

*Evaluation of the Winnipeg
Coming to Terms Program*

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Addictions Foundation of Manitoba

The Addictions Foundation of Manitoba is responsible for providing rehabilitation and prevention services for Manitoba citizens relating to substance use and problem gambling. *The aim of our research is to better inform rehabilitation practice, public education, and health policy.* Research fostered by the foundation contributes to a better understanding of how individuals, families, and communities can most effectively respond to harm associated with substance use and problem gambling.

VISION:

Manitobans living free from the harm of alcohol, other drugs and gambling

MISSION:

To enhance the health of Manitobans by reducing the harm of alcohol, other drugs and gambling through leadership in education, prevention, rehabilitation and research.

VALUES:

We believe our greatest strength and asset is our staff, and acknowledge their contributions and passion in supporting the following organizational values:

- *The dignity and diversity of each individual;*
- *The capacity of clients and our community for change;*
- *Collaborative relationships with stakeholders, partners and the self-help community;*
- *Continuous improvement and best practices;*
- *A continuum of services and programs; and*
- *A safe and respectful work environment.*

EXECUTIVE SUMMARY

The Coming to Terms (CTT) program was developed to assist clients who are not yet at the action stage of change to encourage them to begin thinking about some of the consequences of their substance use. The program is a closed group, consisting of four weekly sessions, preceded by a one-to-one session, and another individual session following the four weeks. The content is primarily educational, designed to help clients identify harm-reduction goals, and to develop a plan to achieve these goals. In order to understand the impact of the CCT program a brief evaluation was conducted at the James Toal Center in Winnipeg in the fall of 2006 by asking clients and staff their perceptions of the program impacts.

In addition to the usual forms that are completed by clients before entering AFM program (e.g., Core Intake, Adult Rehabilitation Forms), 68 clients also completed brief measures of knowledge gain. At the end of the program a satisfaction survey was completed, in addition to measures of program impact. The staff person delivering the program was also interviewed once the pilot phase was complete. Approximately 2/3 of the clients were male, 40% had not completed high school, 57% had an annual income less than \$40,000 and 40% were unemployed, or on a leave of absence from work. For most clients, an alcohol-related problem was their reason for entering the program. About 1/4 of the clients entered the program due to a drug-related problem.

Attendance figures for the program showed that about 2/3 of the clients attended all four sessions, which is excellent, given that this program is delivered to relatively ambivalent clients. However, although most attended all four sessions, many of them did not complete their assigned homework, which is an integral part of the program. For example, only about 1/2 completed their abstinence monitoring logs. This is consistent with the counselor ratings that about 44% were able to maintain abstinence during the 4 weeks of the program.

An important aspect of the CTT program that was evaluated was client confidence in managing high-risk situations (self-efficacy). Clients who completed all four sessions had higher self-efficacy at the beginning of the program compared with those who dropped out. Furthermore, these clients' self-efficacy ratings improved over the course of the program, to the extent that most (58%) were "very confident" in their ability to manage high risk situations at the end of the four weeks.

A second important component of the program is knowledge gain. This was also evaluated by comparing pre-program knowledge with a post-test measure. Statistical comparisons show improved learning, with those who completed the program understanding more about the impacts of alcohol and drugs after the program than before. In addition, they showed more understanding of the Stages of Change model, which is an important component of AFM interventions. Counselor ratings indicate that after the program clients are more likely to be in the preparation and action stages, compared with



contemplation and the pre-contemplation stages that they were in prior to enrolling in the program.

In addition to knowledge gain and understanding the stages of change, communication about drug use was also examined. Over the course of the program self-reports of communication significantly improved. In addition, other self-reported outcomes show that most (80%) stated that they had increased awareness of how their substance use had impacted their lives, and 73% have changed their patterns of substance use. Counselor ratings were in agreement with most of these findings.

Overall the CTT program helps clients move towards an action phase, where they may be more willing to reduce some of the negative impacts of their substance use. They showed increased learning and greater confidence to resist the urge to use, which is an important aspect of maintaining abstinence.



INTRODUCTION

Individuals come to the AFM for a variety of reasons. They may be mandated to come; they may be coming due to their own or a loved one's concern about their substance using habits. During the assessment process their level of involvement with substances, and their motivation to make changes in their lives is evaluated. Together these evaluations form the basis of a recommendation to clients regarding the appropriate service or program that we offer. One of these programs is the Coming to Terms program (CTT).

According to the program logic model (Appendix A) the goal of CTT is to assist clients in the pre-contemplation and contemplation stages of change to better understand and acknowledge alcohol and other drug issues through the provision of individual and group educational sessions. Throughout the assessment process these clients will have already been identified as either "harmfully", or "dependently" involved with alcohol and other drugs, or in "transitional abstinence". However, they may not see themselves as in need of "rehabilitation" and may be resistant to becoming involved with a treatment program. That is, although they may be experiencing some problems due to their use of substances, their motivation is low and they are not yet committed to making specific changes in their lifestyle.

There are two primary objectives of CTT; to increase client's factual and general knowledge about alcohol and other drugs, and to realistically evaluate the effect that this use is having on their lives, and the lives of those around them. The program intends to provide a welcoming environment in which clients can openly explore their alcohol and other drug issues, and related concerns.

The Transtheoretical Model of Behavior Change

With a better understanding of relapse, and a shift from a focus on denial to a focus on readiness to change, the Transtheoretical Model of behavior change (Prochaska and DiClemente, 1986; 1992) offers an understanding of the role of motivation in behavior change that is especially useful in the addictions field. As a result the model is widely used, and has been adopted at the AFM to help describe our clients' situations.

An important aspect of the Transtheoretical Model is the concept of individual motivation. In the original model, modification of addictive behaviors progresses through five stages:

- Precontemplation - the individual is not considering making any change as there is no perceived need for change.
- Contemplation - the person is thinking about making some changes.
- Preparation - the person is preparing and becoming determined to make changes.
- Action – the person is actively making changes through modifying behaviors.



- Maintenance – the person is consistently maintaining changes made over an extended period of time.

The Transtheoretical model also involves a number of intermediate outcomes that include more than changes in substance use or harmful consequences. These include the pros and cons from the decisional balance scale, which reflects the individuals weighting of the pros and cons of changing self-efficacy, which refers to the client's confidence that they can resist temptation to use. The termination stage is the ultimate goal for all people making changes. Substances no longer are a temptation and the individuals are confident in their ability to cope successfully.

In spring 2006 AFM Research was approached to assist with the development of measures that would be consistent with the new accountability model. These were presented to the Adult Rehabilitation Provincial Planning Team (ARPPT) and approved for use in the pilot evaluation of the revised program. A copy of the accountability model is attached as Appendix B.

The Coming to Terms Program.

Individuals who contact the AFM regarding participation in our programs are asked to complete both screening and assessments, in order to assist us in determining the appropriate program for them. They may be a mandatory referral, or a self-referral. They may have come due to concern about their own use, or they may be encouraged by friends or family to come and speak with someone. They also vary widely in terms of their motivation to examine issues around their substance use. Some may be more ambivalent than others, others may be just curious about what counseling options may be available to them, if they so desire.

At the AFM the Coming to Terms program is offered at different sites, with different processes. It is a manualized program, delivered in group settings, in a closed group. The program consists of an individual session, four weekly group sessions, followed by another individual session. The content consists of an examination of the client's level of involvement with alcohol or other drugs, completing a life areas map, learning the signs of drug abuse, identifying the pros and cons of using substances, reducing use and abstaining, identifying high-risk situations, and developing harm reduction goals and the plans to achieve those goals. During the group session period clients are asked to abstain from use, although they are not necessarily terminated for using,. They are also expected to attend at least one self-help meeting, participate in group sessions, and complete their assigned homework. At the final individual session they discuss what they learned, their experience at the self-help meeting, their personal goals, their harm reduction plan and their commitment to make a positive change in their lives.

The measures included an initial client questionnaire containing questions about high risk situations and knowledge of alcohol and other drugs, weekly session evaluations, a staff



checklist regarding whether clients had completed homework and weekly assignments, and a final client questionnaire that contained measures related to the accountability model, post-test questions about high risk situations and post-test knowledge questions about alcohol and other drugs. Finally, a staff questionnaire was developed and staff were interviewed regarding their perceptions of the program and its usefulness.



Method

Participants: 68 Manitoba residents participated in the CTT program during the 6-month period of this evaluation, which ran from May 1, 2006 to October 31, 2006. The age of the participants ranged from 19-74 years, with a mean of 36.8 years, and the majority was male (66.3%). Of these 68 participants, two-thirds attended all 4 sessions (66.2%).

Program: CTT is a 4-week program consisting of 4 sessions (1 per week) designed to enhance knowledge of alcohol and drug use including biological and health facts as well as how use impacts life areas.

Week 1: Why am I here? The group discussed levels of involvement such as indicators for harmful or dependent use, and how substance use affects every aspect of life including family, friends, work/school, and money, and may have serious legal consequences. The first week also included a discussion of the challenges involved in reducing use or abstaining, and various ways to say no when faced with the opportunity to use drugs or alcohol.

Week 2: Alcohol, other drugs and coping. Week 2 included a discussion of causes and facts about alcoholism, such as its hereditary nature, gender effects and individual differences. The group listed and reviewed the pros and cons associated with both using and abstaining from alcohol and other drugs.

Week 3: Understanding change and the stages of change continuum. The third session relayed information about the health effects and other problems associated with marijuana use. The group also talked about the various stages of the readiness-to-change model: precontemplative, contemplative, preparation, action, maintenance and termination

Week 4: Planning. This session included a discussion about triggers, high-risk situations and how to handle them, ways to resist the urge to use, and ideas for alternate activities that do not involve substance use. A review of information covered to date was followed by clients completing their personal development and harm reduction plans.

Questionnaires: All participants filled out standardized Core Intake forms during their initial AFM evaluation, before enrolling in the CTT program. These forms provide information about demographics, substance use and gambling behaviour, and mental and physical health status. During the program, each client completed an initial questionnaire designed to provide information about self-efficacy and general alcohol and drug knowledge, prior to completing the program. The self-efficacy scale includes 8 items that gauge confidence regarding the client's ability to decline drug or alcohol use in high risk situations. The knowledge section includes 13 multiple choice or true/false questions such as "which of the following drugs is a depressant?"

Each week the client completes a short questionnaire about what they learned in that session, how they feel they might apply that knowledge in their daily life, and how comfortable they felt with communicating their thoughts on various issues.



Finally, at the end of the program, the client completes a questionnaire that is identical to the initial questionnaire, with the addition of several questions about program satisfaction, changes in perception of use, and stages of change.

The counselor completed two questionnaires for each client over the course of the program: a checklist, simply to indicate which assignments each client did or did not complete, and a questionnaire in which they indicate how well they feel the client understood the information presented, whether the client maintained abstinence, and the client's current stage of change. This form also indicates any referrals made to other agencies or programs as a result of participation in CTT.

In-class and homework assignments: Each week the client completed assignments, both during the session and at home. Table 1 lists the assignments with a brief description of what each entails.



Table 1. Assignments and a brief description.

Assignment	In-class/ homework	Description
Personal goal development worksheet	class	Reason for attending CTT, list of goals, preliminary questions for the counselor
"Life areas map"	class	Lists of various ways that substance use affects different areas of a person's life (family, social, legal, money, etc.)
"Good and not so good"	class	Lists the pros and cons for both using and abstaining from alcohol and other drugs
Warning signs	class	A checklist of various warning signs for harmful or dependent alcohol or other drug use
"Why I use"	class	Lists most common reasons for use such as social gatherings or stress, and self-identified triggers
"To make or not make changes"	class	Lists changes that could be made and the reasons why those changes would have a positive impact on the client
"Questions to consider"	class	4 questions to assist the client to consider; in what ways life might be better if they were abstinent or reduce their use, what might they lose if they continue using, and what do they want in life that alcohol and other drugs keeps them from having
High risk situations questionnaire	class	50-item questionnaire regarding confidence to manage high risk situations (like the self-efficacy scale described in the <i>questionnaire</i> section above)
Managing high risk situations	class	Client considers 5 situations in which they would feel compelled to use alcohol or other drugs, and describes how they would best handle the situation
Personal development and harm reduction	class	Client develops a list of goals and a plan as to how each might be achieved. Consists of two separate forms: goals for alcohol and other drug use behaviour, and goals for life
Self-Help Meeting evaluation	homework	During the program, the client is expected to attend one self-help group such as AA/CA/NA. They then fill out this form regarding their perceptions of the meeting and why they think people attend these meetings
Abstinence Monitoring Log	homework	Each week the client filled out an abstinence monitoring log to describe what happened that day, what their alcohol or drug use would have been prior to the program, and whether or not they use (and if so, how much they used), and how they feel about handling the situation

Analyses: For the data analyses in this evaluation, the Statistical Package for the Social Sciences (ver. 14) was used. The primary analyses were frequencies and descriptive statistics. When significance testing was done, Paired-Sample T-Tests were performed using only the scores for the clients that participated in all 4 sessions. If fewer than 4 sessions were attended, the client was not included in any pre-post comparisons, though their demographic information would still have been used to describe the clients who participated.



Results

Demographics: The sample for this evaluation was 66.3% male and 33.8% female. The majority of participants were between 20 and 29 years of age (34%). 27% were between 40 and 49 years, and 25% fell between the ages of 30 and 39.

Approximately 40% of all participants had not completed high school, and 32% made less than \$20,000 per annum. Two thirds of the program participants considered themselves as employed full-time (42.6%) or unemployed (25.0%), with the remaining 23% distributed among part-time employment, student, disability, leave of absence or retired. About 35% of participants were married or in a common-law marriage. 47% were single and the remaining 18% were divorced or separated. Approximately 70% have at least one child, though 12% have more than 4 children. See Table 2 for a detailed analysis of these demographics.

At the point of first contact with the AFM, 50.8% of clients that later registered in the CTT program were classified as using drugs or alcohol harmfully, and 43.1% were dependent users. The final 6% were classified as irregular users, regular users, or in a state of transitional abstinence. At this same point, 35.8% of clients stated that they were currently involved in the legal system, and nearly 20% had court appearances pending.



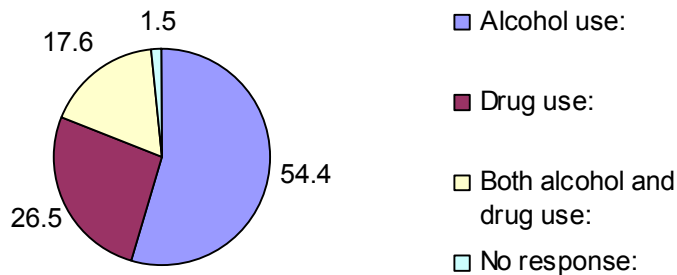
Table 2. Demographic description of CTT participants, percent of clients in each category.

DEMOGRAPHICS	
AGE	
Less than 20 years	2.9%
20-29 years	33.9%
30-39 years	25.0%
40-49 years	26.8%
Greater than 50 years	16.1%
EDUCATION	
Less than grade 9	10.8%
Incomplete high school	29.2%
Complete high school	20.0%
Some post-secondary	13.8%
Post-secondary degree	24.6%
Other	1.5%
INCOME (per annum)	
Less than \$20,000	31.8%
\$20,000 - \$39,999	25.4%
\$40,000 - \$59,999	17.5%
Greater than \$60,000	11.1%
Don't know or refused	14.3%
MARITAL STATUS	
Single	47.0%
Married /common-law	34.8%
Divorced /separated	15.2%
Other	3.0%
EMPLOYMENT STATUS	
Full-time	42.6%
Part-time	8.8%
Unemployed	25.0%
Leave of absence /disability	14.7%
Student	7.4%
Retired	4.4%
NUMBER OF CHILDREN	
None	31.3%
1 or 2	41.8%
3 or 4	22.4%
More than 4	12.0%



Basic program analyses: One of the first questions that participants were asked was why they had enrolled in the program. The results are shown on Figure 1. Just over half of clients identified alcohol (54.5%) as their main concern, while 18% identified more than one substance, usually alcohol and another drug such as marijuana, cocaine or methamphetamines. The remaining 26.5% identified a concern about their drug use only. The high number of people with alcohol-related problems is not unexpected considering that it is the most commonly used drug in our society.

Figure 1. Percent of participants and their reasons for enrolling in the program.



In one of the first assignments completed by the participants, they were asked who referred them to the CTT program. We found that the clients were split equally between self-referred (33.8%), referred by someone else (32.4%), and referred by someone in the legal system (32.4%). Self-referred clients are ones that say they come to the program of their own accord, looking for information. Clients referred by others may have been referred by family or friends, or a counselor either within or outside the AFM. Those that were referred for legal purposes include those for whom participation in the program was a condition of their parole or probation or recommended by their lawyer or the crown, or referred from another program such as Child and Family Services (CFS).

Many of the clients had also previously attended rehabilitation programs. About 29% had attended a program for an alcohol problem (33% did not complete the program), and a smaller percent (about 13%) had previously attended a drug rehabilitation program, most (70%) had completed that program. A few (3) had attended a program for a gambling problem.

It is important from the point of view of a comprehensive evaluation to understand how many of the referred individuals show up for programs. Thus Table 4 shows how many individuals who were expected at each afternoon and evening CTT group showed up.



Some failed to show up without explanation, while others postponed but did show up for a subsequent session. About 41% (68 or 166 referrals) did not show up, more often for the evening group (56%) than the afternoon group (44%).

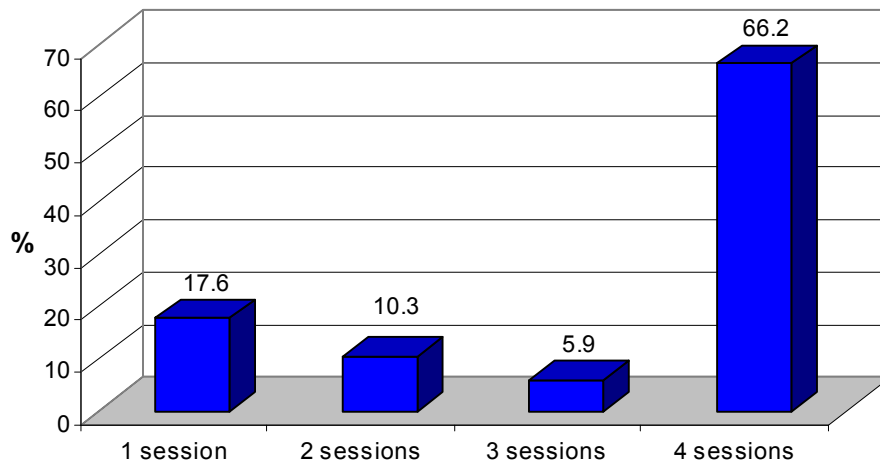
Table 4. Number of clients referred to each group, number who did not show up and the number who rescheduled for a later group.

CTT group	Number referred	No Shows	Postponed
May Afternoon	14	2	3
May Evening	13	7	0
June Afternoon	13	4	1
June Evening	14	7	2
July Afternoon	12	8	0
July Evening	15	6	3
August Afternoon	14	5	1
August Evening	15	8	0
September Afternoon	13	6	0
September Evening	16	6	2
October Afternoon	13	5	1
October Evening	14	4	0
Total	166	68	13

The CTT program consists of 4 scheduled sessions and clients are expected to attend all four sessions. Figure 3 shows the percentage of clients that attended each number of sessions. Most (66%) attended all four sessions, suggesting a reasonably high level of retention.



Figure 3. Percent of clients who attended 1, 2, 3, or 4 CTT sessions



Analyses: in-program requirements.

1) Self-Help Meetings. Throughout the four weeks of the program, the participants are expected to complete several assignments that are given both in class and as homework. Upon enrollment, each participant must commit to attending at least one self-help group meeting during the span of the program. This can be Alcoholics Anonymous (AA), Cocaine Anonymous (CA), or Narcotics Anonymous (NA). Of all the participants, including those who did not finish the program, 50% attended a self-help meeting. Of these, only 32% completed the required handout, describing their experience and their thoughts about the group. This means that 18% of participants claim to have attended a group, but failed to provide the homework assignment. Approximately 62% of the participants who completed the program reported having attended a self-help group, indicating that those who complete all four sessions are more likely to do the homework.

According to the data collected during the assessment process, 30.5% of the people that subsequently enrolled in the program had attended a self-help group in the past. The counselor conducting the CTT program indicated that 71% of the clients attended a self-help group during the program, which was slightly higher than the client's reports (62%).

2) Abstinence Monitoring Logs (AML). A second out-of-class assignment, expected of all program participants is to keep an Abstinence Monitoring Log (AML) throughout the entire program. Each week the client is given a blank log sheet on which they are charged to keep track of what they did each day of the week, what their triggers for use may have been, and what their use would have been in the past. Then the client records whether they maintained abstinence. Though there are four sessions in the program, there are only three weeks in between sessions one and four, so each client fills out three AMLs. 66% of clients who returned for the second session completed the AML for their



first week. Of the clients who returned for the third session, 67.4% completed the AML for week 2. From those clients that attended all 4 sessions, just under half completed all three AMLs (47.7%). Approximately half of the people who filled out a log each week maintained abstinence. Table 4 displays this information. Clients who dropped out obviously did not complete a log and therefore they are not included in the percentages.

Table 4. Percent of Clients who completed abstinent monitoring log and maintained abstinence

	Completed AML	Maintained abstinence
Week 1 (n=56)	66.0%	53.6%
Week 2 (n=46)	67.4%	50.0%
Week 3 (n=44)	47.7%	47.7%

Clients are classified as having completed an AML if they returned a complete or partially complete log. The remaining clients that did not complete an AML either handed back a blank log or did not return a log sheet at all. Those clients who are not classified as having maintained abstinence either did not hand back a log sheet or admitted that they had not maintained abstinence that week. The final number of 47.7% maintaining abstinence is consistent with the results from the final staff questionnaire in which the counselor stated that about 44% of the total clients maintained abstinence throughout the program.

3) Written homework assignments. Each week clients were given a variety of written assignments that were to be completed either in class or at home (if it was impossible to complete them in class). For a complete list of these assignments, please refer to table 1, above. On average, each homework assignment was completed by 60% of clients, though very few clients submitted all of the assignments.

One of the written assignments asked clients to identify triggers associated with their use. This is important, as triggers are related to relapse, and much of the work of CTT is designed to help clients to recognize the risk associated with exposure to triggers. Specifically, clients were asked to list their top three triggers or reasons for using. The most commonly listed reason was emotional. Approximately 50% of people who completed this assignment named an emotional stressor as their number one trigger, and almost $\frac{3}{4}$ (71%) identified emotional issues associated with using. Another commonly identified trigger was socializing, including celebrations and family gatherings. Other frequently identified triggers were things such as Fridays, paydays, boredom, and peer pressure or fitting in.



Analyses: pre and post program data.

1) Self-Efficacy (SE) and confidence to manage high risk situations. During each client's initial one-to-one session with a counselor, an initial questionnaire was completed. One of the sections in this questionnaire is an estimate of self-efficacy (SE). SE is defined here as a person's confidence in their own ability to resist using their drug of choice in various scenarios. The client rates their confidence to resist on a scale of 0%, meaning that they are not confident at all, to 100% meaning they feel completely confident to resist using in that scenario. An example of a scenario might be "If I wanted to celebrate with a friend". This same set of questions is repeated at each client's final one-to-one session with the counselor. In the initial and final questionnaires, there are 8 SE statements. However, in week 3, the clients answer a complete set of 50 SE statements, called the "High Risk Situations and Confidence to Manage" questionnaire (HRS).

To evaluate these numbers, we calculated a score for each person. This score was calculated by assigning a 0, 1 or 2 to low, medium and high efficacy answers, respectively. This means that if a person answered that they were 0% or 20% confident to resist a scenario, that question was given a score of 0, if they responded that they were either 40% or 60% confident to resist, they were given a score of 1 and if they responded that they were highly confident (either 80% or 100% confident) they were given a score of 2. Then the values for each question were summed to yield a confidence score. Each category of confidence scores then corresponds to an average percent of confidence, which allows us to correlate the 8-statement questionnaire with the 50-statement questionnaire. The total confidence scores for all clients can be seen on the Table 5.

Table 5.

Score	Confidence %	Pre (all clients)	Pre (client who completed all 4 sessions)	Post (4 sessions) (%)	HRS (%)
<5	< 50%	7.4	2.2	2.6	6.0
6 to 9	51% - 60%	11.4	8.8	10.3	9.0
10 to 12	61% - 80%	25.0	26.7	2.6	18.1
13 to 15	81% - 99%	23.5	22.2	25.6	27.1
16	100%	32.4	40.0	59.0	39.4

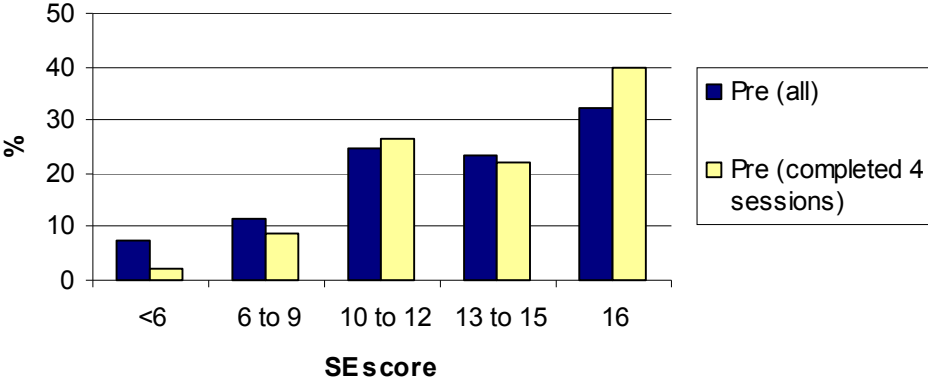
Note: Some columns may not total 100% due to rounding errors.

Since all clients completed an initial questionnaire, the Pre (all) category is the SE scores for everyone that enrolled in the program. However, to evaluate a change in score, we only at the scores of the clients who completed both a pre-test and a post-test questionnaire. Clients who completed all four program sessions had higher initial Self



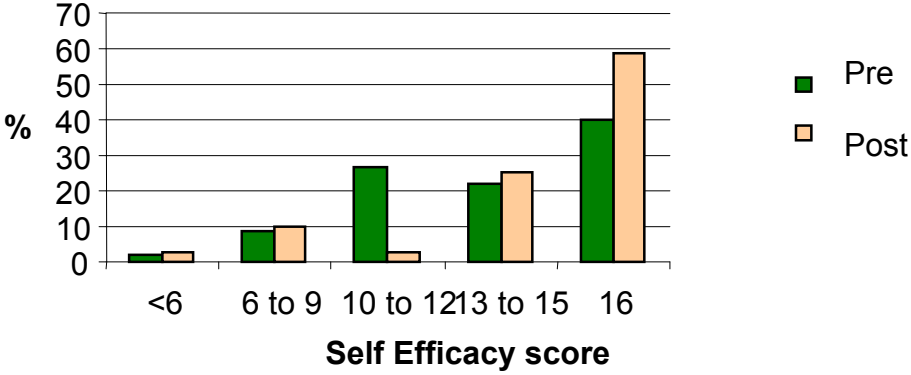
Efficacy scores. The total group of pre scores shows a greater number of scores below 6, and a smaller number of scores of 16.

SE scores for all clients versus those that completed the program



A second finding is the increase in Self Efficacy of the people who completed the program. This data can be seen on Table 6.

Pre and post Self Efficacy scores for clients who completed CTT

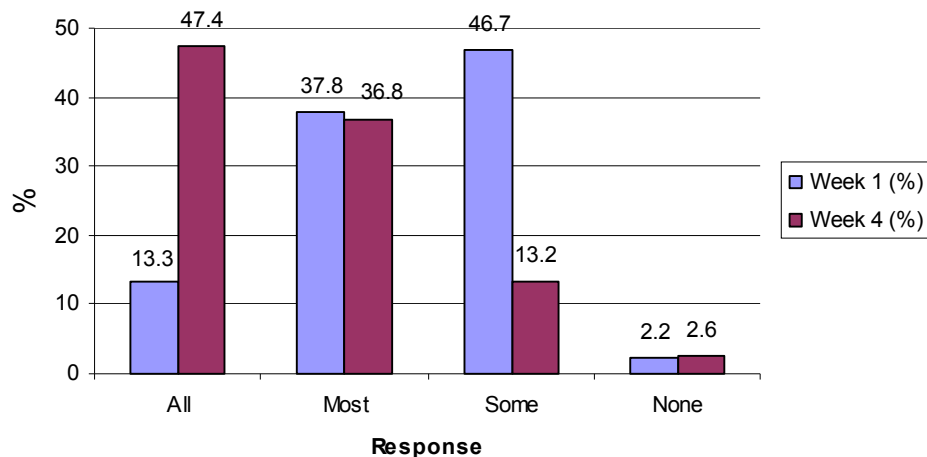


When clients complete all 50 statements of the HRS, the final scores also show that most of the clients feel quite confident with their ability to resist using alcohol or drugs in high risk situations. Only 6% of clients have an average confidence level below 50%. Nearly 40% of clients have a confidence level of 100% for every statement on the questionnaire.

2) Knowledge scale. A second part of both the initial and final questionnaires is a drug and alcohol knowledge scale, consisting of 13 questions. These questions include both true/false questions and multiple choice questions. On average, 6.6 questions were answered correctly, prior to the start of the program. In the final questionnaire, the same 13 questions were asked and 8.1 were answered correctly, on average. In a two-tailed paired differences t-test, these values are highly significant, with a p-value of 0.000. When we compared each client's "pre" score with his or her own "post" score, the overall performance significantly improved.

3) Communication regarding use. Each week the clients completed a session evaluation. Each week they were asked how many of their thoughts and ideas they had shared with the group that day. They could respond with either "all", "most", "some", or "none". As one of the goals of the program was to increase communication regarding drug or alcohol use, we were interested in how open people would be and if they would become more open and the program progressed. When evaluating responses from only clients that completed all four sessions, we found that communication had significantly improved. At week 1, only 13% of clients shared all their thoughts, by week 4, nearly half were sharing all their thoughts. This value was found to be statistically significant, with a p-value of 0.000, when using a two-tailed, paired differences t-test (again, this means that each client's pre and post scores were paired together and used for the comparison).

Progress of communication of thoughts and ideas in group



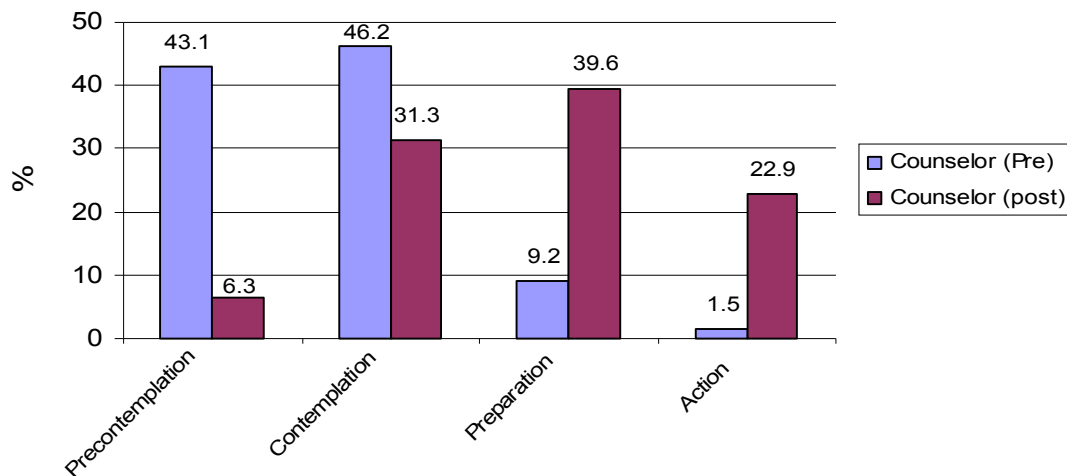
4) Knowledge of the Stages of Change (SoC) model. Two goals can be identified regarding the stages of change model. The first is to teach the client about the stages of



change, so we expect to see an increase in understanding of the model. The second goal is to try and increase the client’s understanding of their addiction and hopefully increase their readiness to change.

At each intake meeting, the client is interviewed and the counselor ascertains which stage of change they believe the client to be in. At the end of the 4-week CTT program, the program counselor re-evaluates this position to determine if the client has become more or less ready to change. We found a significant increase in the number of clients at both the preparation and action stages and a significant decrease in clients at the pre-contemplation and contemplation stages. This would indicate that the counselor is of the opinion that many clients have moved from the lower stages into the higher ones.

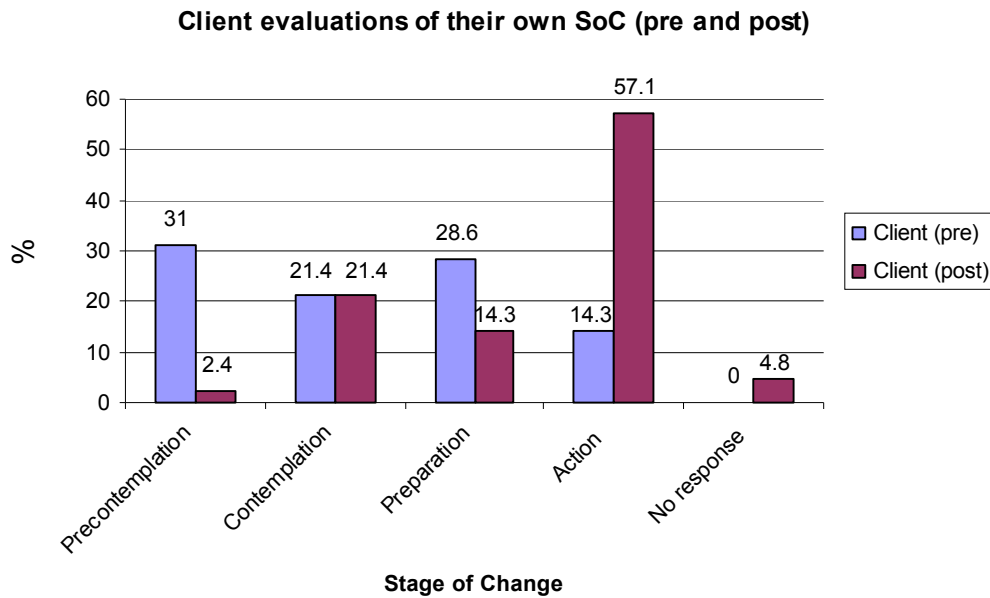
Counselor assessment of SoC (pre and post program)



Stage of Change

We did not expect the clients to be able to describe their own stage of change prior to the CTT program. In the final questionnaire, they were asked what stage they believed themselves to be in at the beginning of the program, and what stage they believed themselves to be in at the end of the program. With this information, we are able to determine if the client believes they have increased in their readiness to change. This can be determined even if the client does not agree with the counselor about what stage he or she is in. A similar trend was found in the client evaluations of themselves, as was found in the counselor evaluations.





On further analysis, it was found that 50% of clients had the same evaluation of their current SoC as did the counselor, while 50% of clients disagreed with the stage the counselor believed them to be in. This may indicate a misunderstanding of the stages in half of the clients, or a skewed view of their own behavior and ideas, or a combination of both of these things. It is most likely a combination, and the counselor believed that 62% of clients had a good understanding of the model at the end of the program. The counselor was unsure about the level of understanding in 36% of clients, and was only certain that 2% of clients did not understand the SoC model.

Analyses: program outcomes

1a) Clients self-report outcomes. As a part of the final questionnaire, clients were asked several questions about their perceptions of drug and alcohol use, their future goals, and their opinion of the program.

- 80% of clients say that their awareness of how their use affects their lives has increased
- 78% say they would use AFM again
- 71% say they would recommend AFM to others
- 71% say they have been making progress toward their goals
- 73% have changed their pattern of use
- 69% have found changes in their perception of alcohol and drug use

1b) Staff report outcomes. Staff members were asked some similar questions about their perceptions of each client. Some congruency between clients and counselors can be seen.

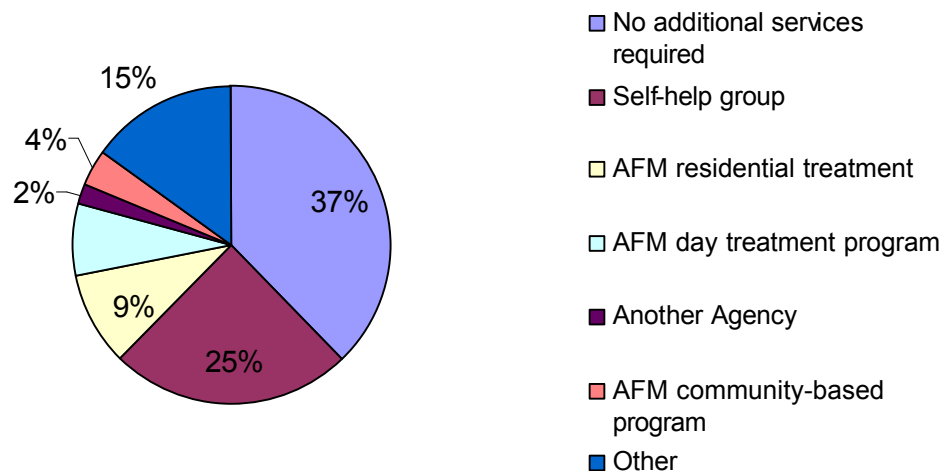


For example, approximately 70% of clients believe they have made progress toward their goals, and the counselor also found that 70% of clients seemed to be making progress.

- 64.4% seem to have appropriate plans for achieving personal goals
- 46.7% seem to have appropriate plans for handling high risk situations
- 73.3% have made progress toward their personal goals
- 55.6% seem to have changed their perceptions regarding their use
- 86.7% of clients link their use to negative personal experiences

2) Referrals. The final question on the staff report questionnaire asks if the counselor has referred the client to any other programs within or outside the AFM. For just over one-third of the clients, no additional services were required, but for the rest, various referrals were made. 25% were referred to self-help groups, and 9% were referred to AFM residential treatment. The remaining clients were referred to various programs such as AFM day programs, other agencies, community-based programs, and counselors.

percentage of clients referred to various services upon completion of the CTT program



The “other” category includes 3 referrals to various counselors, 3 referrals of further one-to-one sessions with the CTT counselor, 1 referral to a 10-week NRTP and 1 referral to a non-AFM parenting program.



Counsellors' Comments.

Karin Archibald, who was involved with CTT during its development and is still among the program's primary counselors, was asked to share her thoughts on the success of the program to date. These are some of the comments she made.

The program was created when a gap in services was identified for people who have experienced some negative consequences due to their alcohol or drug use, such as an assault charge, loss of a job, or an incident involving Child and Family Services, and yet these people may not be substance dependent and therefore do not qualify for other AFM programs. Oftentimes, these people are in a precontemplative stage of change and have trouble fitting in with other groups. Clients entering CTT may be in different phases of precontemplation, but most seem willing to keep an open mind about the information offered by the counselors at CTT. In fact, one of the things that Karin Archibald is regularly surprised by is the willingness of clients to be open to information and engage in self-exploration. She frequently sees movement from precontemplation to preparation, which is also reflected in the perceptions of the clients, previously reported.

Most CTT clients declare a few personal goals at the start of the program. These may be flexible, program-focused goals such as gaining knowledge, abstinence, or modifying use, but may also include personal goals such as getting a job or getting children back. The counselors encourage program-focused goals and find that because clients set their own goals, they are frequently successful. Some personal goals such as putting a family back together are difficult to achieve in a four-week program, and in cases such as these, counselors may offer further one-to-one counseling sessions, or encourage clients to enroll in another program after completing CTT.

As identified in the logic and accountability models, homework and in-class assignments are an integral part of the CTT program. During weeks 1 and 2, most of the assignments are completed in class, and several homework assignments are given in week 3. Sometimes these assignments are completed, but not always. We were interested in finding out which assignments were most beneficial to clients. While each assignment is important in some way, the abstinence logs and life area map were identified as particularly useful. The abstinence logs were to be filled out every day, to identify triggers and use each week. People were generally willing to admit if they had used during the week and this was used as a part of the learning process. Clients did not receive a punitive response when they used drugs or alcohol and this contributed to a feeling of comfort in the group. The life area map was especially useful, in that sometimes people get caught up in a current negative consequence of their use, such as a relationship breaking up or a criminal charge, that they forget about other consequences from their past. This map help identify all the different areas of their life that have been impacted by drug or alcohol use over time.



Some of the most beneficial techniques used in the program are in the way CTT is organized. Clients make their own connections between their use and the consequences. This allows the learning process to be personal and thus effective. For clients, this program provides an environment in which they can discover that they are not alone. There is an intentional break mid-session so that clients can develop relationships informally as well as in the group. They are treated in a respectful and non-judgmental manner, and some are surprised by this. CTT is a group where they are not reprimanded for their use and therefore they feel comfortable opening up about it.

Finally, when Karin was asked to give her thoughts on any aspect of the program that needed improvement or change she failed to think of anything, enthusiastically saying “I just think it’s a great program!”



SUMMARY AND CONCLUSIONS

The objectives of the Coming to Terms program at the AFM are to increase client's knowledge about alcohol and other drugs, and the impact that substance use may have on their lives. Clearly these goals have been met, whether evaluated through testing (knowledge gain) or subjectively, through client and counselor perceptions of learning during the program. Importantly, clients who complete the program have a greater sense of self-efficacy to manage the risk of relapse and to control their behavior in high risk situations, which they will inevitably face. In addition to these successes, many of the clients are able to maintain abstinence during the course of the program. Although this is not mandatory, it is an important first step in trying to address issues related to excessive substance use. Overall, the indications are that the Winnipeg Coming to Terms program meets its defined goals, and is a useful program for helping clients who are somewhat ambivalent about their substance use, recognize the impact of their behavior, and begin to take the first steps towards reducing the harm associated with their use.

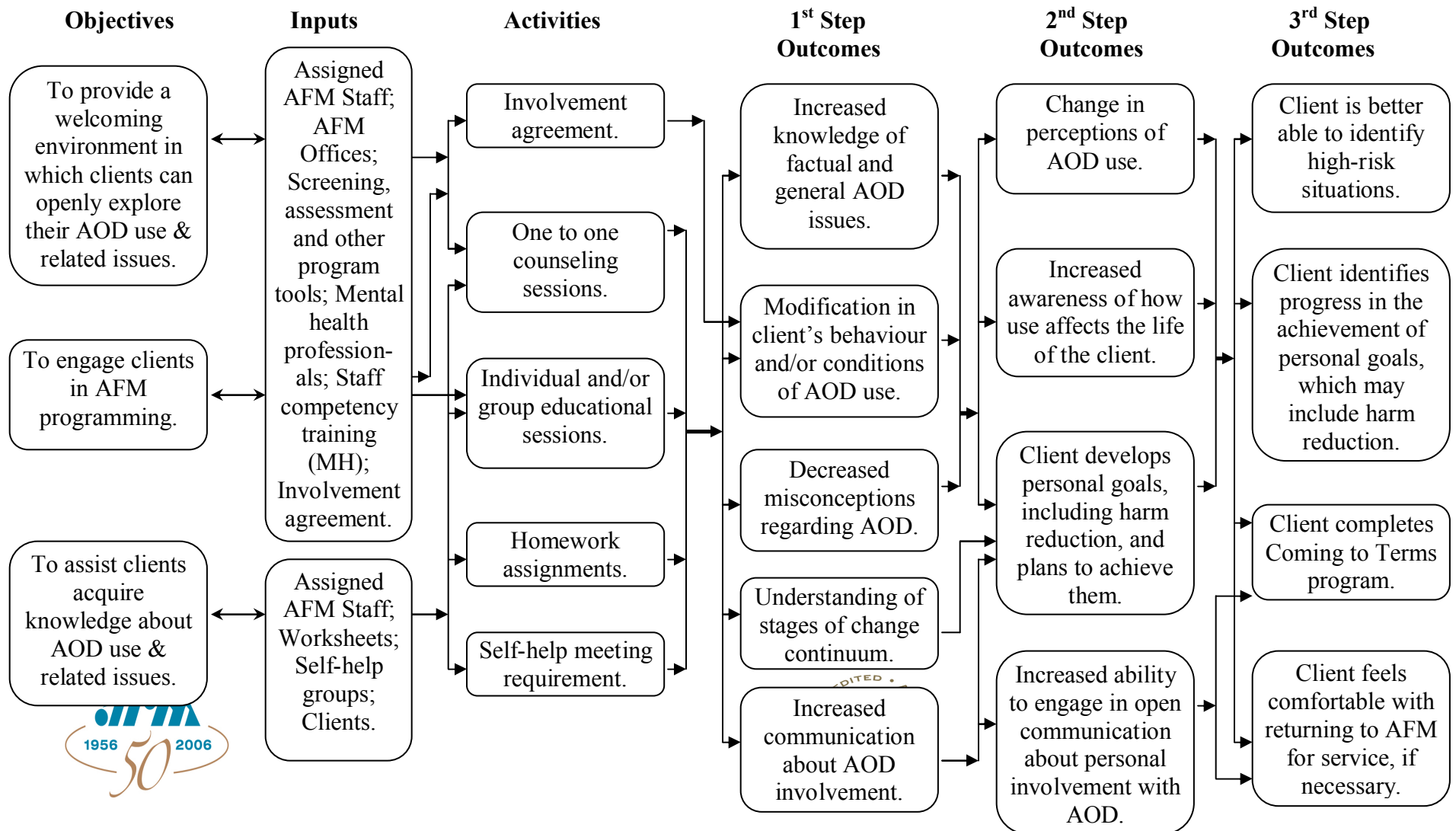


Appendix A
Logic Model for Coming to Terms



Goal: To assist pre-contemplative and contemplative clients to better understand and acknowledge AOD issues through the provision of individual and group educational sessions.

Target Group: Adult clients whose AOD use has been assessed as “Harmful Involvement”, “Dependent Involvement” or “Transitional Abstinence” and who are in pre-contemplation or contemplation with regard to their level of involvement and their original assessment.



Appendix B

Accountability model for Coming to Terms

CTT Objectives and Outcomes	Indicators/Measures	Data Source / Methodology
<p>1.0 To provide a welcoming environment in which clients can openly explore their AOD use and related issues.</p>		
<p>1.1 Increased communication about AOD involvement.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who report that they increased their communication while in the 	<ul style="list-style-type: none"> • Client self-report questionnaire • Staff report



	<p>program.</p> <ul style="list-style-type: none"> • Number and percentage of clients that the staff report increased their communication while in the program. 	
<p>1.2 Increased ability to engage in open communication about personal involvement with AOD.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who report an increased ability to engage in open communication about their involvement with AOD. • Number and percentage of clients that staff report had become more open in their communication by the end of the group sessions. 	<ul style="list-style-type: none"> • Client self-report questionnaire • Abstinence monitoring log • Staff report
<p>1.3 Increased awareness of how use affects the life of the client.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who attend at least three out of four group sessions. • Number and percentage of clients who complete the life area map. • Number and percentage of clients who report an increased awareness of how use affects their life. 	<ul style="list-style-type: none"> • Group session tracking system • Client self-report questionnaire • Abstinence monitoring log
<p>1.4 Client feels comfortable with returning to AFM for service, if necessary.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who report that they would be comfortable returning to AFM for service in the future. • Number and percentage of clients who report that they would refer someone they know to an AFM program. 	<ul style="list-style-type: none"> • Client self-report questionnaire • Follow-up survey



<p>1.5 Client develops personal goals, including harm reduction, and plans to achieve them.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who articulate specific personal goals. • Number and percentage of clients who articulate a plan for achieving their personal goals. • Number and percentage of clients that staff assesses as having developed appropriate plans for achieving their personal goals. 	<ul style="list-style-type: none"> • (Revised) MIS forms • Client self-report questionnaire • Staff report
<p>1.6 Client identifies progress in the achievement of personal goals, which may include harm reduction.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who report that they have progressed in the achievement of their personal goals. • Number and percentage of clients that staff assesses as having progressed in the achievement of their personal goals. 	<ul style="list-style-type: none"> • (Revised) MIS forms • Client self-report questionnaire • Staff report • Follow-up survey
<p>2.0 To engage clients in AFM programming.</p>		
<p>2.1 Modification in client's behaviour and/or conditions of use.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who report maintaining abstinence while completing the CTT program. • Number and percentage of clients who report that they have changed 	<ul style="list-style-type: none"> • Client self-report questionnaire • Staff report • Abstinence monitoring log



	the conditions of their use while participating in the program.	
2.2 Change in perceptions of AOD use.	<ul style="list-style-type: none"> • Number and percentage of clients who report that they have changed their perceptions of AOD use. • Number and percentage of clients that staff report have articulated differences in perception from the first contact to the end of program. 	<ul style="list-style-type: none"> • Client self-report • Abstinence monitoring log • Staff report
2.3 Client completes Coming to Terms program.	<ul style="list-style-type: none"> • Number and percentage of clients who attend at least three of four group sessions and at least one individual session in the CTT program. • Number and percentage of clients who complete at least 75% of the program assignments. 	<ul style="list-style-type: none"> • Staff tracking
3.0 To assist clients acquire knowledge about AOD use and related issues.		
3.1 Increased knowledge of factual and general AOD issues.	<ul style="list-style-type: none"> • Number and percentage of clients who receive instruction on levels of involvement. 	<ul style="list-style-type: none"> • Pre-post test • Abstinence monitoring log



	<ul style="list-style-type: none"> • Number and percentage of clients who receive instruction on the pros and cons of use and abstinence. • Number and percentage of clients who view at least two of the three scheduled videos on marijuana, cocaine and alcohol use in Winnipeg Region only). • Number and percentage of clients who have an increase in test score from pre to post test. • Number and percentage of clients who complete the abstinence monitoring logs. 	
3.2 Decreased misconceptions regarding AOD.	<ul style="list-style-type: none"> • Number and percentage of clients who view at least two of the three scheduled videos on marijuana, cocaine and alcohol use (in Winnipeg Region only). • Number and percentage of clients who have an increase in test score from pre to post test. 	<ul style="list-style-type: none"> • Pre-post test
3.3 Understanding of stages of change continuum.	<ul style="list-style-type: none"> • Number and percentage of clients who attend the third group session. • Number and percentage of clients who staff report have a good understanding of the stages of change continuum. • Number and percentage of clients 	<ul style="list-style-type: none"> • Pre-post test • Staff report



	<p>who have an increase in test score from pre to post test.</p>	
<p>3.4 Client is better able to identify high-risk situations.</p>	<ul style="list-style-type: none"> • Number and percentage of clients who attend the fourth group session. • Number and percentage of clients who fill out the high-risk questionnaire. • Number and percentage of clients who have a plan for how they will handle high-risk situations. • Number and percentage of clients who the staff assesses as having an appropriate plan for handling high-risk situations. • Number and percentage of clients who have an increase in test score from pre to post test. 	<ul style="list-style-type: none"> • Pre-post test • Staff report

