

*Evaluation of the Women Invested in Sobriety,
Empowered in Recovery (WISER):
A women's program of the
Addictions Foundation of Manitoba*

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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

Based on Best Practices, the Addictions Foundation of Manitoba developed an outpatient program specific for women. Entitled “Women Invested in Sobriety, Empowered in Recovery” (WISER) this is a twelve-week group program that runs three times a week during the day. Individual counseling sessions are also offered to participants. Topics covered during the sessions include addiction education, understanding relapse prevention, managing moods, dealing with guilt and shame, and addressing issues related to substance misuse. A follow-up Continuing Care program is offered once a week to provide additional support.

Nine clients provided fairly detailed reports of their attitudes and behavior on the first day of the program and after they had completed the program. Most of the clients reported higher levels of social support at the end of the program, suggesting that they have been able to get some encouragement from their friends and family during this difficult time. There were also signs that depression has decreased in this group, which is important as they may be at risk due to their efforts to make change. A couple of clients also had much lower Post Traumatic Stress scores after the program, although for some their scores were a little higher. One measure that showed a consistent change was self-esteem. Almost all (8 of 9) of the clients reported higher levels of self-esteem at the end of the program. The degree of spirituality has also increased in these clients over the course of the program. Average scores indicate about a 20% increase in spirituality, which is consistent with the focus on abstinence and the use of AA as a required support. Last, most (8 of 9) clients showed increased knowledge about alcohol or other drug use and addiction.

A satisfaction survey completed by 14 clients (some did not provide information at the pre-test as the evaluation was being prepared as the program began) shows a very positive response, with almost all indicating that they would recommend the program to a friend and attributing positive life change to the program. Comments on the satisfaction survey indicate both satisfaction with the process and the counselor.



INTRODUCTION

Program Rationale

In light of a progressive increase in the number of women accessing addiction treatment services, as well as growing support for women-specific substance use treatment, the Addictions Foundation of Manitoba has increased the number of programs specific to women. Since many women's treatment outcome studies lack reliability and validity, or contain numerous methodological flaws, gender differences in treatment options have been neglected, often due to lack of evidence of their efficacy.

Women are underrepresented in treatment for many reasons. Frequently, prevailing sociopolitical, cultural, and moral views place greater stigmatization on women with substance problems than on men. This means that fewer women are prepared to acknowledge their problem and seek help. There are also additional reasons why women may avoid treatment for addictions, which are different from the reasons men avoid treatment. For example, they may fear intervention by Child and Family Services (CFS) who may be concerned about the client's ability to be a competent parent due to their impairment by addiction. They may also fear that their need for treatment is an indicator of lack of ability to parent, and this information may also be used by a vindictive partner, who is trying to gain custody of their children. It may also be difficult to women to participate in a residential program due to the need to develop other child-care options, which, again might highlight the difficulties created by their addiction..

Those who do enter into treatment programs may experience lower success rates in co-educational programs due to an unwillingness to open up to men. Jarvis (1992) found that women in co-ed groups minimize the focus on their own issues, while Ford (1987) found that women are likely to take on a nurturing role and simply encourage the men to



do the talking. These concerns prompted the AFM to pilot a women-only day program – Women Invested in Sobriety, Empowered in Recovery (WISER). Previously most community-based AFM programs were gender-neutral, allowing both males and females in the same group.

WISER's approach to women's addiction treatment incorporates 4 different psychological theories. The *Self-in-Relation* theory (Finkelstein, 1993), when applied to women's sensitive treatment, holds that girls do not develop towards a greater autonomy, but rather that they develop in a direction of growth within a relationship (Creamer and McMurtie, 1998). This in turn means that women place high value on traits such as intimacy and empathy. A second theoretical approach, the *Empowerment Model* (Burman, 1994; Health Canada, 2001) has been the basis for several suggestions for methods to empower women in treatment, including identifying and building on individual strengths, teaching problem solving skills, and emphasizing flexibility, creativity and choice (Kasl, 1995; Gutierrez, 1990). The *Stages of Change* (SoC) model (Prochaska and Diclemente, 1984) and *Motivational Interviewing* (Rollnick and Miller, 1995) are fundamental to treatment at the AFM. Both are well-established Best Practices in the field. The SoC model recognizes that people are at different stages of readiness to change and different treatment strategies are optimum for different stages. Motivational interviewing is a client-centered intervention that aims to reduce resistance to treatment and the ambivalence that is usually encountered during efforts to change.

These various approaches are outlined in Health Canada's Best Practices (2001) and Best Practices in Action (2004) documents. These guidelines and others (e.g., United Nations Substance Abuse Treatment and Care for Women, 2004) report that women in treatment need a safe and nurturing environment that encourages trust and bonding, with an emphasis on skill- building and self-efficacy, while incorporating each woman's life experiences. The four models used in the WISER program aim to accomplish these things by providing such an environment.



Program Design

Who Is Referred

The Women's Day Program is for adult women who are assessed as having a dependent level of involvement with alcohol and/or other drugs, and who are in the contemplative or preparation stage of change. It is offered as abstinence-based program with consideration given to the principles of harm reduction. This means that a woman accepted into program that is preparing to abstain from her primary drug of choice but is precontemplative about other drug use will be allowed to participate in the program. Further, if a woman relapses while in program she will be invited to continue in the day program. Rather than being discharged or punished for relapsing, the focus will be on the learning that may occur for the individual and the group. Self examination, a redefining of treatment goals and alternate methods of coping will be processed within the group sessions. The intention is to support changes a woman can make, thereby reducing the pressure to use. Women who are prescribed mood altering substances such as benzodiazepines or opiates and are regularly monitored by a physician will be eligible for admission. Often this is an exclusion criteria for other programs, which may not admit clients who are not willing to try to abstain from **all** other drugs (with the exception of tobacco). These inclusion criteria allow for a more client centered, clinically-driven and flexible approach. It is hypothesized that one of the benefits will be higher rates of engagement and retention of clients. Other criteria for acceptance into this program are: (a) a willingness and ability to actively engage in a process group environment; (b) being assessed as living in a safe home environment, and; c) an ability to commit to attending scheduled programming for 12 weeks.

Program Structure

There are differing clinical opinions cited in the research regarding the optimal treatment duration and intensity for an outpatient population. As well there are only a handful of published articles exploring this within a female population. More treatment for more severely impaired individuals is the general rule. Substance abusers in early recovery are seen as needing more support than those in advanced stages of recovery. However, there



are a wide range of variables that influence treatment outcomes, which makes it difficult to determine more precisely how long treatment should last.

One rationale for determining length of treatment is relapse risk. Accounting for individual variability, most relapse occurs within the first year of recovery. That is, the greatest risk occurs within the first weeks and months of sobriety. Assuming relapse risk lessens with increased and regular contact, a recovering woman would need the most support during the first several months. Waltman and others determine that a minimum length of care for the average client in outpatient treatment should last 3 to 6 months with flexibility built in to the individual program. Following that line of reasoning, the Women's Day Program pilot has been based on a 12 week or 3 month cycle. Within this time frame, the program will be run 3 days a week, Tuesday, Wednesday, and Thursday from 1000hrs. until 1500hrs. Mondays and Fridays are therefore available for additional individual counseling sessions. This provides for flexibility and allows participants to attend to personal or family matters during the non program days and times. The program is facilitated by one female counselor with a maximum number of 6 clients assigned to her.

Program Content

Primary interventions directly address the substance abuse problems and include the following topic areas: addiction education, (using Stages of Change and Levels of Involvement) physiological effects of drug and alcohol use, understanding relapse prevention and recovery, affect management, dealing with guilt and shame, an introduction to self help involvement, smoking cessation, and treatment services such as interactional process groups, individual counseling/ family counseling when needed. Adjunctive treatment addresses issues secondary to substance misuse. These help clients solve practical problems of daily living and have been found to augment the strength of primary interventions (Friedman and Glickman, 1986; 1987). Topic areas will include stress management, self care and alternative healing (meditation, yoga), female sexuality, spirituality, grief and loss, assertiveness training and skill development, domestic



violence and healthy relationships, self esteem and body image, vocational counselling, mental health and addictions. With this wide range of programming options it is anticipated that many of the significant issues related to women's addictions will be addressed.

Prior to commencing the program, client and counselor meet individually to review client's initial goals and concerns, the program guidelines, and expectations. Ongoing recovery planning is emphasized and reviewed during the last individual counseling session. A Continuing Care program is offered once a week during day time hours as additional support. This is an open ended group available to all graduates of WISER. If a client is unable to attend the scheduled Continuing Care, she is able to meet with the program facilitator for individual follow up.

METHODS

Participants

9 women who completed the WISER program also completed a personal evaluation before entering the program and upon completion of the program. All provided informed consent and were advised that the evaluation was voluntary, with no repercussions should they choose to decline or to withdraw from the study.

Instruments

9 measures were used to evaluate the impacts of the program. The M.I.N.I. was used to assess drug and alcohol use in the past year. This included signs of substance dependence, such as unsuccessful attempts to reduce use, and any physical or social consequences from use such as legal or family problems. The URICA was used to assess stage of change before and after treatment. We measured degree of social supports using a 12-item questionnaire on a 7-point likert scale developed specifically for this project. The Assertion Inventory was used to measure the degree to which clients feel discomfort with being assertive in various situations, as well as the likelihood that they will perform



the action. (e.g., “rate the degree of discomfort and response probability of turning down a request to borrow your car”). Self-esteem was assessed using the Rosenberg Self-Esteem scale, which is a commonly-used 10-item questionnaire used to measure global feelings of self-worth or self-acceptance. Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D), a 20-item scale that assesses current depressive symptoms with an emphasis on recent mood. The Modified PTSD Symptom Scale is a 17-item scale that measures both the frequency and severity symptoms related to post traumatic stress disorder (PTSD). We assessed spirituality using a 26-item questionnaire designed to measure spiritual attitudes and beliefs, as well as behaviours and frequency of engaging in spiritual activities such as prayer or meditation. The final tool used in this evaluation was a 20-item, multiple-choice, knowledge scale created to reflect the specific educational goals of each module in the program.

RESULTS

*Please note that on graphs and tables that identify clients by numbers 1 through 9, clients are presented at random, and client 1 in one table is not necessarily client 1 in any subsequent tables.

Drug and Alcohol Use

The first questionnaire that the clients in the WISER program completed was the MINI – a short assessment of the kinds of substances that are being used. In the past year, 4 clients had used only alcohol and no other illegal substances. Approximately half of the clients had used stimulants (44%), cocaine /crack (56%), narcotics (56%), hallucinogens (56%), or marijuana (44%). All of the clients who were participating in the program because of drug use (other than alcohol) had used at least 4 of the listed classes of drugs in the past year. One had used at least one drug from each class. The following table shows the number of clients that listed each substance as their most used substance. The total is greater than 9 because several of the clients listed more than one substance.



DRUG	# of clients
alcohol	5
crack cocaine	2
crystal meth	2
opiates	1
THC	3

This measure also includes several yes/no questions about and the extent to which the client's use has been affecting her life such as "have you tried to reduce or stop drinking /using drugs but failed", and "do you spend less time working, enjoying hobbies, or being with others because of your drinking /drug use". The greater the number of "yes" responses, the more the client's use has been affecting her lifestyle. Out of 12 questions, one woman chose "yes" 8 times. The remaining 8 women chose "yes" more than 8 times. This response indicates that the women in the program are quite heavily involved with their substance of choice, and have been seeing major repercussions from their use. These questions all refer to the past year, and therefore we did not expect to see any change in response during the three-month program, and any change that might occur cannot be attributed to participation in WISER, and so we did not analyse pre and post responses to these questions. If we were to do a second evaluation, it would be important to ask these questions, but to refer only to use in the past 3 months, so that pre and post responses could be comparable.

Stages of Change

In order to provide the best possible service for addicted clients, it is very important to determine what stage of readiness to change each person is at. According to the theories, there are four stages of readiness to change in clients that are typically seen in programs such as WISER:

- 1) precontemplation: in this stage people do not think they have a problem and are not thinking about changing.



- 2) contemplation: people here are starting to notice that there may actually be a problem and that some change may be necessary to solve it.
- 3) preparation: clients in this stage are aware of a problem and know that they need to make changes
- 4) action: in this stage, people are actively attempting to make the necessary changes.
- 5) A fifth stage of change is the ‘maintenance’ stage, where clients have already made some major changes and are just working to keep themselves in this new position. This is the target stage for most interventions, as it demonstrates that clients have remained sober and free from the negative consequences of their prior levels of use.

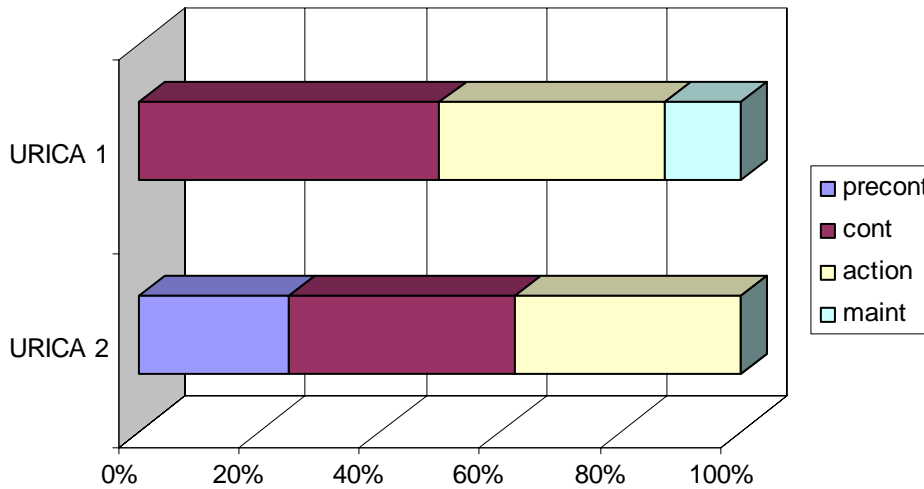
We assessed stage of change (SoC) before the program and after completion. Due to extreme scores the data from one client appeared questionable and was not used in this analysis. The following table shows what SoC each client was in at the start of the program (pre) and after completing the program (post).

Client #	URICA pre	URICA post
1	cont	cont
2	action	precont
3	maint	action
4	cont	action
5	action	cont
6	cont	action
7	cont	precont
8	action	cont

There is movement through stages from pre to post, however, there is no consistent directionality. That is, although some clients moved towards a more action-oriented stage, a few moved from action to precontemplation or contemplation. There are several reasons why this may be the case. Obviously, readiness to change may increase due to participation in the program. Readiness may decrease though because clients feel really good about themselves and their effort to make changes when the program begins. They



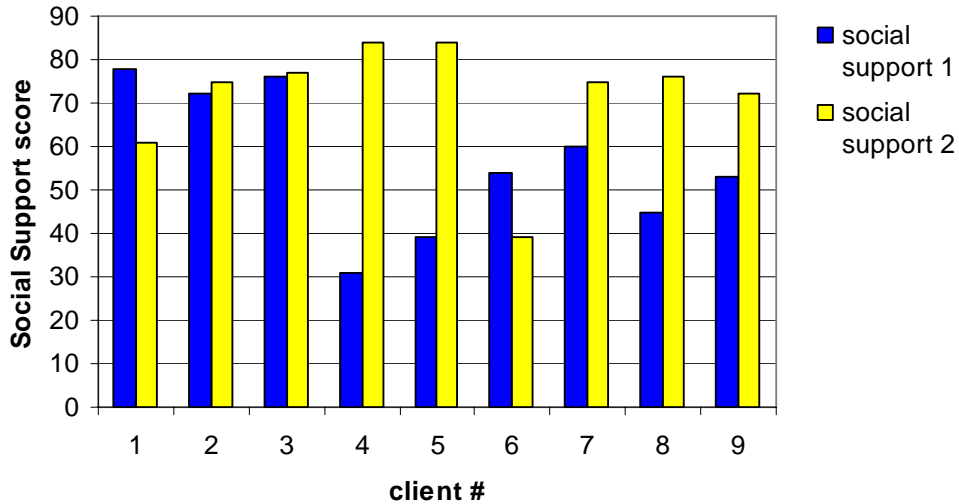
may feel that simply their participation in the program indicates a willingness to change. Thus their responses at the start of the program reflect their eagerness to show their current efforts (i.e., “action”) towards achieving sustainable life change. However, as the program progresses and time passes, clients may realize that change is harder than they expected and perhaps they were not as ready to change as they first thought. They may begin to ‘re-think’ their efforts, becoming somewhat abivalent about the need to make these difficult adjustments. This has important implications for the program itself. Counselors are going to be aware that this is a potential problem and take steps to help clients realize that change is necessary and that, while difficult, is possible. This graph is a summary of the movement within stages of readiness to change.



Social Support

The extent to which clients felt they had a supportive social network was assessed using a short questionnaire comprised of 12 face-valid items such as “my friends really try to help me” and “I get the emotional help and support I need from my family”. These questions are answered on a 7-point Likert scale from “very strongly disagree” to “very strongly agree”. Higher scores are indicative of greater social supports. The following graph displays the results of pre- and post- program assessment.





Day programs in the AFM typically accept people that already have some social support (people with no social support are better candidates for the residential program). The results of this questionnaire indicate that most of these women felt that they had medium to high social supports at the beginning of the program.

The changes in social support scores across the three month program likely show changes in cognition regarding social supports, rather than actual changes in the extent to which friends and family are supportive. In the cases where social support scores increase, it may be that clients started the program feeling like they were going to have to go through the recovery process alone, because perhaps their friends and family were not supportive during the addiction. When they began the program, they may have slowly become aware that their friends and family were actually very supportive of them. On the other hand, drops in social support scores may occur because at the start of the program the client felt they had very supportive friends. These friends were likely part of a social network created around drug or alcohol use. When the client quit using, there was nothing left to connect her to this group.

Assertion

Client	DISCOMFORT		RESPONSE PROBABILITY	
	PRE	POST	PRE	POST



1	63	70	77	103
2	56	63	79	88
3	97	108	77	104
5	154	99	152	102
6	93	123	137	95
7	83	81	99	80
8	140	149	122	125
9	88	67	79	67

Assertion was measured using the Assertion Inventory. The 38-item scale included scenarios that may require assertion such as “ask for a raise”, “tell someone you like them”, and “tell a friend or coworker when he/she does something that bothers you”. Clients were asked to rate their degree of discomfort with the scenario on a scale of 1 to 5. Low scores mean a low degree of discomfort. Then they were asked to rate the likelihood that they would perform that action (response probability), also on a 5-point scale, but in this case, low scores mean that they would always do the action, high scores mean that they would never do the action.

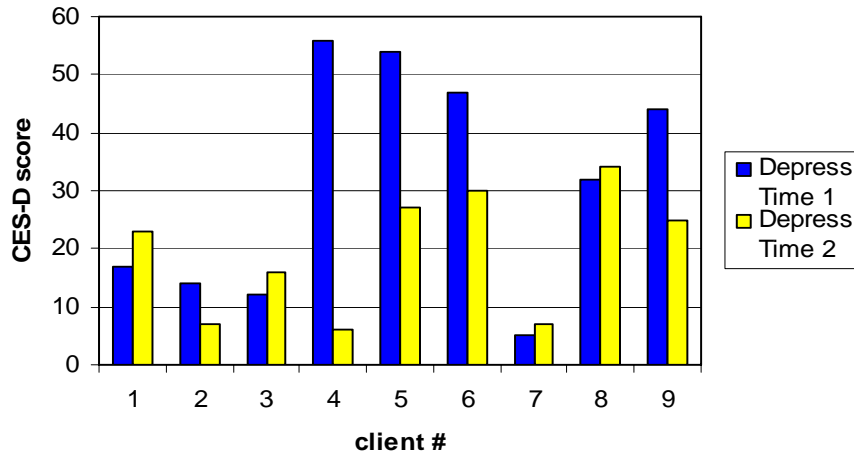
Many of the discomfort scores increased over the course of the program, while a few of the extremely high scores dropped. While we hoped to see assertion increase, it was unexpected that discomfort scores would start out so low. This may be because at the start of the program, women really did not care about confrontation. The increase in discomfort places these women closer to the discomfort score in a normal, healthy adult population, which is 93.9. The increase in discomfort may mean that the women in the group were starting to realize how the other person in each scenario might feel – they may be sympathizing in a positive way.

The response probability scores show a similar trend. Most of the scores move closer to the population mean of 103.8. This may indicate that the clients are exercising healthy reasoning when deciding how frequently they would perform an assertive action.

Depression and Post-Traumatic Stress Disorder (PTSD)

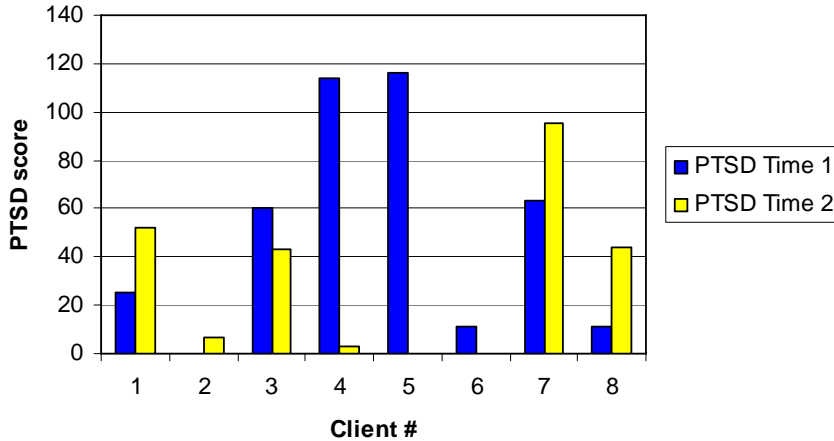


Level of depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D). On this scale, lower scores indicate lower levels of depression. On average, depression levels substantially decreased from time 1 (pre) to time 2 (post). However, several of the depression scores did increase somewhat.

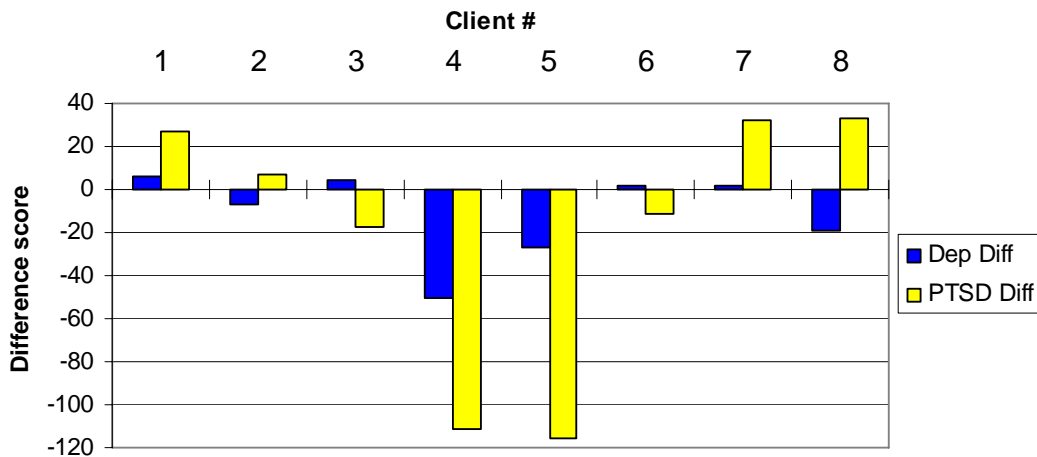


High scores on the PTSD scale indicate high levels of symptom severity and frequency. One of the clients failed to fill out the PTSD measure properly, and therefore her data was not included in any graphs or data analyses related to PTSD. The data for clients 4 and 5 below should be interpreted with caution. Such a dramatic decrease in PTSD scores in 3 months is possible, but there may also have been some effort on the client’s part, to answer the questions in a way that they believed to be desirable to the counsellor. In some instances, women had goals such as getting their family or a job back, and perhaps there was the belief that if they were to show real improvement over the course of the program, that those goals may be more easily met.





Interestingly, many of the changes in depression correlated to changes in level of PTSD. The following table shows **difference scores** for depression and PTSD. This means that the bars on the graph show how much a person’s score increased or decreased from time 1 to time 2. Bars that fall *below zero* (0) indicate a *decrease* in depression or PTSD by the end of the program. Bars that extend *above zero* (0) show that a person’s depression or PTSD score has *increased* from time 1 to time 2.



Only one client’s depression and PTSD scores moved substantially in opposite directions (person 8 appears less depressed at time 2, but had an increased PTSD score at time 2). These results may show that these two factors are linked. Some PTSD scores increase

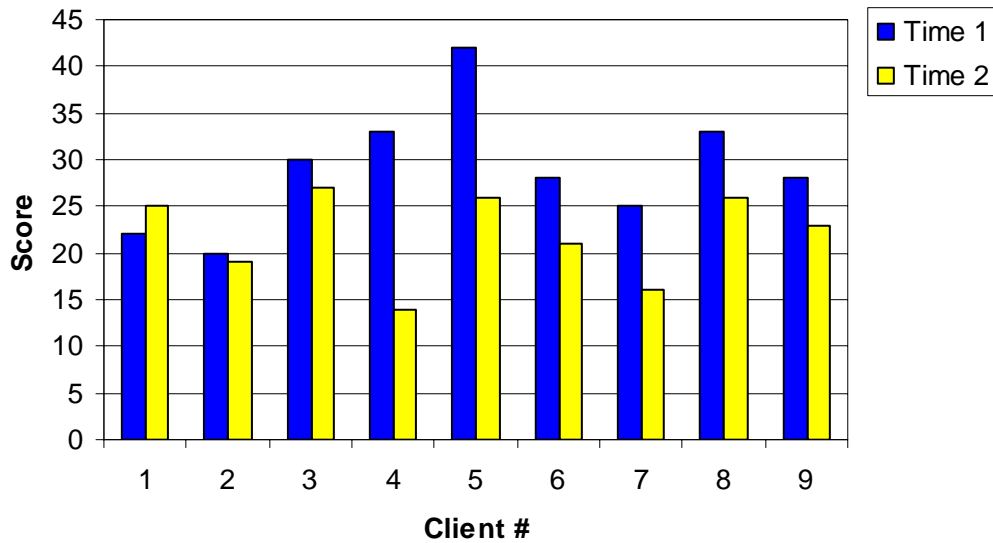


and this may be because rehashing the incident in a group may bring back symptoms that had previously been buried. This return of PTSD symptoms may then be accompanied by a higher level of depression. It is important for counselors in the program to be aware of this effect and be prepared to spend extra time or resources on treatment of PTSD symptoms.

Self-Esteem (SE)

As *lower scores* are indicative of *increased self-esteem* it is easy to see the significant improvement in self-esteem over the course of the program. The mean SE score at the start of the program was 29.0, and this dropped to 21.9 after completion of the three-month program. SE was measured using the Rosenberg Self-Esteem Scale. This scale is commonly used and has high validity and reliability. It consists of 10 face-valid items such as “on the whole, I am satisfied with myself”. Items are rated on a 4-point scale ranging from “strongly agree” to “strongly disagree”.

Rosenberg Self-Esteem Scores

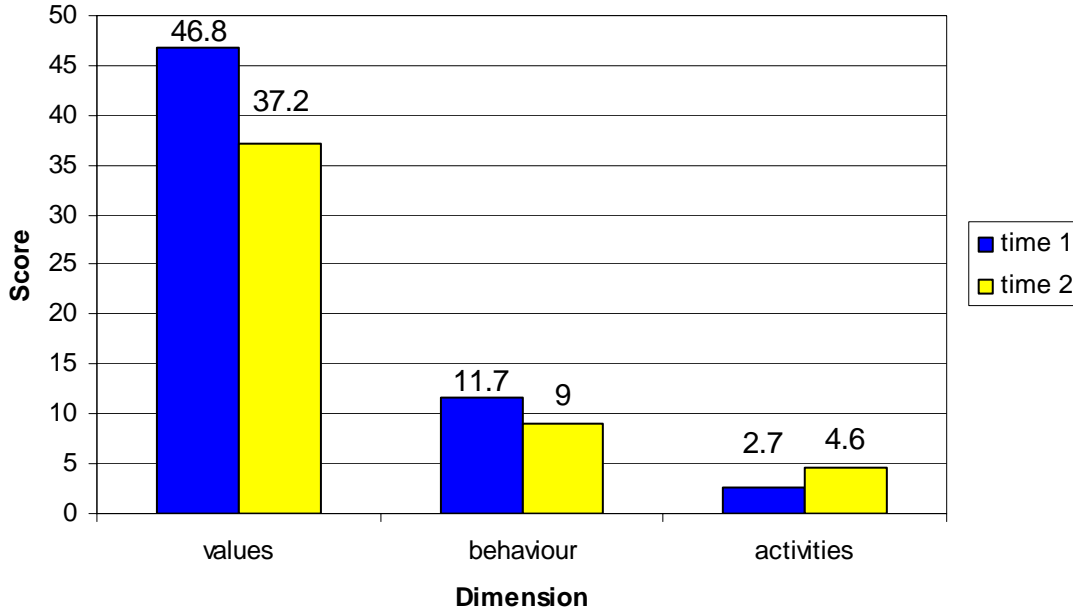


Spirituality



The spirituality scale that was used measured three dimensions of spirituality. The first is personal beliefs and values. This scale included 19 items such as “a spiritual force influences events in my life” and “in the future, science will be able to explain everything”. These items are rated on a 5-point scale from “strongly agree” to “strongly disagree”. The second scale included only 4 items measuring behaviour related to spirituality such as “when I wrong someone, I make an effort to apologize”. These items are rated on a 5-point scale from “always” to “never”. The third scale measured the frequency of engaging in spiritual activities with three simple questions: “how many times did you pray last week?”, “how many times did you meditate last week?” and “how many times did you participate in spiritual activities with at least one other person in the last month?”. There were 5 possible answers ranging from “0” to “more than 15”.

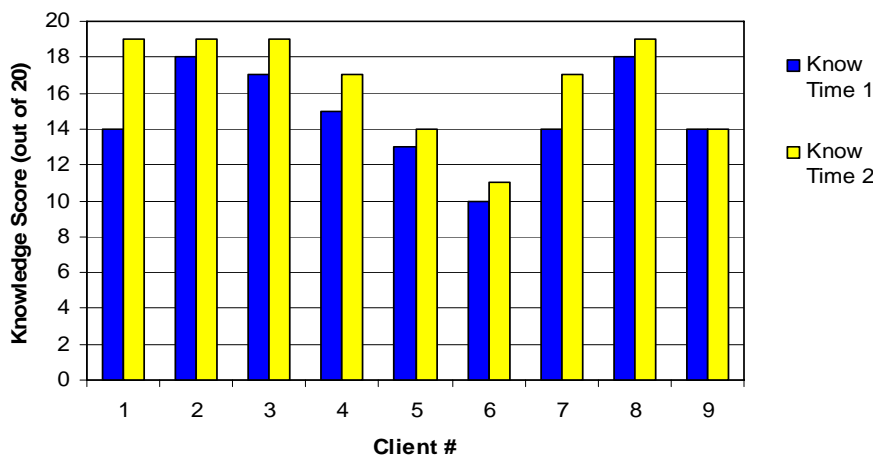
For the first two scales, a lower score means a higher degree of spirituality. For the final scale, the more spiritual activities engaged in, the higher the score. The results for the pre and post test are optimal. Spirituality increased significantly across all three dimensions.



Knowledge Scale



One of the goals of the WISER program is to increase client's knowledge about drug or alcohol use and addiction, including how their use affects their both their body and their family, identifying triggers, abstinence, and recovery. Counselors also discuss other issues that are indirectly related to use such as stress, spirituality, and mental health. Each of the 12 modules of the program addresses a different topic. In order to determine if clients' knowledge of these ideas has increased, we developed a 20-item multiple choice knowledge scale, with one or two items taken from each module. The following graph shows the results.



The knowledge scores increase significantly across the group, from a mean of 14.5 at the beginning of the program, to 16.5 after completion. It was expected that no one would lose any knowledge, but it is interesting that many of the knowledge scores were quite high at the start of the program. This may indicate that the women in the program are aware of the consequences of drug use but perhaps are unsure what that knowledge means, or how it pertains to them. Importantly, certain questions were answered correctly by every client. This might mean that either the questions were very simple, or that the correct answers could be easily identified from the options without any prior knowledge. In other words, some questions may have been easy to guess. If we were to run a second evaluation, it would be important to use some new questions find out how



many of the clients guessed on their answer by asking them to both choose an answer and to rate their level of certainty about their choice.

This postulation aside, even if some of the questions were answered correctly because they were too easy, scores still increased in almost every client, and that can likely be attributed to success of the program.

WISER Satisfaction Survey

Qualitative self reports were available for 14 women who completed the program. Clients were asked to respond on 4-point scales to a variety of questions. A summary of the quantitative information is provided in table CLIENT. You can see that all of the clients positively rated each item on the questionnaire.

In addition, clients were asked to provide comments regarding which modules they found most or least helpful, what they would change about the program, and any further comments or suggestions. Their comments were overwhelmingly positive, and a few have been reproduced in this document.

“I can’t imagine where I’d be without this program”

Most participants were satisfied with the pace of the program, that is, the program was spread out over three months. However, some would have liked to have visited most modules in greater depth and felt that they could have benefited from having the program run longer. While the content of the program was positively rated, a second suggestion for change was the quality of the food.

“It did so much for me; I know it will help others.”

Most participants did not comment regarding parts of the program that were the least helpful, but had many positive comments regarding various specific modules.



“I’m so grateful for being able to participate in this program. I’m more aware of the changes that I need to make.”

The skills and personality of the facilitator were frequently complimented in the qualitative comments section. Her sense of humour and ability to make people feel relaxed and comfortable, as well as her wisdom and consideration were noted.

“I feel a hope within me that I haven’t felt for a long time.”

Table 1. CLIENT: Frequency of responding to satisfaction questions on a 4-point scale.

	Very negative response (1)	Negative response (2)	Positive response (3)	Very positive response (4)
Overall satisfaction	0	0	3 (21%)	11 (79%)
Recommend to friend	0	0	1 (7%)	13 (93%)
Program met needs	0	0	6 (42%)	8 (58%)
Positive life change due to program	0	0	1 (7%)	13 (93%)
Confidence to work on recovery goal	0	0	4 (28%)	10 (72%)

