B-ATTITUDES

Formal Evaluation: AUGUST 2006

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Introduction

This report examines the role of B-Attitudes in promoting the social, psychological and physical wellbeing of seventeen clients. Moreover, it explores significant changes that have occurred in the lives of these clients since commencement of their treatment with the B-Attitudes service.

Summary of Service

B-Attitudes provides an ongoing support service for individuals and their families suffering from the personal and social problems of drug abuse. The nature of the B-Attitudes service means that programs of care are both labour intensive (clients are often seen several times a week) and lengthy (often facilitated for more than 12 months). In addition, progress with this client group is invariably slow. The majority of the clients are seeking support as a result of increasing life stresses, but have not necessarily made any commitment to drug abstinence at the time of their first meeting. Moreover, the service aims not only to help individuals to give up drug abuse, but to help them in all aspects of personal and social functioning and to provide a support network until a time when the individual feels able to commit to a drug-free lifestyle.

Bearing in mind the complex nature of the aims and objectives of the service, it is worth examining the means with which success can be determined through this evaluation. Unlike traditional drug user support services which may have only considered drug abstinence as a means of measuring success, the nature of B-Attitudes means that the definition of success needs to be expanded beyond this limited definition. The ability of B-Attitudes to continuously support clients through long term difficulties and in decision over drug use means that success can be defined in part as the clients continued attendance the service and continued commitment to explore their own life choices. This measure of success affords B-Attitudes the credit

it is due in "buying people time". Often clients have severe life threatening problems such as ongoing drug abuse, depression and violent relationships. B-Attitudes has shown great success in supporting people through such difficult life stresses until such a time when they begin to make their own independent decisions to lead a more independent, more responsible and healthier life.

The nature of B-Attitudes means that it is only able to deal with small numbers of clients at any one time. Furthermore these clients are often unwilling and/or unable to complete any type of formal evaluation of the service. As a result, it should be noted that this service is fundamentally extremely difficult to evaluate using traditional quantitative survey methodology. Bearing this fact in mind, a thorough evaluation of seventeen clients is presented in this updated report. Statistical results are supported with qualitative data.

Participant Group

Seventeen individuals participated in this second formal evaluation of the B-Attitudes Service. Each of these individuals has been a client of the B-Attitudes service for between five months and four years, and has received extensive counseling and support. Eight of the participants completed a second questionnaire enabling changes in the data over time, to be explored. Four of these eight participants completed a third questionnaire.

Participants completed their first questionnaire between one day and four years after commencing with B-Attitudes. This large variation in treatment commencement and questionnaire completion needs to be recognized when results are examined. Overall it is suggested that the initial impact of treatment has already passed for the large majority of clients once they have completed a questionnaire. This means that less significance can be placed on the clients' current state of wellbeing, as a way of evaluating the service. However, it also means that the large majority of clients were able to provide reflective answers about the impact of B-Attitudes when they first entered the survey.

Demographic data was collected for each participant along with details of drug use, physical health, anxiety, depression and perceived stress levels. Participants also provided an indication of their overall satisfaction with the B-Attitudes service. Nine of the participants provided qualitative data with descriptive responses to questions about their previous and current self-perceptions and the perceived role of B-Attitudes in facilitating positive personal and social development.

Materials

In addition to requesting background information, the following questionnaires were included in the evaluation:

Substance Abuse: Participants were asked a number of questions about any ongoing abuse of illegal and prescription drugs. This sub-scale takes approximately two minutes to complete

Physical Health: Five questions were asked about physical aspects of health not influenced by drug use (e.g. sleep without the use of sedation). Participants were asked to state changes in health over the past two week period by indicating their most accurate response on a three point scale (worse than it was two weeks ago, the same as it was two weeks ago, better than it was two weeks ago). Scores were summarized to give an overall view of recent changes in physical health (a higher score meaning more positive changes in health than a lower one). The scores ranged between 5 and 15. The scale proved to be reliable, $\alpha = 0.71$ across the five items.

Wellbeing: Depression and anxiety was assessed using the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983[1]). This is a 14-item scale that provides a measure of both anxiety and depression. It is ideal for those who may be suffering physical consequences of drug abuse, as the scoring cannot be contaminated by reports of physical symptomatology. The HADS takes approximately ten minutes to complete. Both subscales proved to be reliable (depression: $\alpha = 0.84$ across seven items; anxiety: $\alpha = 0.83$ across seven items).

[1] Zigmund, A & Snaith, R. (1983) The Hospital Anxiety and Depression Scale *Acta Psychiatrica scandinavica*, 67, 361-70

Life Stresses: The Perceived Stress Scale (PSS-10) (Cohen et al, 1983[2]) was used to measure the degree to which situations in the participant's life are appraised as stressful. The PSS-10 consists of 10 items and relates to events occurring in a one-month time frame. This scale proved to be reliable ($\alpha = 0.86$ across 13 items).

Service satisfaction: Participants were asked two questions about their degree of overall satisfaction with B-Attitudes as a service.

Qualitative Reports: Participants were invited to provide descriptive answers to four open questions about perceived changes experienced and the role of B-Attitudes in facilitating these changes.

Procedure

All questionnaires were completed in the presence of a B-Attitudes counselor. The interviewing counselor assured each participant that their results would remain confidential, and would in no way affect the standard of care they received.

Results

All quantitative data was analyzed using SPSS. All qualitative data is referred to in summary in this results section.

Group Results

Demographics: Seven male and ten female participants have now completed initial surveys. They were aged between 19 and 37 at the time of the first questionnaire completion with the mean age of participants being 26.6 years. Thirteen of the participants were single, three lived in a defacto relationship and one was married.

[2] Cohen, S., Kamarck, T. & Mermelstein, R. (1983) A global measure of perceived stress *Journal of Health and Social Behavior*, 24, 385-96

This finding suggests that the perceived loneliness often described by B-Attitudes clients is reflected in the fact that most are single when initially seeking help. Six of the participants lived with their partner, six with parents, three alone, one with friends and one was in hospital receiving psychiatric care. At time two, of the eight participants who had completed a second survey, all were single. Two lived with parents, five with friends and one lived alone. It is tentatively suggested that often the partner was a contributing factor to difficulties rather than a supportive family member and as such, those who remained committed to the service either did not have partners or certainly did not remain committed to them.

Six of the seventeen participants had one or more child. It is not known whether the children lived with their parents or elsewhere. However, qualitative findings suggest that at least one of the participants had "lost" her children to care before attending the service.

Reported Drug Use: Ten of the original seventeen participants reported non-prescription substance use when they first completed the questionnaire. It should be noted that since there was a large variance in time passed between commencing the service and completing the first questionnaire, the majority of those not reporting substance abuse at Time One, had already made a decision to become drug free while attending the service. Unfortunately there were not enough participants to investigate a statistical relationship between time spent attending the service and non-prescription drug use. However, in support of the claims made suggesting that long term attendance at B-Attitudes led to ultimate reduction in substance abuse, it was found that only one of the eight who completed a time two questionnaire reported non-prescription drug use. The non-prescription drug most commonly reported at time one was cannabis. It is hypothesized that many clients would cease to use more severe drugs such as hallucinogenics, heroin and amphetamines long before they ceased to use cannabis which has more social connotations. Thus, it is to be expected that even after initial success with B-Attitudes, cannabis would often continue be used by clients.

Ten of the seventeen original participants reported using drugs prescribed for them by a medical practitioner when they first completed questionnaires. Drugs most

commonly taken were for psychological distress, namely anxiety and depression. Four of the eight time two participants continued to use prescription drugs of this nature.

Average Scores for evaluative questionnaires: Mean scores for all time one data are presented in the following table.

Measure	Mean Score (N=17)	Sd	Severity (according to population norms)[3]
Depression	7.57	4.79	Normal/mild
Anxiety	11.12	4.35	Moderate
Stress	28.58	6.02	High
Physical Health	10.07	2.74	No population data available

As can be seen from the results, the average participants' depression, anxiety and perceived stress scores were all above those expected for a normal population. In particular the participants appeared to be suffering from ongoing stress and anxiety.

Changes in health over time: As only eight of the participants completed two surveys, it should be noted that it is very difficult to identify significant changes in mental or physical health using standard statistical techniques. However, independent samples t-tests were carried out on the time one and time two data for physical health, stress, depression and anxiety questionnaires.

No significant results were obtained other than for depression which significantly decreased over time ($t = 2.78$, $p < 0.05$). However, it should be noted that the mean levels of both anxiety and perceived stress decreased over time. The inclusion of greater numbers of participants in the survey may lead to significant results. Although there was little difference between time one and two levels of perceived health, it is interesting to note that at time one the mean score of the thirteen

[3] **Depression and anxiety score ratings: Normal (0-7), mild (8-10), moderate (11-14), severe (15-21). Mean population perceived stress score is 19.62 (sd = 7.49).**

participants who rated their overall health, was as just below average (mean = 2.76, sd = 1.3)[4] and at time two the mean score of the six participants who rated their overall health was just above average (mean = 3.67, sd = 1.21). This result is particularly interesting in light of the recorded substance abuse and prescription drug intake of the participants. The participants had all abused drugs to a serious degree and many continued to smoke cannabis and take prescription drugs for their psychological health and often for asthma. These statistics lead to a realistic assumption that in fact, the majority of these participants would have very poor health compared to others their own age. It is suggested that health perceptions and subsequent questionnaire ratings are largely based on social comparison with an immediate peer group. Thus, if your neighbour consumes heroin on a daily basis, it may be possible to perceive your health to be excellent as a smoker and regular cannabis user. It is suggested that it would be of value to therapy and ongoing support services to further investigate the impact of social comparison on perceived wellbeing and health status.

Measure	**Time**	**Mean Score**	**Severity**
Depression[5]	Time one	7.57 (sd = 4.78)	(normal/mild)
	Time two	3.56 (sd = 2.42)	(normal)
Anxiety[6]	Time one	11.12 (sd = 4.35)	(moderate)
	Time two	7.59 (sd = 3.18)	(mild)
Perceived Stress (population mean = 19.62, sd = 7.49)	Time one	28.58(sd = 6.02)	(high)
	Time two	26.5 (sd = 7.73)	(high)
Physical wellbeing	Time one	10.07 (sd = 2.74)	
	Time two	10.68 (sd = 0.71)	

[4] Overall health was rated on a scale from 1 (very poor) to 5 (excellent) with 3 being "average for my age"
[5] **Depression score ratings: Normal (0-7), mild (8-10), moderate (11-14), severe (15-21)**
[6] **Anxiety score ratings: Normal (0-7), mild (8-10), moderate (11-14), severe (15-21)**

Qualitative Results

Additional qualitative data was received from all seventeen of the original participants: a summarized representation of this data follows:

Description of Life Prior to Attending B-Attitudes

The participants use a range of descriptors to summarise their life prior to commencing with B-Attitudes. All describe their life in extremely negative terms. For example

"I was a mess, on my way to the grave"

"My behaviours [were] basically society's worst nightmare"

"Hate, anger and guilt"

"I wouldn't be alive if it wasn't for the help of B-Attitudes"

Many of the responses expressed a mixture of self hate and anger. In addition all commented on excessive drug use often heroin and or amphetamines. Many also admitted to daily crime.

There was a strong sense of life being out of control and an inability to cope. For example:

"…my life was falling apart"

"…my life was a big mess"

There was also a sense of overwhelming depression and disillusionment with life. For example:

"…no direction, and no desire for life"

"…my life was falling apart"

Description of Current Life

Without exception all participants summary description of their current life (when completing questionnaire) was turned around from the earlier descriptions. Hope and motivation to live a healthy and happy life shone through all descriptions. For example:

"I have good accommodation; I'm currently studying at TAFE and living a healthy lifestyle"

"Slowly becoming stronger and not so scared…"

"More confidence"

"Very well, drug free and cigarette free"

"I've got my son back – Bloody Fantastic!"

"Calm and rational"

Overall there is a sense of calm and a sense of renewed belonging within society. Rather than fighting society with crime and addiction, the participants talked about participation in study, accommodation, getting along with others. This leads me to conclude that the process of attending B-Attitudes had given isolated and frightened individuals the opportunity to have a fundamental sense of belonging to humankind.

Comments on the Value of B-Attitudes and overall perception of the service

Every one of the participants credited B-Attitudes with helping them get their lives on track. Overall the role of B-Attitudes very much mirrors that of healthy parenting of children. This suggests that it is the nurturing environment provided by the service, offering ongoing unconditional support and gentle guidance, which has enabled the participants to find a sense of belonging so necessary for long term wellbeing.

Typical comments included the following:

"B-Attitudes gave me the key to place my life back on track"

"[B-Attitudes] pushed [me] to positive motivation"

"I generally feel not so lost…"

"If it weren't for B-Attitudes I would have overdosed"

All of the participants stated that B-Attitudes was responsible for helping them to make positive changes to their self-beliefs and in their social relationships. They also suggested that the service had helped them to reduce or stop taking illicit drugs. All of the participants stated that the service had excelled beyond their expectations and had excelled in meeting their needs (for both items this response was recorded as point five of a five point scale ranging from "have not met any of my expectations" to "have excelled..."). Several of the participants suggested that the service needed greater resources.

Discussion of results

Substance abuse and dependence is a significant problem in contemporary Australian society. It is associated with negative consequences in physical health, mental health and social functioning. In addition it creates significant social and economic costs for society as a whole. Treatment of drug abuse must therefore address a multitude of personal and social factors if it is to be of benefit to users and to the wider community.

Treatment for substance abuse has a low rate of success when success is defined as long-term or permanent abstinence from drug usage. Hulse & Basso, 1999[7] , identified a relapse rate of 62% after 6 months of treatment for heroin use in an oral naltrexone treatment program. This study is one of many which highlights the caution with which "success" and "failure" should be interpreted in treating drug dependence.

[7] Hulse & Basso (1999). Reassessing naltrexone maintenance as a treatment for illicit substance abusers. *Drug and Alcohol Review*, 18, 263-269.

Although 62% had used heroin (hence "failing" from a conventional viewpoint), 60% were still on daily naltrexone and 12% had completed treatment and were heroin-free at 6 months. While abstinence from drug use may remain the ultimate goal of treatment, it is suggested that improvement in quality of life and psychosocial functioning a decrease in high-risk drug-taking behaviour and adverse health outcomes may all be legitimately recognised as successful endpoints (Hulse & Basso, 1999). For the purposes of this evaluation, success has been defined as improvement in perceived quality of life with a view to abstinence.

Substance abuse is associated with poor psychosocial measures. Potential providers of psychosocial support include the users' family and friends, as well as dedicated services available within the community. These social networks have been shown to influence recovery from illicit drug dependence. Knight & Simpson, 1996[8] , found that peer deviance predicted frequency of injecting drug use and participation in illegal activities by the recovering substance abuser. Reductions in family conflict decreased frequency of injecting and other drug use in addition to participation in illegal activities.

For many substance abusers, desirable social contacts are limited or absent. However, community services such as B-Attitudes can play a role by improving relationships with friends or family and by providing additional psychosocial support.

B-Attitudes offers practical and emotional support to individuals suffering with the problems of substance abuse. The service is provided to current and former substance abusers and to close friends and family members who are also deeply affected by the onslaught of drug abuse.

B-Attitudes offers practical help to individuals who are often dealing with legal issues, employment difficulties and problems with family relationships. The service aims to help clients meet appointments and successfully negotiate their way through the legal system, employment possibilities, and financial and family matters.

[8] Knight DK & Simpson DD (1996). Influences of Family and Friends on Client Progress During Drug Abuse *Treatment. Journal of Substance Abuse*, 8(4), 417-429.

B-Attitudes also offers on-demand social and emotional support to clients and their families. In doing this, the service aims to improve client wellbeing, decrease stress and help clients build healthier relationships with others.

In a program such as this it is vital to ascertain the overall effectiveness of service provision. However, due to the generic nature of B-Attitudes, it is difficult to evaluate the success of the program in any single domain of client functioning. This evaluation has attempted to obtain and evaluate a mixture of quantitative and qualitative data from seventeen clients who have used the B-Attitudes service from between two months and four years.

Overall the data suggests that these clients perceive the B-Attitudes service to be invaluable in providing long term counseling and ongoing psychosocial support. The clients believe that this support has been necessary to allow them to have time to find increased psychological independence, improved social relationships and to finally live without drug abuse. The quantitative data obtained supports the anecdotal reports from the clients. It shows that this client group do indeed suffer more depression, anxiety and stress than do normal members of the population. It has also shown that these levels of depression, anxiety and stress may be reducible with the ongoing support of B-Attitudes staff. Furthermore, the clients participating in this survey have reported a decrease in drug use and an increase in physical wellbeing during their time with B-Attitudes[9].

[9] **Possible problems with evaluation data collected**

Although the data obtained provides support for B-Attitudes the following points need to be noted with reference to this evaluation:

Collection of data: Although the counselors assured each participant that their results would remain confidential, and would in no way affect the standard of care they received, it should be noted that the presence of B-Attitudes staff may well have influenced some participant responses, particularly in relation to questions about overall service satisfaction.

Participant Numbers: Some clients did not complete the evaluation (it is not known how many). The views of this group are not known. Thus it could be that those refusing to complete the evaluation do not agree with the responses of those willing and able to participate. It is hoped that future evaluation methodology may be improved to ensure wider participation from all B-Attitude clients.