, M. and Geddes, I., 2010. *Strategic Review of Health Inequalities: Fair Society, Healthy Lives - The Marmot Review Final Report*. [online] Available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> [Accessed on 25 May 2016]

Mason et al., 2003. *How much does higher education enhance then employability of graduates?* [pdf] Available at: http://aces.shu.ac.uk/employability/resources/rd13_03sum.pdf [Accessed 6 December 2015]

McAvoy, B.R., 2000. Alcohol education for general practitioners in the United Kingdom – a window of opportunity? *Alcohol and Alcoholism*, 35(3), pp. 225-229

McCambridge, J. McAlaney, J. Rowe, R., 2011. Adult Consequences of Late Adolescent Alcohol Consumption: A Systematic Review of Cohort Studies. *Public Library of Science*, 8(2).

McKenna, L. Boyle, M. Brown, T. Williams, B. Molloy, A. Lewis, B. Molloy, L., 2011. Levels of empathy in undergraduate midwifery students: An Australian cross-sectional study. *Women and Birth*, 24, pp. 80-84.

McLaughlin, D. Long, A., 1996. An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing*, 3(5), pp. 283-288.

Meltzer, E. C. Suppes, A. Burns, S. Shuman, A. G. Orfanos, A., Sturiano, C. Charney, P. Fins, J. J., 2013. *Stigmatization of substance use disorders among internal medicine residents*. *Substance abuse: official publication of the Association for*

Medical Education and Research in Substance Abuse. [online] Available at: <http://vivo.med.cornell.edu/display/pubid84887803324> [Accessed 24 June 2015].

Miles, M. Francis, K. Chapman, Y., 2011. Challenges for midwives: pregnant women and illicit drug use. *Australian Journal of Advanced Nursing*, 28(1), pp. 83-90.

Miller, P.G. Miller, W.R., 2009. What should we be aiming for in the treatment of addiction? *Addiction*, 104(5), pp. 685-686.

Misuse of Drugs Act, 1971. London: HMSO.

Miyake, N., 2007. Computer supported collaborative learning, in Andrews, R. Haythornthwaite, C., (Eds) *The Sage handbook of E-Learning Research*. London: Sage.

Morse, J. M. Barrat, M. Mayan, M. Olson, K. Spiers, J., 2002. Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), pp. 13-22.

Moses, J. W. Knutsen, T. L., 2007. *Ways of knowing competing methodologies in social and political research*. Basingstoke: Palgrave Macmillan.

Moule, P., Goodman, M., 2009. *Nursing Research: An Introduction*. London: Sage.

Murray, C.J. Richards, M.A. Newton, J.N. Fenton, K.A. Anderson, H.R. Atkinson, C. Davis, A., 2013. UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet*, 381(9871), pp. 997-1020.

NatCen, 2010. *British Social Attitudes Report*. 26th Report. London: Sage.

Nazari, J. Raistrick, D. 2014. Effectiveness of a nurse led hospital in-reach team and assertive follow-up of frequent attenders with alcohol misuse complications: a retrospective mirror image evaluation. *Drugs and Alcohol Today*, 14(4), pp. 187-193.

Neale, J. Tompkins, C. Sheard, L., 2008. Barriers to accessing generic health care: a qualitative study of injecting drug users. *Health and Social Care in the Community*, 16(2), pp. 147-154.

Newby, P., 2014. *Research Methods for Education*, 2nd edition. New York: Routledge.

NICE: National Institute for Clinical Excellence 2010. *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors*. [pdf] Available at: <http://www.nice.org.uk/nicemedia/live/13167/50861/50861.pdf> [Accessed 28 September 2011].

Nieswiadomy, R.M., 2012. *Foundations of Nursing Research*. Boston: Pearson.

Nixon, J., 2001. 'Not without dust and heat': The moral basis of the new academic professionalism. *British Journal of Educational Studies*. 49 (2), pp 173-186.

NMC: Nursing and Midwifery Council, 2015. *The Code*. [pdf] Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> [Accessed 26 June 2016].

NMC: Nursing and Midwifery Council, 2009. *Standards for Pre-Registration Midwifery Education*. London: NMC.

NOFAS: National Organisation on Fetal Alcohol Syndrome – UK, 2011. *Alcohol in pregnancy, information for midwives*. [pdf] Available at: [www.nofas-](http://www.nofas-uk.org/)

[uk.org/PDF/Midwives%20Booklet%20Preview.pdf](http://www.nta.nhs.uk/PDF/Midwives%20Booklet%20Preview.pdf) [Accessed 28 September 2011].

Norman, R., 2001. Have you an attitude problem? Caring for illicit drug-using patients. *Contemporary Nurse* 10(1-2), pp. 83-91.

NTASM: National Treatment Agency for Substance Misuse, 2010. *Statistics from the National Drug Treatment Monitoring System* [pdf] Available at: <http://www.nta.nhs.uk/uploads/ndtmsannualreport2009-10finalversion.pdf> [Accessed 28 September 2015].

NTASM: National Treatment Agency for Substance Misuse, 2011. *Effective treatment, changing lives*. [online] Available at: <http://www.nta.nhs.uk/about-benefits.aspx> [Accessed 28 September 2011].

NTASM: National Treatment Agency for Substance Misuse, 2012. *Progress Made: Challenges Ahead*. [pdf] Available at: [www.nta.nhs.uk/uploads/commentaryfinal\[0\].pdf](http://www.nta.nhs.uk/uploads/commentaryfinal[0].pdf) [Accessed 13 September 2012].

NTASM: National Treatment Agency for Substance Misuse, 2013. *Why Invest* Presentation. [pdf] Available at: <http://www.nta.nhs.uk/uploads/whyinvest2final.pdf> [Accessed 13 March 2016].

NTASM: National Treatment Agency for Substance Misuse, 2014. *Parents with drug problems: how treatment helps families*. [pdf] Available at: <http://www.nta.nhs.uk/uploads/families2012vfinali.pdf> [Accessed 25 March 2015].

NTASM: National Treatment Agency for Substance Misuse, 2015. *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015*. [pdf] Available at: <https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse>

[e/adult-statistics-from-the-national-drug-treatment-monitoring-system-2014-2015.pdf](#) [Accessed 25 September 2015].

O'Brien, D., 2006. *An introduction to the theory of knowledge*. Cambridge: Polity Press.

Olesen, V., 2011. Feminist qualitative research in the millennium's first decade: developments, challenges, prospects, in N.K. Denzin and Y.S. Lincoln., 2011. *The Sage Handbook of Qualitative Research*, Chapter 7. London: Sage.

Onwuegbuzie, A. J., 2002. Positivists, post-positivists, post-structuralists, and post-modernists: Why can't we all get along? Towards a framework for unifying research paradigms. *Education*, 122 pp 518–530.

Oppenheim, A.N., 1992. *Questionnaire design, interviewing and attitude measurement*. London: Continuum.

O'Reilly, F. Reaper, E. Redmond, T., 2005. '*We're People too*'; views of drug users on health services. "*We're people too.*" *Views of drugs users on health services. UISCE, Mountjoy Street Family Practice, Participation and Practice of Rights Project, Dublin*. [pdf] Available at: http://www.drugsandalcohol.ie/5989/1/2783-Were_people_too.pdf [Accessed 23 June 2016].

Oxford Online dictionaries, 2016. [online] Available at: <http://oxforddictionaries.com> [Accessed 1 March 2016]

Padgett, D.K., 2012. *Qualitative and mixed methods in public health*. London: Sage.

Papert, S. Idit Harel, I., 1991. *Constructionism*. Norwood, New Jersey: Ablex Publishing Corporation.

Parahoo, K., 2006. *Nursing Research: principles, process and issues*. Basingstoke: Palgrave Macmillan.

Perry, M., 1999. Alcohol screening and early interventions in the medical setting. *Alcoholism, the newsletter from the medical council on alcoholism*. 189 (2), pp 3–4.

Perugini, M. Richetin, J. Zogmaister, C., 2010. *Prediction of behaviour*. In Gawronski, B. Payne, K., 2010 (eds) *Handbook of implicit social cognition: Measurement, Theory and Applications*. 255-277. New York: Guilford Press.

Petty, R. E. Cacioppo, J. T., 1986. *Communication and Persuasion: central and peripheral routes to attitude change*. New York: Springer-Verlag.

Petty, R. E. Fazio, R. H. Brinol, P., (Eds) 2009. *Attitudes: insights from the New Implicit Measures*. New York: Psychology Press.

Plowright, D., 2011. *Using mixed methods frameworks for an integrated methodology*. London: Sage Publications Ltd.

Polit, D. F. Beck, C. T., 2004. *Nursing Research, Principles and Methods*. Philadelphia, USA: Lippincott.

Polit, D. F. Beck, C. T., 2008. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. London: Wolters Kluwer.

Polit, D. F. Beck, C.T., 2014. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*. Philadelphia, USA: Lippincott

Polit, D.F. Hungler, B.P., 1997. *Essentials of nursing research: Methods, appraisal and utilisation*. 4th ed. Philadelphia: Lippincott.

Prentice, S., 2010. Substance misuse in pregnancy. *Obstetrics, gynaecology and reproductive medicine*, 20(9), pp. 278 – 283.

Pritchard, A., 2014. *Ways of Learning: Learning theories and learning styles in the classroom*. 3rd ed. London: Routledge.

Public Health England, 2013. *Nursing and Midwifery Contribution to Public Health: Improving health and wellbeing*. London: Public Health England.

Race, P., 2001. *A briefing Paper on self, peer and group assessment*. LTSN Generic Centre Assessment Series, Number 9.

Race, P., 2007. *The Lecturers toolkit. A practical guide to assessment, learning and teaching*. 3rd ed. Oxon: Routledge.

Radcliffe, P., 2010. Pregnancy and substance misuse: an ethnographic study of maternity services. *ESRC End of Award Report*, RES-000-22-2794. Swindon: ESRC.

Radcliffe, P. Stevens, A., 2008. Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social science and medicine*, 67(7), pp. 1065-1073.

Raeside, L., 2003. Attitudes of staff towards mothers affected by substance abuse. *British Journal of Nursing*, 12(5), pp. 302-10.

Ramirez-Cacho, W. A. Strickland, L. Beraun, C, Meng, C. Rayburn, W.F., 2007. Medical students' attitudes toward pregnant women with substance use disorders. *American Journal of Obstetrics & Gynaecology*, 196(1), pp. 86.e1-5.

Ramsden, P., 2003. *Learning to Teach in Higher Education*, 2nd edition. London: Routledge.

Rassool, H. G., 2009. *Alcohol and Drug Misuse. A Handbook for Students and Health Professionals*. Oxford: Routledge.

Rassool, H. G., Rawaf, S., 2007. Educational intervention of undergraduate nursing students' confidence skills with alcohol and drug misusers. *Nurse Education Today*, 28, pp. 284–292

Rasool, H. G., Rawaf, S., 2008. The influence of learning styles preference of undergraduate nursing students on educational outcomes in substance use education. *Nurse Education in Practice*, 8 pp 306–314.

RCM: Royal College of Midwives, 2001. *Royal College of Midwives*; Position Paper No. 24: *The Midwives Role in Public Health*.

RCOG: Royal College of Obstetricians and Gynaecologists , 2011. Royal College of Obstetricians and Gynaecologists and Centre for Maternal and Child Enquiries (CMACE). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. *British Journal of Obstetrics and Gynaecology*, 118(1), pp. 1–203.

Regan, J.A., Baldwin, M.A., Peters, L., 2012. Ethical Issues in Pedagogical Research. *Journal of pedagogic development*. [Online] at <https://www.beds.ac.uk/jpd/journal-of-pedagogic-development-volume-2-issue-3/ethical-issues-in-pedagogical-research> Accessed, April, 2017

Rees, J., 2011. A consideration of ethical issues fundamental to researching sensitive topics: substance use during pregnancy. *Evidence Based Midwifery*, 9 (1), pp.1622.

Riessman, C. K., 2008. *Narrative methods for the Human Sciences*. London: Sage.

Ritchie, J., 2013. *Qualitative Research Practice*. London: Sage.

Ritchie, J., Spencer, L., 1994. Qualitative data analysis for applied policy research in Bryman, A. and R. G. Burgess [eds.] *Analysing qualitative data*, pp. 173-194.

Roberts, S., Nuru-Jeter, A., 2010. Women's perspectives on screening for alcohol and drug use in prenatal care. *Womens Health Issues*, 20, pp. 193-200.

Robson, C., 2011. *Real World Research*. 3rd ed. Chichester, Wiley.

Rogers, C., 2004. *On Becoming a Person*. London: Constable.

Rogoff, B., 1990. Cultural similarities and variations in guided participation, Chapter 6 in *Apprenticeship in thinking: Cognitive development in social context*. New York: Oxford University Press.

Room, R., 2005. Stigma, social inequality and alcohol and drug use. *Drug and Alcohol review*, 24, pp. 143-155.

Schomerus, G. Lucht, M. Holzinger, A. Matschinger, H. Carta, M.G. Angermeyer, M.C., 2011. The stigma of alcohol dependence compared with other mental disorders: a review of population studies. *Alcohol Alcohol*, 46, pp. 105-112.

Schon, D., 1987. *Educating the Reflective Practitioner: Toward a new design for teaching and learning in the professions*. California: Jossey-Bass.

Schon, D., 1991. *The Reflective Practitioner: How professionals think in action*. Farnham: Arena.

Schwandt, T. A., 2000. *Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. 2nd ed. Thousand Oaks, CA: Sage. pp. 189–213

Sciarra, D., 1999. *The role of the qualitative researcher*. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology*, Thousand Oaks, CA, Sage, pp. 37–48.

SCIE: Social Care Institute for Excellence., 2005. *SCIE research briefing 6: Parenting capacity and substance misuse*. [Online] Available at: www.scie.org.uk/publications/briefings/briefing06/index.asp [Accessed 29 September 2011]

Selleck, C., Redding, B., 1998. Knowledge and attitudes of registered nurses toward perinatal substance abuse. *Journal of Obstetrics, Gynaecology and Neonatal Nursing*, 27(91), pp. 70-77.

Shavitt, S., Nelson, M. R., 2002. The role of attitude functions in persuasion and social judgment. In J.P. Dillard & M. Pfau (Eds.), *The persuasion handbook: Developments in theory and practice*. Thousand Oaks: CA, Sage. pp. 137-153.

Sheets Cook, S. Rogers, S., 2002. Evaluating the merits of interdisciplinary education. *Nursing Times*, 98(41), p. 30.

Shelton, M. L. Rogers, R. W., 1981. Fear-Arousing and empathy arousing appeals to help: The pathos of persuasion. *Journal of applied social psychology*, 11, pp. 366-378.

Shrigley, R., Koballa, T., Simpson, R., 1988. Defining attitude for science educators. *Journal of Research in Science Teaching*, 25(8), pp. 659-678.

Sikes, P., 2004. Methodology, procedures and ethical concerns. In Opie, C., 2004 (Ed). *Doing Educational Research: a guide for first timers*. London: Sage.

Silins, E. Conigrave, K.M. Ravkin, C. Dobbins, T. Curry K., 2007. The influence of structured education and clinical experience on the attitudes of medical students towards substance misusers. *Drug and Alcohol Review*, 26(2), pp. 191-200.

Silverman, D., 2007. *A very Short, fairly interesting and reasonable cheap book about qualitative research*. London: Sage.

Simons, H., 2012. *Case study research in practice. A guide for students and researchers*. London: Sage.

Siney, C., 1999. *Pregnancy and drug misuse*. 2nd ed. Midwives Press.

Smith, J., Firth, J., 2011. Qualitative data analysis: the framework approach. *Nurse Researcher*, 18(2), pp. 52-62.

Smith, M. K., 2011. *Donald Schön: learning, reflection and change*. The encyclopedia of informal education. [online] Available at: http://www.andrew.cmu.edu/user/skey/research_prev/reading/reflection_educational_role/et-schon.htm [Accessed 8 May 2015].

Snape, D., & Spencer, L., 2003. The foundations of qualitative research In J. Richie & J. Lewis (Eds.), *Qualitative Research Practice* pp. 1-23. Los Angeles: Sage.

Social Sciences Dictionary, 2016. Attitude Definition. [online] Available at: <http://www.socialsciencedictionary.com/attitude> [Accessed 9 June 2016].

Stake, R. E., 2000. Case Studies. In N. K. Denzin, Lincoln, Yvonna S. (Ed.), *Handbook of Qualitative Research* 2nd Edition. (pp. 134-164). Thousand Oaks, CA: Sage.

Stake, R. E., 1995. *The Art of Case Study Research*. London: Sage.

Stanford Encyclopedia of Philosophy, 2016. Kant's Moral Philosophy. [online] Available at: <http://plato.stanford.edu/entries/kant-moral/> [Accessed 8 July 2016].

Strang, J. Hunt, C. Gerada, C. Marsden J., 2007. What difference does training make? A randomized trial with waiting-list control of general practitioners seeking advanced training in drug misuse. *Addiction*, 102(10), pp. 1637-47.

Stuart. C. C., 2007. *Assessment supervision and support in clinical practice* 2nd edition. Edinburgh: Churchill Livingstone

Swansea Love Story, 2009. *Rehab helper* [online] Available at: <http://www.uk-rehab.com/rehab/swansea-love-story/> [Accessed 24 February 2016]

Taplin, S. Mattick, R. P., 2011. Child Protection and Mothers in Substance Abuse Treatment; *NDARC Technical Report No. 320 2011* [pdf] Available at: <http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.320%20%28Nov%202011%29.pdf> [Accessed 26 June 2016].

The Mental Health Foundation, 2016. Drugs [Online] Available at: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/d/drugs/> [Accessed 1st March, 2016]

Thomas, G., 2011. *How to do your case study*. Sage, London.

Thuy Tran, D. Stone, A. M. Fernandez, R. S. Griffiths, R. D. Johnson, M., 2009. Changes in general nurses' knowledge of alcohol and substance use and misuse after education. *Perspectives in Psychiatric Care*, 45(2), pp. 128-39.

Tobin, G. A., Begley, C. M., 2004. Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), pp 388–396.

Tsai, Y.F. Tsai, M.C. Lin, Y.P. Weng, C.E. Chen, C.Y. Chen, M.C., 2010. Facilitators and barriers to intervening for problem alcohol use. *Journal of Advanced Nursing*, 66(7), pp. 1459-1468.

UKDPC United Kingdom Drug Policy Commission, 2010a. *Getting Serious about Stigma: the problem with stigmatising drug users*. [online] Available at: www.ukdpc.org.uk/publications.shtml#Stigma_reports [Accessed 1 March 2016]

UKDPC United Kingdom Drug Policy Commission, 2010b. *Representations of Drug Use and Drug Users in the British Press*. Chapter 6 – Attitudes to drug use and drug users within media coverage. London: UKDPC.

United Nations Office on Drugs and Crime, UNODC, 2015. *World Drug Report* (United Nations publication, Sales No. E.15.XI.6). [pdf] Available at: [http://www.unodc.org/documents/wdr2015/World Drug Report 2015.pdf](http://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf) [Accessed 4 July 2016].

Universities UK., 2007. *Beyond the honours degree classification. The Burgess group final report*. [pdf] Available at: http://www.hear.ac.uk/sites/default/files/Burgess_final2007.pdf [Accessed 21 June 2016].

Usher, R., Bryant, I., 1989. *Adult Education as Theory, Practice and Research: The Captive Triangle*. Routledge, London

Vygotsky, L., 1986. *Thought and Language*. Massachusetts: Harvard University Press.

Walkin, L., 1990. *Teaching and learning in further and adult education*. London: Stanley Thornes

Wambui, J., 2013. An introduction to feminist research [online]. Available at: [www.researchgate.net/publications.PublicPostFileLoader.html?id](http://www.researchgate.net/publications/PublicPostFileLoader.html?id) [Accessed 22 January 2015].

Wang, X., 2012. The role of attitude functions and self-monitoring in predicting intentions to register as organ donors and to discuss organ donation with family. *Communication Research*, 39, pp. 26-47.

Watson, H. Maclaren, W. Shaw, F. Nolan, A., 2003. *Measuring staff attitudes to people with drug problems: The development of a tool. Effective Interventions Unit, Scottish Executive Drug misuse research programme.* [pdf] Available at: <http://www.gov.scot/Resource/Doc/47133/0013810.pdf> [Accessed 26 June 2016]

Watt, K. Purdie, D. Roche, A. McClure, R. 2006. Injury Severity: Role of Alcohol, Substance use and Risk taking. *Emergency Medicine Australasia*, 18, pp. 108-117.

Wilkinson, R. Pickett, K., 2010. *The spirit level: why equality is better for everyone.* London: Penguin Books.

WHO (World Health Organisation), 2011. *Global Status Report on Alcohol and Health.* Geneva: WHO.

WHO, World Health Organisation, 2016. *Substance Misuse* [online] Available at: http://www.who.int/topics/substance_abuse/en/ [Accessed 1 March 2016]

Williams, B. Brown, T. Boyle, M. Webb, V., 2012. The medical condition regard scale (MCRS): An examination of its factor structure using paramedic students. *Nurse Education Today*, 33(9), pp.938-43

Wimpenny, K., 2010. *Participatory action research: an integrated approach towards practice development*, in Savin-Baden, M. and Major, C.H., (eds) *New approaches to qualitative research: wisdom and uncertainty*, Chapter 10. London: Routledge

Witz, A., 1992. *Professions and Patriarchy.* London: Routledge

Wright, J. C., Baril, G., 2011. The role of cognitive resources in determining our moral intuitions: Are we all liberals at heart? *Journal of Experimental Social Psychology*, 47 pp. 1007–1012.

Yin, R., 1993. *Applications of case study research*. London: Sage.

Yin, R., 2009 *Case Study research design and methods*. 4th ed. London: Sage.

Yin, R., 2014 *Case Study research design and methods*. 5th ed. London: Sage.

Young, A., 2004. Experiences in Ethnographic Interviewing about Race. *Researching Race and Racism*. Eds. M. Bulmer and J. Solomos. pp 187-202. London: Routledge.

Zanna, M. P., Rempel, J. K., 1988. Attitudes: A new look at an old concept. In BarTal, D. Kruglanski, A. W., *The psychology of knowledge*. pp. 315-334. Cambridge: Cambridge University Press.

Appendix 1

Anglia Ruskin
University

The role of Education in attitudes toward substance misusing women amongst student midwives

Spring Semester 2014

Purpose

This survey is part of a study to explore the effect education has upon attitudes (positive and negative) toward substance misusing pregnant women. In this phase, I want to find out a little about you, your baseline views regarding a couple of medical conditions (including substance use) and also to see what your general empathy levels are, I will then compare this to the questionnaire you completed last semester.

What you need to do

Everyone's opinion is useful whether it is positive, negative or neutral. Please read each question carefully and answer honestly. Select your answer from the categories provided to give the answer that best fits you. Please tick or number the relevant box or boxes, preferably using a black or blue pen. There are three parts to this survey; please complete them all.

To assist in this survey I would first like to gain some information about you:

1. **What is your gender?** 0 Male 1 Female
2. **Age on 1 Jan 2014** years

Part 1.

The following questions are about your attitudes and feelings to caring for women. Please turn to the next page and for each statement circle the number that corresponds most with your view using the scale:

1 Strongly disagree	2	3	4	5	6	7 Strongly agree
-------------------------------	----------	----------	----------	----------	----------	----------------------------

This is not a test, so remember there are no right or wrong, good or bad answers.

No	Item	Strongly disagree							Strongly agree
3.	Women feel better when their midwives understand their feelings	1	2	3	4	5	6	7	
4.	Understanding body language is as important as verbal communication in midwife-patient relationships	1	2	3	4	5	6	7	
5.	A midwife's sense of humour contributes to a better clinical outcome	1	2	3	4	5	6	7	
6.	Midwives should try to stand in their patients' shoes when providing care to them	1	2	3	4	5	6	7	
7.	Patients value a midwife's understanding of their feelings which is therapeutic in its own right	1	2	3	4	5	6	7	
8.	Empathy is a therapeutic skill without which the midwife's success is limited	1	2	3	4	5	6	7	
9.	Midwives should try to think like their patients in order to render better care	1	2	3	4	5	6	7	
10.	Midwives should try to understand what is going on in their patients' minds by paying attention to their nonverbal cues and body language	1	2	3	4	5	6	7	
11.	Midwives' understanding of the emotional status of their patients, as well as that of their families is one important component of the midwife-patient relationship	1	2	3	4	5	6	7	
12.	I believe that empathy is an important therapeutic factor in medical treatment	1	2	3	4	5	6	7	
13.	I do not enjoy reading nonmedical literature or the arts	1	2	3	4	5	6	7	

No	Item	Strongly Disagree							Strongly Agree						
14.	Midwives should not allow themselves to be influenced by strong personal bonds between their patients and their family members	1	2	3	4	5	6	7	1	2	3	4	5	6	7
15	Patients' illnesses can be cured only by medical or surgical treatment; therefore, midwives' emotional ties with their patients do not have a significant influence in medical or surgical treatment	1	2	3	4	5	6	7	1	2	3	4	5	6	7
16	Attentiveness to patients' personal experiences does not influence treatment outcomes	1	2	3	4	5	6	7	1	2	3	4	5	6	7
17	Attention to patients' emotions is not important in history taking	1	2	3	4	5	6	7	1	2	3	4	5	6	7
18	Because people are different, it is difficult to see things from patients' perspectives	1	2	3	4	5	6	7	1	2	3	4	5	6	7
19.	Midwives' understanding of their patients' feelings and the feelings of their patients' families does not influence medical or surgical treatment	1	2	3	4	5	6	7	1	2	3	4	5	6	7
20.	It is difficult for a midwife to view things from patients' perspectives	1	2	3	4	5	6	7	1	2	3	4	5	6	7
21.	Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints	1	2	3	4	4	5	7	1	2	3	4	4	5	7
22	I believe that emotion has no place in the treatment of medical illness	1	2	3	4	4	5	7	1	2	3	4	4	5	7

Part 2.

This next section is interested in finding out your views in relation to specific pregnancy related conditions.

Use the scale below to rate your degree of agreement or disagreement with each of the following items regarding substance misusing pregnant women.

Tick the box that corresponds most with your view using the scale. Remember there is no right or wrong answer:

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

	Item	1	2	3	4	5	6
23.	Working with patients like this is satisfying						
24.	Insurance plans should cover patients like this to the same degree that they cover patients with other conditions						
25.	There is little I can do to help patients like this						
26.	I feel especially compassionate toward patients like this						
27.	Patients like this irritate me						
28.	I wouldn't mind getting up on call nights to care for patients like this						
29.	Treating patients like this is a waste of medical resources						
30.	Patients like this are particularly difficult for me to work with						
31.	I can usually find something that helps patients like this feel better						
32.	I enjoy giving extra time to patients like this						
33.	I prefer not to work with patients like this						

Use the scale below to rate your degree of agreement or disagreement with each of the following items regarding women suffering from **Reduced Fetal Movements:**

1 Strongly Disagree	2	3	4	5	6 Strongly Agree
----------------------------------	----------	----------	----------	----------	-------------------------------

	Item	1	2	3	4	5	6
34.	Working with patients like this is satisfying						
35.	Insurance plans should cover patients like this to the same degree that they cover patients with other conditions						
36.	There is little I can do to help patients like this						
37.	I feel especially compassionate toward patients like this						
38.	Patients like this irritate me						
39.	I wouldn't mind getting up on call nights to care for patients like this						
40.	Treating patients like this is a waste of medical resources						
41.	Patients like this are particularly difficult for me to work with						
42..	I can usually find something that helps patients like this feel better						
43.	I enjoy giving extra time to patients like this						
44.	I prefer not to work with patients like this						

Part 3

Finally I would like to find out about your previous experiences/exposure to substance misuse. Please answer the question below adding further detail if you feel comfortable to do so.

45. Have you had previous experience of substance misuse?

a. Professionally? 0 No 1 Yes

(Please Expand)

b. Personally (you or others you know)? 0 No 1 Yes

(Please Expand)

Thank you for taking the time to be a part of this study, it is very much appreciated.

Please now sign the consent form attached.

Appendix 2

Anglia Ruskin
University

The role of Education in attitudes toward substance misusing women.

About the Research:

Pregnant substance using women and their infants are known to face significant inequalities in health outcomes. Evidence suggests however that women in this group often don't engage with health care, including maternity services for fear of judgments and stigmatisation about themselves and the fear of removal of their children.

The focus of this study is to explore this area and in particular see what effect education has upon attitudes (positive and negative) toward substance misusing pregnant women.

All students undertaking the module 'substance misusing parents' will be invited to take part.

Phase one involves the completion of two short anonymous questionnaires about attitudes toward substance misuse; one before the start of the module and the other following completion of the module and assessment. Phase two involves some participants being invited to be interviewed regarding the module and its effects upon knowledge and attitudes toward substance misuse gained by undertaking the module.

The research is being organised by Claire Hooks (midwifery lecturer) as part of her educational doctorate at Anglia Ruskin University, it is not funded research. The results of the study will form the basis of her doctoral thesis; all participants will remain anonymous in this and in any resultant publications in the medical/midwifery field.

For further details please don't hesitate to contact either Claire directly at Claire.hooks@anglia.ac.uk or either of her supervisors; Dr Geraldine Davis Geraldine.davis@anglia.ac.uk or Professor Sharon Andrew Sharon.andrew@anglia.ac.uk.

Your Participation in the Research Project:

You have been invited to take part in this research because you are a student midwife undertaking the module 'substance misusing parents', however, participation is completely

voluntary and you can only take part by express consent (completion of the attached consent form).

You can consent to phase one (which is totally anonymised), two (where your identity during the interviews will be known to Claire alone) or both. You can of course withdraw from the study at any stage without any repercussions, by informing the third party recruiter (Louise Jenkins) during phase one, or Claire Hooks during phase two. Whichever phases you agree to take part in, your identity will not be known to Claire Hooks until completion of the module and assessment feedback has been given; your agreement to participate will in no way have any effect upon your assessment for this or any other module.

It is not anticipated that any adverse effects will result from taking part in the research for example psychological effects, however, if you find that the content of the study or the module are challenging please refer to the guidance on the VLE site for the module regarding available support and help.

If you agree to participate in this study please bring your completed consent form with you next week to Emergency Midwifery Practice (EMP) on ...(Date TBC), whereby Louise will hand out the questionnaires for completion in the class at the end of the morning session. It is anticipated that the questionnaire will take approximately 10 minutes to complete.

You will then be asked to complete a second questionnaire in February 2014, again in EMP.

Following completion of both questionnaires a sample of participants will be contacted by Louise Jenkins via their university emails and invited to take part in face to face interviews with Claire Hooks. If you are happy to be interviewed you will then contact Claire directly to arrange a convenient time/date to be interviewed.

The questionnaires and interviews will be analysed by Claire Hooks and following completion of the project will be destroyed with the exception of the summarised, anonymous data that will be kept on a password protected computer.

Your participation in this valuable project will not only be greatly appreciated by the researcher, but will help to illicit much needed valuable information to contribute to the research in this field and ultimately improve practice and experience in the area of pregnant substance misusers. In addition on a personal level as a participant you will be entitled to receive feedback from both your individual questionnaires/interviews and also to receive information on the findings from the overall participant group which may aid your personal development.

Thank you for your time,
Claire Hooks (Researcher)

Agreement to participate in this research will not compromise your legal rights.
YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Name of Participant:

Title of the project: The role of Education in attitudes toward substance misusing women amongst student midwives.

**Main investigator and contact details: Claire Hooks; Email – Claire.hooks@anglia.ac.uk
2nd Floor William Harvey Building, Anglia Ruskin University, Bishops Hall Lane, Chelmsford,
Essex, CM1 1SQ. Tel – 0845 1964696**

Members of the research team: First Supervisor – Dr Geraldine Davis; Email, Geraldine.davis@anglia.ac.uk Second Supervisor – Professor Sharon Andrew; Email, Sharon.andrew@anglia.ac.uk

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.
2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.
3. I have been informed that the confidentiality of the information I provide will be safeguarded.
4. I am free to ask any questions at any time before and during the study.
5. I have been provided with a copy of this form and the Participant Information Sheet.

Data Protection: I agree to the University² processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me

Consent for phase one (questionnaires) yes No

Consent for phase two (interviews) yes No

Name of participant
(print).....Signed.....Date.....

Name of witness
(print).....Signed.....Date.....

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

² "The University" includes Anglia Ruskin University and its partner colleges

Appendix 4

Anglia Ruskin University Ethics Approval

16 September 2013



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Claire Hooks
Faculty of Health, Social Care & Education
Anglia Ruskin University
William Harvey Building
Bishop Hall Lane
Chelmsford
CM1 1SQ

Dear Claire,

Re: Application for Ethical Approval

Project Number: 13/C09
Project Title: How does specialist education affect the attitudes of student midwives toward substance misusing pregnant women?

Principal Investigator: Claire Hooks

Thank you for your application for ethical approval which was considered by the Faculty (of Health, Social Care & Education) Research Ethics Panel (FREP), by Fast Track Ethical Review via 9 September 2013.

I am pleased to inform you that your research proposal has been approved by the Faculty Research Ethics Panel under the terms of Anglia Ruskin University's *Policy and Code of Practice for the Conduct of Research with Human Participants*. Approval is for a period of three years from 16 September 2013.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Policy and Code of Practice for Research with Human Participants and specifically:

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement those changes until you have received approval from FREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1993) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the FREP Secretary copies of this documentation.

- Any laws of the country where you are carrying the research out (if these conflict with any aspects of the ethical approval given, please notify FREP prior to starting the research).
- Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a project risk assessment must have been carried out prior to starting the research).
- Notifying the FREP Secretary when your study has ended.

Information about the above can be obtained on our website at:

<http://web.anglia.ac.uk/ehc/index.htm>

Please also note that your research may be subject to random monitoring by the committee

Please be advised that, if your research has not been completed within three years, you will need to apply to our Faculty Research Ethics Panel for an extension of ethics approval prior to the date your approval expires. The procedure for this can also be found on the above website

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely



Dr Paulette Luff
For the Faculty (of Health, Social Care & Education) Research Ethics Panel

T: 0845 196 3544

C: paulette.luff@anglia.ac.uk

cc: Dr Geraldine Davis (Supervisor)
Prof. Sharon Andrew (Supervisor)
Beverley Pascoe (RFSC Secretary)

Appendix 5

Phase two interview schedule

Introduction –

Introduction to interview, explanation of research and right to terminate the interview at any stage. Voluntary participation – consent. Prompt of the content of module.

Attitudes –

Can you tell me about your experience of the substance misuse module? Prompts – did you enjoy it? Why/why not?

Overall, would you say that your views/attitudes toward substance use in pregnancy have changed from prior to the module? In what way? Why?

Where do you think your attitude/opinion stems from?

- Prompts

Education, experiences, practice, family/background, media, school

Knowledge/Learning/content –

Here is a reminder of the main sections of the module (show sheet): can you identify and explain what you learnt from each section?

How do you think learning could have been enhanced in the module?

Was the method of delivery important? Why? How? online, discussion boards etc

Effect in practice –

What do you feel about the knowledge that practitioners have around substance misuse is in midwifery practice? Can you explain? What do you feel influences this?

- Prompts

Content, extent, how used, effectiveness

If not answered above ... What influence do you feel knowledge of substance misuse has upon attitude/opinion in relation to substance use? Do you feel this impacts on the way in which individuals practice? How?

Do you feel guidance/policy (local and national) is useful in this area? In what way?

In what way will undertaking this module affect your practice in this area?

Overall - If you can pick just one thing from undertaking this module that will directly impact upon your practice, what would it be?

If there is one thing you would change about the module what would it be?

Appendix 6

SPSS Raw Data Tables MCRS

Table 1. Before the module comparison of Mean scores; Reduced Fetal Movements compared to Substance Misuse

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	SM	49.550000000000000	40	7.699317319054149	1.217368957829622
	FM	57.08	40	6.330	1.001

Table 2. Before the module paired t-test; Reduced Fetal Movements compared to Substance Misuse

		N	Correlation	Sig.
Pair 1	SM & FM	40	.080	.623

Paired Samples Test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1	SM - FM	-7.525000000000006	9.567539940487341	1.512760890828591	-10.584847718065285	-4.465152281934727	4.974	39	.000

Table 3. Following the module comparison of Mean scores; Reduced Fetal Movements compared to Substance Misuse

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	SM	53.551724137931030	29	5.302197704029042	.984593395731261
	FM	57.00	29	4.796	.891

Table 4. Following the module paired t-test; Reduced Fetal Movements compared to Substance Misuse

	N	Correlation	Sig.
Pair 1 SM & FM	29	.138	.476

	Paired Differences					t	df	Sig. (2 tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1 SM - FM	-3.448275862068968	6.641784435873453	1.233348406918601	-5.974675547122581	-.921876177015354	-2.796	28	.009

Table 5. Reduced Fetal Movements mean before and after module Independent t-test

	VAR00004	N	Mean	Std. Deviation	Std. Error Mean
FM	Q 1	40	57.08	6.330	1.001
	Q 2	29	57.00	4.796	.891

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means							
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference		
								Lower	Upper	
FM	Equal variances assumed	1.369	.246	.054	67	.957	.075	1.400	-2.719	2.869
	Equal variances not assumed			.056	66.842	.956	.075	1.340	-2.599	2.749

Table 6. Substance Misuse before and after the module, independent t-test.

Group Statistics					
	VAR00004	N	Mean	Std. Deviation	Std. Error Mean
SM	Q 1	40	49.55	7.699	1.217
	Q 2	29	53.55	5.302	.985

Independent Samples Test										
		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Substance Misuse	Equal variances assumed	6.124	.016	-2.413	6/	.019	-4.002	1.659	-.7313	-.691
	Equal variances not assumed			-2.556	66.861	.013	-4.002	1.566	-7.127	-.876

Table 7. Paired t-test results for both SM and FM before and after module

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	SM Q1	50.79	29	7.007	1.301
	SM Q2	53.5517	29	5.30220	.98459
Pair 2	FM Q1	56.41	29	6.722	1.248
	FM Q2	57.0000	29	4.79583	.89056

Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 SM Q1 & Q2	29	.627	.000
Pair 2 FM Q1 & Q2	29	.339	.072

Paired Samples Test

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
SM Q1 – Q2	-2.75862	5.53337	1.02752	-4.86340	-.65384	-2.685	28	.012
FM Q1 – Q2	-.58621	6.80608	1.26386	-3.17510	2.00269	-.461	28	.646

Table 8. Individual question means prior to the module Q1.

Substance Misuse

	1	2	3	4	5	6	7	8	9	10	11
Mean	4.30	3.47	5.35	3.75	4.42	4.75	5.48	4.68	3.83	4.15	5.37
N	40	40	40	40	40	40	40	40	40	40	40
Std. Deviation	1.506	1.664	1.027	1.428	1.534	1.080	.679	1.228	1.259	1.210	.838

Reduced Fetal Movements

	1	2	3	4	5	6	7	8	9	10	11
Mean	4.55	4.63	5.60	4.73	5.70	5.25	5.85	5.55	4.57	4.93	5.73
N	40	40	40	40	40	40	40	40	40	40	40
Std. Deviation	1.011	1.409	.778	1.414	.758	1.214	.580	.932	1.174	1.207	.716

Table 9. Individual question means after the module Q2.

Substance Misuse

	1	2	3	4	5	6	7	8	9	10	11
Mean	4.86	3.83	5.41	4.17	5.28	4.93	5.62	5.10	4.21	4.55	5.59
N	29	29	29	29	29	29	29	29	29	29	29
Std. Deviation	.915	1.391	.733	1.197	.960	.998	.494	.976	1.177	1.021	.628

Reduced Fetal Movements

	1	2	3	4	5	6	7	8	9	10	11
Mean	4.66	4.52	5.48	5.07	5.72	5.21	5.69	5.59	4.55	4.86	5.66
N	29	29	29	29	29	29	29	29	29	29	29
Std. Deviation	1.203	1.479	1.184	.923	.649	1.048	.850	.867	1.021	.953	.857

Appendix 7

Framework Data Matrix

1 Student Perceptions of Practice

SMM – substance Misuse Midwife, SM – substance Misuse, BI – brief interventions, MI – motivational interviewing

	Guidelines/processes (AIP G)	Training needs (AIP T)	Attitudes/Judgments of staff (AIP A)	Knowledge base of staff (AIP K)	Avoidance of care by midwives (AIP Av)	Different view of licit vs illicit drugs (AIP Dif)	Anomalies (AIP anom)
Participant 1	I was really surprised that there's no guidelines in my trust for substance misuse which I was quite surprised about because I work in an area where there is a lot of substance misuse issues and there's no guideline. So I found that really surprising. I also found it surprising that when I went to see CDAT, it's actually situated above a pub! 3:75	I think there needs to be more training courses on it. Including BI ... With the brief interventions we could really make a big difference. But there needs to be more training	I see a lot of midwives look down their nose at people who smoke during pregnancy and someone that drinks 1:18	I think it's pretty rubbish actually in terms of what they know I think 4:116			I don't think there's much support for the women if they are just sort of in the medium/light using bracket, because the midwives don't really know what to say. So I think I'm not blaming the midwives for that, but they just don't have enough training and they have very busy jobs 5:137
Participant 2	I think there should be more things in place for referring early on to get to the root of the problem 1:20	there needs to be more training put in place in practice to help raise strategies coping methods and how midwives can deal	I remember my mentor being totally and utterly gobsmacked that she had said that yes, she smoked weed ... he was totally and	I don't think the midwife would know how to deal with it 3:79	I know that the midwives I have been out with. Try to avoid it. For example, if a woman says I did drink but don't		

There's lots and lots of information out there on how to deal with it, but once again I don't think anybody would access it. Unless that had the problem arisen in the first place 6:158

We have guidance and there is a pro forma at the back of the guidance on how to do referral which I found really useful because I didn't know that before I looked at it. 6:173

with asking the questions and if they then get a yes answer how they go on from there, 3:78

and of recognition there are midwives that have been out there long time and have had no training at all 5:133

if midwives were bought into a training programme, than they would access the different websites and guidelines because they would have to do and then they would be aware of what was out there.6:

by educating midwives we can

utterly shocked by it.... it was just horrific, like someone just told that they had killed her mother! There was a look of horror on her face in front of the woman 5:145

I feel personally. They have very little.

I think most midwives in practice probably wouldn't have a clue if I'm perfectly honest. And I think that's why they can't deal with it when I have it thrown at them 5:137

We need more understanding.

drink now, the midwife will say, oh, okay, that's fine then. And it's just tick tick tick and moving on 3:75

It is like a total no-no subject

Participant 3	<p>The guidance that we have for it is only one little guideline and really relates to how we make a referral to the substance misuse midwife. That was it. And it was about six or seven years out of date 5:141</p> <p>There were no proper guidelines for me to look at no policy 5:148</p> <p>my trust is useless in this area. Policy is useful if there is some.</p>	<p>educating the women for future pregnancies 7:</p> <p>I think that they need to be taught more about why these people are taking the drugs and be less judgemental 6:175</p>	<p>I know we not supposed to be judgemental, but people are ... there were midwives who were being judgemental looking after her saying things like, silly girl. She's only 16 what's she doing. And really slating her, she is taking marijuana that poor baby. The baby did have withdrawal when it came out and that was awful, but they were really slagging her off. 6:183</p>	<p>I think that midwives don't really understand the full picture of what's going on with that woman 5:138</p> <p>it was a lack of knowledge, purely just not understanding their side of the story, and being ignorant and not understanding that they do have a tough time 6:172</p> <p>The wider picture of drug use is key to it, we need to know their story really. Knowledge definitely affects the way people practice. 6:179</p>	<p>if the midwife comes into contact with anyone they substance misusing they can pass you on to her and have nothing more to do with you (to SM Midwife) 5:137</p> <p>when I asked the other midwives about substance misuse because I was doing this module to help me on posts etc. Almost all of them were like, I don't really know. We just refer them 5:156</p>	<p>We ask about do you drink alcohol do you smoke</p>
Participant 4	<p>There is a lack of guidance in the area - Trust and</p>	<p>Midwives need to educate themselves.</p>	<p>Midwives who go into those houses (don't) see it,</p>	<p>Lack of knowledge of guidance I'm not sure that they know</p>	<p>There is a keenness to just pass on to the consultant.</p>	

NICE. Despite a SMM and high SM rate. Including of referral process and other agencies to help. So only have experience to go on.

She was being seen by our drug and alcohol midwife, but it didn't seem like she had a lot of help, there just wasn't a proper plan in place or anything. (2:54)

Should be a compulsory element to STAT training ... but not in place at present.

because they're quite set in their ways, many of them and have been there a long time. (3:79)

what is there. (6:184)

Lack of knowledge of talking techniques. They (midwives) skirt around the question or they ask it so directly that the women is taken completely off-guard and wouldn't tell the truth anyway (5:137).

Generally knowledge poor.

Lack of knowledge of available resources/support. they don't have a very good knowledge of what's available in the area (5:146)

cigarettes, but we don't ask about illegal substances so much anymore (3:86)

Participant 5

Policy present but lots of things missing and it was disjointed. Didn't tell you what you

Training seems a bit hit and miss (5:150)

I asked her what did the midwife say to you about cutting down? She said, they looked down on me. The woman looked

Midwives have the knowledge. I think the midwives often have the knowledge, but they don't talk

Midwives don't talk about it unless a woman discloses. They seem reluctant.

Midwives tend to just ask directly rather than use MI and BI techniques.

needed to do, when. NICE guidance limited re SM Some good guidelines but not mid specific

really upset by it and it really upset me to think the midwives judgement was going on the woman and caused her to think that she's doing even more harm. And then she is even less likely to give up because of the stress is causing her to smoke. And then she won't disclose anything else, for fear of judgement. It's sad (4:124)

I don't think I've seen much in terms of judgement. I haven't really seen anything different to how they interact with other women (5:138)

about it very much unless there woman discloses that she is using the drug and then it all comes out. (4:101)

mainly midwives only talk about smoking and alcohol or heroin. Those are all the midwives talk about, not anything in between (4:109)

Midwives with greater knowledge are less likely to refer. Its not judgement, but knowledge ... It's just that they seek more help if they have less knowledge. (5:138)

**Partici
pant 6**

Time demands are too great. you are attending a discharge planning meeting for women, you may be

More training is needed. There is not anything mandatory training that I'm

If its normal to you as a midwife or you use yourself, you may see nothing wrong with it. Or hypocritical challenging it.

I think the general consensus and attitude towards these women is very caring, not nasty. They are just

it's no different saying I've smoked cannabis in my pregnancy then I've had the odd glass of wine in my

A lot of the journal's focus on clinical skills and a clinical improvements to practice, but I guess this subject challenges opinions. Do people

met twice. I don't think that's appropriate that you're there to give a judgement on how that woman has interacted with that baby over the last couple of hours. You may have come on shift three hours ago and have spent two minutes with her. How can you make that judgement, and yet it's so important for her and can be life changing. (7:221)

Not known about guidance. I don't think a lot of people are aware of change and guidance around substance misuse and things (8:253)

There is a lack of literature as well.

aware of in relation to substance misuse. (9:266)

Positive, but knowledge is what is lacking and this leads to poor care. I think are very supportive of the woman. I've not heard of bad attitudes (7:218) and

They feel empathy for the woman. The woman is very much the focus and the first concern (7:208)

lacking in the knowledge(8)

although these (personal experience views) are valid. They may not be accurate and may not be informed by evidence (8:248)

I don't think that a lot of midwives understand all of the different areas and policies etc. for example. Scoring systems (7:210)

Midwives become task focused as lack knowledge.

pregnancy but the reaction of the midwife is entirely different (5:144)

really want to read things which are a little bit challenging (8:259)

**Partici
pant 7**

There is a lack of trust policy and midwives need this guidance to refer etc.

Midwives have so much info to give A/N they just skirt over drugs.

Training needed. Training just helps people to be able to interact with these people better and not be so judgemental 4:119

If They've had bad experiences every time they've looked after a substance misusing parent they may always feel like that 4:107

I saw in the neonatal unit with neo-natal nurses and how they are with the women, they aren't looking after the women, but the babies so they are often very judgemental. Like this is what she's just done to this baby! 4:111

NNU ... they were very rude to her, they just came in and bought the baby to her and didn't even speak to her 4:113

The ones with greater training and more experience were less judgemental.

When CO monitors were introduced it helped to broach subject ... so training helps.

Midwives aren't always aware enough. Knowledge limited.

midwives shy away from trying to help because they don't know how to don't know what they're supposed to do. 5:

Knowledge is variable – between different midwives.

**Partici
pant 8**

The module was good to be able to share guidelines where some trusts were lacking them.

There are guidelines to follow. They are quite slapdash on how they apply 4:110

I think that the community midwives struggle enough providing continuity of care. The way our system is set up and they might only see that women twice because somebody else has seen the other times, and so they don't feel confident. 4:119

with knowledge and training you are more empathetic to them and more aware of the underlying needs. You not just like, what they doing smoking a joint? But you're more intriguingly think why are they doing that. You're thinking about it rather than just saying that's wrong 1:23

training is needed re asking.

Older midwives better ... who had been midwives longer. Newer ones were task focussed.

Midwives just done feel confident – attitude is poor.

I would say it's uncomfortable, and in my experience, a lot of my mentors have been of a certain age, where perhaps they feel it's not that important 4:125

In my personal experience I feel that there is a distinct lack of understanding of misuse and misusers all the way from smoking up 4:108

They lack the understanding re assessing women and asking re use.

The midwives say you don't have to do it, and the women then say okay, I decline. 4:116

midwives just take the answer and leave it at that .. e.g. alcohol, ... not now I'm pregnant, but actually that's not really a great answer is it because we don't know what she drunk beforehand and when she found out she was pregnant.5:

I think a lot of guidance are for substance misuse and so when people look at the guidelines they think oh well. She is only a heavy smoker and it's not the same as injecting heroin. So they are reluctant then to do anything 6:180

But if someone says the used to use heroin or cannabis. It's like ooo red flag, we need to watch them. When the reality is they probably don't need as much watching because they're probably

Without specialist knowledge in the area. Those care pathways are basic and can lump everyone together and that's the difficulty.6:177

All vulnerable women are lumped together but their needs are very different.

Specific guidance is needed re different drugs too.

already receiving help or have 5:

Had scenario in practice of a baby withdrawing from nicotine, but no support because mum was ex-heroin addict ...

Licit drugs are often ignored and the focus is on illicit even if no longer used ... e.g. if someone has a bad back and using pain killers ... no further questions.

Participant 9

Had a mental health midwife who dealt with SM.

Staff were unsure who dealt with SM in the trust.

Guidelines are good though ... just not dealt with well.

Midwives need to understand why people use.

I think that generally speaking that a lot of staff can be quite judgemental. And I think that stems from either just literally being someone who has a no tolerance stance towards drugs or because they are anxious or unsure themselves on how to approach and care

Midwives don't know what support there is locally.

. It became apparent that there are a lot of midwives who didn't even know how to recognise when I've done home visits, many midwives don't take

There's a lot of avoidance. They carry out the care that they need to carry out according to guidelines in terms of making sure that mums monitored babies monitored etc, but there's no emotional support and they become

Participant 10

Have a specialist midwife but she's too busy.
Local policy lacking
the local and national guidelines are very generalised and everybody's situation is quite specific, so they aren't specific to specific substances
5:

More training needed in specific drugs to support the guideline. No training in trust ... needs to cover recognition etc – should be mandatory.
it's knowing what to expect from them, their behaviour and things like that that they really need to know

for those women.
3:75
Poor attitude – quite negative in the way they deal with them. It may not be while they are in the room with the women, but outside of it. Then everybody's got an opinion of it 4:
I think the older midwives have more of an opinion than the younger newly qualified midwives, but I think maybe

any notice of the things lying around. I've done visits, mainly smoking appliances laying around and said all did you see that and then the mentor has said no, I didn't. They just don't seem to be aware of the things around them or don't know what to look for 4:122
There are guidelines, but I don't feel a lot of people have a lot of knowledge around substance misuse at all 4:114
Knowledge in general is poor.
they're getting sub optimal care really and midwives are missing the signs and symptoms that could that could

task orientated.
3:93
Midwives often refer on and think they've done their bit ... but haven't!
I feel they just pass the buck saying oh we don't deal with that. 4: 119

PN ward is too demanding and busy and things get missed.

about in the beginning. And to try and pick up on some of the signs and symptoms of them having a substance misuse problem. I feel this is lacking 4:

they didn't have too much of the training when they trained 2:129

prevent things 5: 156

2. Distance Learning Delivery

F2f – face to face BL – Blended Learning

	Flexibility of completion (DL F)	Community of learning (DL C)	Scope of learning (DL S)	Gained researching/wider learning tools (DL R)	Anomalies (DL anom)
Participant 1		because it made you feel that that it was a module that you were taking part of part of the community rather than on your own and also that your questions were important 6:181	I really enjoyed doing this online and the setup of it. ... it worked really well to and you could go back and look at things again. If you didn't understand it or you need to read up on it again, and all of the links and things are there for you to go back and look at whenever you want. The discussion boards at the time will be infuriating, but it's been good since the module to be to go back and have a look at them again and gain more knowledge because some really good stuff in there. 3;104	it's given me is the tools to go and find out information if I don't know it. So in knowing where to look want go online 5:155	Some in class. Also time scales stricter for posting.
Participant 2	I found it quite hard to do any online stuff at home because of having a family and the distractions that go on. But that's my personal view. Even like after my dissertation. I ended up coming into the library to do my work 7:226	I liked reading different points of view. 4:102			I would have liked to have had lectures, in-class to have an open discussion and here because online, you can't really get into a debate 3:92 But BL so DL too.

Participant 3

It being online was really good ... because it meant you could do it whenever you wanted it was much more flexible. So for me when my husband was at work and the children at school ... and do it at my own speed 3:92

I personally feel I got more from it at home because I think you're easily distracted in the classroom 4:121

Module leader really supportive.

this way allowed me to give my time and attention to whatever I was looking at and to do my own research and to do what I was interested in and look at the area I was going to make my post on ... which in a class you don't have that aspect 4:126

online is really good because you can do it in your own Time at your own pace and anything you don't understand you can go

if you're having an open debate in the classroom and this 30 of you in that room 30 if you get involved with it, whereas I found that you may only get two or three people commenting on one status. 4:104

Also timing ... relies on others completing so you can read their posts – so worked because a big cohort. I think our cohort was quite big and so there were quite a few who were in their already doing it

I would have liked more classroom time to feedback and discuss. BL.

we had quite a lot of work going on at the same time as this module and so it was quite good to not have to waste time coming into uni and home again with the traffic etc. That traffic time could be spent at home on the computer doing the work, so I did preferring that way, doing the module from home and petrol costs etc. I

			through as many times as you want or need to. Not having to feel conscious that someone else is getting fed up with you 4:130		did enjoy that it was at home.4:116
Participant 4		Although it was online, still had face to face chats. We spoke about it (each other's experiences) like that anyway. Just not in facilitated and formal way (4:112).	Flexibility in self learning. you could take it as far as you wanted (4:125)	Independent learning skills gained	May have been useful to meet f2f too to share experiences and learning
		It was good to learn from each other.	It was very much about you deciding what parts were going to be more useful to you and being efficient with your time (4:126)	Its important to take responsibility for further learning	
Participant 5	like how it was just in small chunks (3: 79)	Having other people's ideas to reads meant could learn from each other.	I liked that you could follow whatever links you want to, online, that you wouldn't be able to do in the classroom (3:89)	you're learning to do it yourself. So it helps with your research skills. So in a classroom, you might be given those links to go and have a look at yourself when you get home, but very few people do that. Whereas online, you're more likely to. (3:92)	Clear tutor support and instruction was important. the main downside was that it was really time-consuming to be able to read through other people posts (3: 65)
	you could just go home and do it and, read it in your own time (3:87)				some blended learning or an open discussion board would be useful to bounce ideas around.
Participant 6	you get to explore and do slots of small snippets of work (6:175)		you had included so many different links could go off and look at your own stuff	Adult learners ... but I think you get out of it what you put in. But that's one of the learning skills with a degree. It's up to you how much you take from it. (6)	Difficult to do alongside other demands (module). A more general discussion board would be useful to dip in and out of.
			The fact that you could go where you want it was an		

			individual was really important (6:186)	it teaches you a different way of doing things. ... if I came across something I would be better prepared to deal with it and I would know where to look ... rather than just googling it. (9)	
				It's given me like a model for way of dealing with things appropriately when I come across something I don't know about (9)	
				how to research probably and how to write a reasoned evidence-based argument concisely	
Participant 7	There were so many links you could go where you wanted not like at home.	It was good to see what others said.	Could research where you wanted.	But I have learnt much more about discussing, having to read it all, process it and then write a post 3:86	Time was limiting. Could read through material in class and a lot of material was just doing that.
Participant 8		Tutor support was essential so you knew you weren't just left on own. As a group we were supportive and respectful of each other.	There were the links there to help you start that journey and you could then navigate to where you wanted to go to where you are interested 3:	It gave you the tools to research 3: It was self-learning and these skills learnt too. I think the learning isn't as deep in class as you haven't had to do this. I think when it's in the class. It's more of	

Participant 9

I liked that you could go where you wanted.

You can't go off as far in the classroom. As you may want to, but if it's their online for you to look at when you go home you could do that then3:65

It was good that you could take your own path.

what you know, rather than what you've learnt because you fall back on what you feel you know and are not perhaps a confident with the new things that you've learned 4:

I did go back to this module and use it as a resource for reflections on other things are needed to write for later modules to look at references and so on. So it's definitely given me the skills to know where to look. 5:144

Yes research skills gained.

Would like to come to uni for an hour and then go away and do online after. BL.

Reading a computer screen all day was hard.

It was quite difficult to motivate self at home studying alone.

Participant 10

3. Discussion Boards

	Shared resources (DB R)	Sharing of experiences (DB SE)	Critical discussion skills (DB D)	Challenge of views (DB C)	Anomalies (DB anom)
Participant 1	It allowed me to not only have a different perspective put across but also to have the references to go and find it read about it myself from others 4:111	Good to share experiences – professional ones.	There were specific people who were coming back with a really good argument or discussion, but there were others who weren't and that was a bit disappointing. 3:81	for me personally it's something I need to do more because people think in a completely different way. For me, and come from a really different angle and you don't see them so much in class because they don't speak up and haven't really considered and thought about it, whereas with the online discussion boards, you've got to have thought about it before you post it and reference it 4:106	More discussion needed – restrictive and also time ... there wasn't enough.
Participant 2		different people's experiences and views. It was nice listening to how other people feel and when we went back to the introduction, bit, you could go back and see what sort of age range. They were in a match them with their experiences and so on,			

which I found quite interesting 4:108

Interesting to read others posts. I was kind of a bit jealous at times because some people had some really good experiences and I kind of felt like oh, I've had nothing 4: 100

like that smoking one was a personal experience and her personal view and then other people talked about difficulties they had had in placement with heroin users and staff, and with difficult families and family members because of it. It was good to get both sides4:115

we were able to interact with each other and find out about each other's experience (1:9)

there was learning from others different trusts and choices of substance and also sharing of others views

getting other people's feedback on one of my posts.4:102

Describing a reply to her post ... So it was really good to get that alternative point of view.4:106

Allowed challenge of trust practice/position

Participant 3

Participant 4

Participant 5

It was good to share others ideas.

Good to learn from others experiences of what worked and what didn't in practice, including guidance etc.

Other peoples posts gave insight to aspects not considered

There were too many posts to read overall.

Participant 6

Really good to hear how other people do things.

It was good to learn from what other people wrote about their different experiences ... but you have to read with caution as it's a personal view, I think you've got to read that with caution because it's going to be subjective and usually its third hand 7:198

Also it helped me to be diplomatic in the way you presented that view to other students because you had to respond to their posts online (1:28)

your snapshot was always quite different to somebody else's, which made for good discussion

you can develop an argument or response back which disagrees with it which you needed to write supported with evidence (2:32) so you had to develop balanced arguments.

you get the opportunity to read your peers work and to get them read yours and where your names attached to the post you put up you want your peers to think

reading other people's ideas on things makes you think about the way other people do things, and when you think oh I don't really agree with that or the evidence I've read contradicts that. Or you've taken something completely different from the evidence than I did. So have I got that wrong? So you might read it again and reconsider and reflect on your view, having different views like that (1:24)

you kind of gave different waiting to different people's comments, depending on their writing style (2)

			well of you (2) it helped improve writing skills	
			It made you ensure that it was balanced and well considered. It makes you step up your game a bit more because other people are going to be doing to your work. What you're doing to theirs, which is critiquing it 2:51	
Participant 7		It was good to see what others wrote and to learn from their experiences in practice.	I've learnt lots more about discussion skills.	
		Because you had to reply to someone you had to read lots of others posts which was good.		
Participant 8	It was good to learn from others posts. it was really interesting to read the other posts ... because people chose different subjects 2:57		when you're going to write a post you were able to think about it. Consider it and think about what you're going to write whereas when you're in class just talking. You can often get a bit confused about where the	. It made me think, would I have challenged that or asked that when I read other people's posts 2:

			discussions going on or go off on a tangent 4:	
			having to consider the arguments before you write it makes people more respectful in what they're writing, they have to engage the brain before their mouths! 4:	
Participant 9	some of the services they found, other references they might find were different to the ones that I found and that all helped with my learning 3: 70	everybody works in a different area and people see things from different perspectives on their writing their posts. Their writing it from their thoughts and feelings 3: 65		
Participant 10	<p>It was good to see what others wrote.</p> <p>Lots of references to share and good to learn from other subjects picked by others.</p> <p>I printed lots off and kept as a reference guide for portfolio.</p>	Good to share experiences.	<p>Others posts put ideas in your head and made you think.</p> <p>From reading other people's things and thinking oh, that's quite an interesting thing I will look into that bit further. And then I could for my own opinion from something they've said 4:</p>	Would like to read all posts but too many!

4. Student Attitudes/Judgements/reflection

MP – midwifery Practice

	Origin (A O)	Reflection in module, self-reflection and self-challenge (A R)	Attitude change from service user accounts (A SU)	Experiences (A E)	Student Judgments (A SJ)	Anomalies – (A anom)
Participant 1	Social circle. Parents	. It made free think slightly in a different way 1:9 I think yes, it has changed my perceptions of it. I think I am a little bit less judgemental than I was 1:29		when I had my first child I still smoked	I think you can't help when someone walks in. That's heavily pregnant and they stink of smoke, there's that human instinct that kicks in and thinks err you stink of smoke or when you walk into a house with as a newborn baby and they are smoking around the baby. It just makes she think, oh, God, they are smoking around that baby 2;32	
Participant 2	Personal previous work experiences . There is a greater social awareness. Media.	before I set out thought I had a reasonable understanding of drugs and how many were out there and how often they used and things, but until I actually underlook the module I didn't realise how little I did know 1:8	The Swansea love story was a heart-breaking and really moving. I found that really, really eye opening and useful. 8:233 <i>The reasons behind the drug use were really powerful. And it's such a vicious circle. They just can't get out of.</i>	Attitude formed from previous employment, where exposed to a range of drug taking and dealing ... illicit/licit.	I'm pretty open minded 1:16 It's actually the ones that you least expect to be using substances are the abusers 2:30	

Participant 3	<p>Media, school, family, parents.</p> <p>The media reinforce negative stereotyping, with negative connotations which you associate with drugs 2:37</p>	<p>When I've got to care for patients who substance misuse the care that I give them is going to be more beneficial – following the module.</p> <p>Describes a journey of reflection and learning throughout the interview.</p> <p>because I went into it being so judgemental with my views towards drug users. I came out of it a really different person 3:78</p>	<p>I saw their side of the story really 1: 10</p> <p>Swansea love story very impactful. the whole thing it really upset me to see that people are living lives like this. It's just heart-breaking 1: 18</p> <p>the Swansea love story that really change my perspective.3:67</p>	<p>before I took the module I was really judgemental towards substance misusers ... But doing this module I saw their side of the story really and find that I am far less judgemental 1:</p> <p>The ones that are doing the drugs are the ones who aren't really academic and I really have any motivation to do anything in life. So you create a stereotyping your head that the people who take drugs are people who just don't care about anything? ... the media reinforce this. 2: before.</p>	
Participant 4	<p>Previous work environment where drugs were prevalent</p>	<p>I was quite naive about it all and quite sheltered (2:34)</p> <p>I think my knowledge, has expanded (1:9) and this has changed my attitude toward the way I care (6:151)</p>	<p>Attitudes came with me from previous experiences and roles. Though ... I think maybe I had quite a narrow view about it (1:22)</p> <p>Negative experience in MP of cannabis user who was aggressive and physically abusive... I ended up</p>	<p>alcohol is normalised</p> <p>I don't think I ever judged people (1:22)</p> <p>But ...</p> <p>I was so annoyed with her that I judged her on her substance misuse rather than thinking, she really</p>	<p>many of them, although maybe this stereotypical, that I have come across have been from low social economic backgrounds. They've not got jobs, they've got children in care of things like that of history because of their drug use, it becomes a vicious circle and why are</p>

		<p>Able to reflect on a 'horrible' experience in practice in the module ... I treated this module very much about reflecting upon the scenario that I had encountered because I think it was so problematic for me that I needed to make sense of it (3:71)</p> <p>Able to reflect on trust practices and challenge them</p> <p>I've changed as a person. I've grown in confidence as well and as a midwife (6:172)</p> <p>that's what changed because I didn't realise how much judgement around substance misuse issues can affect women (1:19)</p> <p>Reflected on own position in interview ... I feel like my attitude isn't that bad towards drug use, but then that could mean that I don't give women the</p>	<p>caring for her from afar, from the corner of the room (2:44)</p> <p>It was an awful experience. I think that's the first time I've ever judged someone for substance misuse, (2:46)</p> <p>Attitude came from own personal experience – family.</p>	<p>needs help. She's taking this for a reason (6:168)</p> <p>I've never felt so angry at a women before and so upset at the same time (2:42)</p> <p>I think you need to remain non-judgemental and I definitely judged that women (6:165)</p>	<p>we not helping them more, because we then see them twice, three times having children and their circumstances don't improve (5:153)</p> <p>I like to be hopeful and optimistic for them</p>
Participant 5	<p>Personal ... in my personal life, my brother was quite a big drug addict (2:30)</p>				

<p>Participant 6</p>	<p>I had a bit of a sheltered upbringing 3:74</p> <p>Mostly secondary school – where people were using cannabis/alcohol</p> <p>Your own attitudes toward something affect the way you are with other people 5:</p>	<p>help they need. So for example if I feel so optimistic, then I may end up trivialising their problem and saying it's okay, you can get through it. So it was really helpful for me (6:167)</p> <p>I think substance misuse is more controversial and I don't think people always want to deal with it. It's like a moral dilemma and I don't always want to think about it. I don't have the headspace for it. And substance misuse has quite a lot of this. It really challenges you (8:263)</p> <p>I found the module really interesting because it took me through a lot of thought processes that you've had along the way and (I) saw all it's quite complicated and help me to make sense of those 1:20</p> <p>My past/school was so different.</p>	<p>Swansea love story made me cry, I didn't actually believe people looked like that. I knew the drugs were a problem, and I've travelled quite a lot, but I saw that and really didn't realise that there were people who lived like that and that was quite an eye-opener for me I guess seeing that and thinking that's in the UK and the culture around eight and the children around the drugs at the school gate and stuff 3:87</p>	<p>Difference between alcohol/smoking and other drugs ... module allowed reflection on this.</p> <p>I think quite open-minded, but I was aware that I may have a bit of an inbuilt prejudice.</p> <p>I thought that I need to be a bit more impartial</p> <p>Own judgement linked to knowledge level.</p> <p>Feel very much that if you don't understand something or don't know what it's going to do then I don't want to take it.</p> <p>When I'm around people who are drinking, I just think you're not really</p>	<p>first section looking at understanding your own views and attitudes and normalisation of the drug culture. All of the things really that challenged me and challenged my 5:146</p> <p>? need section looking at personal challenge of views/attitudes ... not just reflection on them.</p> <p>When you read the definition of what alcohol do to the body and then what its long-term effects were it sounded a lot worse than many of the other drugs did and I was really shocked by that 4:</p>
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Participant 7

I think media is the most influential 1:

it felt really odd challenging your own views and thoughts. 4:114

It certainly made me think a lot more than just oh, that was an interesting topic. It really challenged my views and thoughts 4:127

I think it's more of subconscious thing. I don't think I was aware when I got to that part of the module. Quite what the impacts of the previous parts had been - it's now, looking back I can see how far I have come 5:154

Realised knew more than I thought. But realised I only knew what I did from NN experiences.

The knowledge that I've gained during the module has changed my attitude 1:

View has changed as understand more about who uses etc.

acting normally it's just silly 3:

Attitude has come from experiences – personal and work.

Module has helped me to be less judgemental.

I think it's just the people they've been hanging around with and how they got into it. 2:

how they react with us as health practitioners as well. Thinking that we are trying to take babies away

I never really thought about people who smoked during pregnancy as substance misusing but obviously it is I've just never considered it before 2:

Participant 8

Experiences from previous work in the city ... but different profile of user to that which see now. Also school, family and media.

I think it makes you clouded in your judgement because when you've got a lack of knowledge you jump to your old conclusions and opinions like you would have before your training 1:

I think that I've got a more positive view of substance misuse 1:

Module has made me think, challenge and reinforce what I knew.

you've got to think outside the box 1: the knowledge gain has helped me do this. 6:

There was a journey of knowledge that expanded towards the end 3:84

may be speaking to misusers, so having more service user perspective in the module ... would help. 3:

Good to share experiences and guidelines etc.

from them when actually we want to help them. 2: Preconceptions shown re how users start using.

there is no face to misusers 2:

you know that shouldn't be judgemental, but not really very much knowledge and so you're bound to be a little bit judgemental because that's not your life choice 1:15

These people are vulnerable. It's not just about substance misuses about all the things that go with that 1:20

they come from deprived social backgrounds and you can't always escape those influences 2:43

It's awkward there's no doubt about that at but awkward questions have to be asked sometimes. 6:188

Participant 9

I have family members who are heroin addicts 1:

No change in attitude.

That (media e tivity) was a massive eye opener really.

Personal experience.

Lots of women who use in my clinical placement.

Lots of personal experience, so it was just about gaining knowledge for me 1:13

women are still people usually that have got substance mis using issues because of underlying issues either depression or other health conditions or just inequalities or really bad luck, so I don't think it's something that anybody would just choose to do so. You can't judge them 1:17

I'm really just not a judgement al person in any aspect, whether that be, religion, culture and what everybody. People are people. Whatever that got going on in their life 1:24

I think I'm non-judgemental, because I understand that everybody has a history and that led them to where they are today. And everyone can change 2: 30
Positivism and optimism shown re how women feel.

Participant 10

Previous employment in medical setting

after doing the module I started to realise that it's really important to be non judgemental, because you can come from all different backgrounds and have a problem for whatever reasons, and may not be to overcome that problem. It's not as simple as just, your pregnant so stop doing it now. 1:21

module has made me less judgemental and look at why people use.

I've been educated into thinking differently 2:28

I've had quite a lot of experiences throughout my practice 1: 10

I think I was quite judgemental towards the sort of people and found it quite difficult to understand why they would be allowed to keep children and things like that 2: 33

5. Student Knowledge Gain

MI – Motivational Interviewing, TP – Theory-Practice, T-theoretical

	Practical (KG P)	Knowledge of drugs (theoretical) (KG T)	Reasons for use (KG R)	Anomalies (KG anom)
Participant 1	it will definitely benefit my practice and went looking at safeguarding issues and stuff running around people's houses and staffing. You see, papers et c on the side so you might think that taking joints, tinfoil and so on, and it gets your mind thinking 3:69	I knew a bit about them but nowhere near as much as I do now from this module – of drugs. Drug knowledge increased.	there's lots of reasons why people do substance misuse and it was very informative 1:12	
Participant 2	MI was useful motivational interviewing was really interesting because that encouraged us and taught us a way of asking open questions, so I found that really rewarding and helpful on how to deal with it if I come across it 3:82 If I do come across it. I will be able to access the guidelines and know-how to refer someone now also the recognition of substance misuse of a little bit more knowledgeable on that now even I would like more training on that and refresher courses all the time 7:	Did extra training to improve knowledge ... NOFAS. Of the drugs ... I was absolutely amazed at how many there are out there 3:63	If there's a reason behind substance misuse and there's a reason behind it 1:18 I just think why would you want to put yourself through that. But then, that's me and everyone's got a reason behind doing it 3:64	I don't know whether it's just me being knowledgeable after doing the course and everything, but I think there's a bit more out there now 2:44
Participant 3		motivational interviewing and brief interventions and that was about	I think it was when looking at other aspects like why people take	Struggled as a lot of the module asked us to draw on experiences

<p>Participant 4</p>	<p>Gained practical skills, like MI and of where to get help in the local area. Also skills on recognition of substances and of use.</p>	<p>how to ask questions which was really good. But I think I feel really uncomfortable if I had to ask a woman any of those questions. I think because I've not had to experience it ... so still need to experience. 3:70</p> <p>Able to apply previous drug knowledge to midwifery. my knowledge has grown especially around the different types of substances that people use and how it affects them and how it could affect their baby (1:24)</p> <p>The T knowledge helped to know what to expect in practice – so bridge the TP gap.</p> <p>certainly the knowledge has come from this module (6:168) – improved confidence</p>	<p>substances and there were all sorts of mental health issues involved like there are people with bipolar or had depression and so they started doing alcohol 2:54</p> <p>Gained understanding that there are reasons people use ... its not personal when they are aggressive etc.</p>	<p>and I didn't have much. So needed practical too, to gain confidence.</p> <p>In order to improve the module ... I think it would have been experience. But you can't get someone experience 3:75</p> <p>Bridged TP ... I think bringing in legal and ethical issues and professional challenges was really helpful and really helped the theory, practice link (1:13)</p> <p>When guidance is lacking only have experience and knowledge gained to go on. (6:178)</p>
<p>Participant 5</p>	<p>Applied the theory learnt to practice ... made realise how much own practice needs to change. What changed was not attitude, but knowledge of how to care for women. For example for particular drugs, knowing what to do.</p>	<p>Exploring the substances made me change attitude. Gained knowledge of different substances and of other support agencies.</p>	<p>Gained knowledge of why people use.</p>	<p>Bridged PT gap ... looking at motivational interviewing ... it took me a long time to get my head around what it was and what it was doing. But then you realise you are actually doing it ... you're just not doing the theory. You're just talking to people and asking questions (2:52)</p>

Participant 6	<p>I know about appropriate websites appropriate agencies and guidelines etc on what there is.</p> <p>I'm perhaps better informed about how to provide care for them 2: 64</p> <p>The knowledge gain has shifted attitude.</p> <p>Brief interventions.</p>	<p>Gained knowledge from others posts.</p> <p>Knowledge of drugs and alcohol improved</p>	<p>After doing the module I've got more of an understanding, I think I'm probably less prejudice if that makes sense and I think I am more understanding of the contributing factors and the reasons behind drug use as to why they behave the way they do 2:61</p> <p>This has meant I am able to provide better care</p>	<p>I didn't know enough about it to make an informed judgement, ...I just didn't know enough about it. I didn't know enough about them 1:9</p> <p>The module was quite complex with lots going on sub consciously which added to knowledge and self-reflection.</p>
Participant 7	<p>Learned safeguarding protocol.</p> <p>Gained knowledge of recognition and of how to ask the questions in open ended way.</p>	<p>Attitude has changed because I know more.</p>	<p>Swansea love story fed into this. Better understanding of where they are coming from.</p> <p>Better knowledge re how it began for them.</p>	<p>To gain greater knowledge it would be good to have a placement alongside to facilitate learning.</p>
Participant 8	<p>it's given me more skills. Like the motivational interviewing 5:136</p> <p>More on local services would be useful.</p> <p>It was beneficial to share guidance.</p>		<p>Learnt about why they are doing drugs.</p> <p>it could be anybody, and I think that's what people do lose sight of, and that's something I took from that part of the module 2:48</p>	

Participant 9

It was just really interesting for me to pick things up that I could take into practice with me 1:

I think that's where us doing this type of module now coming through, will give us a basis to be less fearful because we have some knowledge 4:104

Participant 10

Module reinforced my previous knowledge from study days and practice.

MI was very useful.

it's definitely given me some skills that I could take into practice 5:158

It was useful to learn about recognition and clinical management from each other.

Knowledge of types of drugs and effects and where to look for resources/info.

women are still people usually that have got substance mis using issues because of underlying issues either depression or other health conditions or just inequalities or really bad luck, so I don't think it's something that anybody would just choose to do. 1:17

Learnt a lot from who misuses and why.

I learnt a lot from the interactive videos and learning approach. (SU videos)

Understand reasons for use.

because of where I work I got that experience and practice of being around substance misusing women alongside the module, so for me, there was the theory side of it and practice side of it and I don't even get me better than that 2: 53

6. Other

SM – substance misuse

	Confidence (O C)	Comparison to other conditions (O sim)	Protection of discussion board (O DB)	Changes to own practice (O ch)	Bridge of theory-practice divide (O TP)	How women feel
Participant 1	<p>when someone comes in from booking having the confidence to probe and ask questions whereas I remember somebody coming in last year into booking and saying yes I smoke, but I'm on an alcohol rehabilitation programme and I'm not drinking as much now. I sat there and thought, oh God, what do I say now, as did my midwife of 30 years.2:57</p>	<p>I think if you haven't got a lot of knowledge about something, it's very easy to judge very easy to be judgemental, not just be substance misuse, but with everything. For example, if you see a woman with a BMI 40 coming to give birth... You think oh she's lazy. She must be a bit of slob she must be this she must be that, but the fact is they don't know what's behind the obesity because you could class substance misuse as food, so I think with anything if you don't know about anything is very easy to judge someone on that falls across the</p>		<p>I went down and looked at my local CDAT unit because I didn't feel I knew much about it 1:23</p>		

		board with mental health as well. 5:149		
Participant 2	more confident with asking if I do get a yes answer, but as I said I would like to keep having refresher courses to keep me up to date with this.	It's like with domestic violence. It's only from doing all of those sessions that we realise how common it is 5: 151	When reflecting on peer sharing a personal account ... so I guess because it was online. It meant people felt able to share these sorts of things, whereas face-to-face may be more embarrassing or you may fall that you were being judged. So that's so the flipside to do any online are not face-to-face. I mean, it is a bit of a taboo subject, isn't it, not everybody will be open and honest. Will they not everybody feels comfortable discussing it 4:115	she ended up having a BBA and afterwards when reflecting with my about the reason for this was mainly because she knew she wouldn't have to go into hospital and she had avoided all of her screening blood tests, et cetera antenatally and thought that by having this baby at home, she wouldn't have to be screened or go into hospital at all 3:70 training, not just staff but also people like receptionists and people who were front-line so as not to be judgemental, so it would enable people to feel more at ease with coming forward with an issue in the problem 6: 175

Participant 3	Gained confidence dealing with SM. Described case. If I hadn't done this module I probably would have been so judgemental 6:158	Looked after a sex offender ... could see the similar skills/principles to apply ... but unable to at the mo!! So, I can't say the skills I've picked up have made it into other areas yet!	I think that because of this module I can achieve this (6cs). I'm happy to care for these women to give them support and commitment courage, compassion, I have a lot of compassion for them now, I really want to help them now 6:193		
Participant 4	Gained confidence for dealing with SM in practice		Motivation to write a policy for own trust		
Participant 5	Confidence to change practice and write a new guideline. Wanted to become a drug liaison midwife.		Wrote a new trust pathway.		
Participant 6	Gained confidence in looking after women	It also taught me to look at my attitude around things and challenge my views not just in relation to substance misuse. It's given me like a model for way of dealing with things appropriately when I come across something I don't know about all that	I now feel better equipped to provide good care.	And I'm perhaps better informed about how to provide care for them because I understand where they're coming from 2:62	so if they think you don't really know how much are they questioning the ability of the midwife across the board? Do want them looking after you how safe do you feel them looking after you and so on and do you want to open up to them and let them know that you're
			The knowledge gained will change the way I practice. 9: so much more confident be able to ask. So in my practice I now know the various pieces of evidence and	It allowed you to look back at the things you'd done in practice.	

		<p>makes me feel a little bit uncomfortable 9:</p> <p>I think it's the same in all of your values ... sim to eating issues. (4)</p>	<p>have formulated what I'm going to say what evidence I am going to present and how to the woman. Like the use of brief interventions as a tool 9:</p>	<p>The module reaffirmed what I knew to be so from practice.</p>	<p>finding it difficult looking after your baby. Probably not (8:241)</p>
Participant 7	<p>Gained confidence in practice ... asking questions/recognition.</p>	<p>like around domestic abuse, mental health, anything that there's a stigma around. It's made me realise that if you don't ask the question, then you aren't going to be able to find out and help the family 5:146</p>			
Participant 8		<p>once you have the knowledge can't un-know it, so you can no longer ignore it. You have to deal with it. I think that. For example, I'm interested in antenatal and postnatal depression. So when I'm doing bookings I've seen midwives (because it's a sensitive area). A lot of them find it difficult to</p>			<p>I think we need to talk to them, rather than at them and I think a lack of knowledge sometimes stops us doing this 7:</p>

Participant 9

Gained confidence – less fearful of dealing with.

discuss this, however, I feel confident to discuss this 6:163
it's the same for lots of women is the same for women who have depression for women who self harm, who have mental health all vulnerable women 4:116 when discussing need for a counselling approach.

I know that when I'm qualified there is so much that I still want to do in a few areas, but I like counselling and so I'm quite interested in doing some mini courses in counselling for vulnerable women 4:

because of where I work I got that experience and practice of being around substance misusing women alongside the module, so for me, there was the theory side of it and practice side of it and I don't even get me better than that 2:

worked well to bring both TP together.

sometimes when babies are born with neonatal abstinence syndrome. It's just being on the NICU ward you can see why staff get upset, but they aren't doing it on purpose and that's what you have to remember and have already upset themselves and feel guilty. And for you to even slightly have some expression that your upset with them because of the baby isn't that make them feel any better 3:82

It gives them a lot of built on top of the guilt they already have and probably causes them to continue to use as opposed to thinking. I have support around me and feeling positive

**Participant
10**

Research skills for the
future.

about things. You can
still make positive
comments to them,
even though their
behaviour may be
negative 3:89

