

# **AN ANALYSIS OF THE IMPACT OF A MODIFIED “WOMAN ALIVE” PROGRAM FOR WOMEN WHO HAVE EXPERIENCED A MENTAL HEALTH CHALLENGE.**

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## **Introduction**

People who have been diagnosed and treated for a mental illness face a multitude of challenges following discharge from a hospital. Psychological challenges, including poor self-esteem and lack of confidence are evident whether the diagnosis is schizophrenia, depression or addictions etc. Both the symptoms of the mental illness in combination with the side effects of medication can result in poor physical health as well.

A Poor physical health can even go as far as exacerbating the psychotic symptoms of mental illness, further debilitating the functional status of persons suffering from psychiatric disabilities@ (Cipriano, Anderson & Sailor, 2003, p. 28). In addition, there are many social issues that must be faced including: overcoming dependence on the hospital, loss of friendships due to the stigma of having a mental illness, misunderstanding by family members about the illness, and loss of contact with the community while they are hospitalized. As well, many individuals are not employable, resulting in dependence on welfare or disability and thus finding they face a life of poverty. Many report a sense of loss of control over their lives because the mental illness controls them, and for many, return to the hospital as in-patients is common. The impact of these multiple challenges on daily life can be overwhelming for people struggling to recover from a mental illness.

Psychosocial rehabilitation (PSR) is a service delivery approach that is being increasingly implemented throughout psychiatry. PSR and therapeutic recreation share many common outcomes. PSR services help people in the community compensate for, or eliminate, the functional deficits, interpersonal barriers, and environmental barriers that result from the disability of a serious mental illness (Hughes & Weinstein, 1994). The approach is guided by the basic philosophy of rehabilitation: that individuals with disabilities need skills and supports to fulfill the demands of their living, learning, social, and working environments. Leisure skills are integral to the rehabilitation process. The purpose of this study is to examine the impact of participation in a community-based leisure education program in combination with an Aqua Fit program by women who have experienced a mental health challenge and have been discharged from a psychiatric facility.

## **The Woman Alive program**

The goal of Woman Alive (2002) program, developed by the Ottawa Heart Beat program is “To provide women on limited income with a combination of fitness activities, heart health education, and positive social interaction in order to promote heart healthy behaviours” (p. 2) . Barriers to participation in physical activity have been identified to be finances, child care, transportation, clothing/equipment, accessibility (time, location of program), marketing approaches, and attitudes of program providers. The Heart Health initiative provided the expertise and a training manual to help the recreation therapist modify the program for low income women who also have the

additional barrier of recovering from a mental illness. Funding was provided from the Ministry of Health to the public health unit for this initiative. A partnership was formed between public health, parks and recreation and the Royal Ottawa hospital which allowed the program to be community rather than hospital based. Funding was also made available to help some women pay for 50% of the cost of a bathing suit and to assist with transportation. The women pay \$1.00 a week and have their name entered for a draw. Prizes have been donated from the Health unit and other supporters. The criteria for inclusion in the “Woman Alive” program are threefold: they must be female, they must be low income, and they must have had an experience with mental illness. The most critical part of the application process to the program, was the decision to have women “self-refer” to this program which gave women the opportunity to be self-determined to take control of their health by choosing to participate. Each person was screened by the recreation therapist and required to complete a PAR -Q health form (Health Canada, 2002) to determine if they could be involved in the program. Initially, the Aqua-fit, leisure education program was offered once a week. Unlike the original “Woman Alive” program, a 45 minute leisure education and healthy lifestyles session was offered prior to the Aqua-fit class with topics including nutrition, leisure and community resources, and smoking cessation.

## **Methods**

After being approved to participate in the program, each participant wrote their personal goals, and then monitored them each week. A round table discussion was held after each session allowing the women to debrief about their experiences. At the end of the first three month trial period, which included 14 sessions, a focus group was videotaped with 4 of the regular 12 participants. The women suggested that a videotape might be helpful in promoting the program to other service providers. Individual interviews were audio taped with the same 4 women, with the remaining women in the group completing a program evaluation form. Goal attainment for all of the women was also reviewed at this time. Prior to the interviews and focus group, the Recreation therapist asked the women to suggest questions they wanted to discuss with the researcher.

## **Results**

Qualitative analysis was conducted on the first stage of data collection, resulting in the development of a 3 stage service delivery model. The outcomes of the model include: decreased recidivism, increased health and well-being, increased happiness, increased life satisfaction, and increased connection to the community. The first stage is a “readiness” component for participation. This includes intrinsic motivation, self-determination and support of the recreation therapist and other staff. The women stated that it was important that it was their decision to participate through self-referral, and that they had to be emotionally open to the idea of participating in a community program, despite their perceived barriers. Another readiness factor was the trust in the recreation therapist who believed in the participants’ abilities. At this stage, the recreation therapist puts the components in place to create an environment that is perceived by the women as “safe” enough to encourage participation.

The second stage of the model is the intervention itself, which consists of Leisure Education, Healthy lifestyle information, and the Aqua-fit program. The women felt that it was important to self-monitor their own goals through the informal debriefing process following each session. In addition, there were both intrinsic and extrinsic motivating factors that kept them returning each week. The intrinsic factors include: the common bond the women shared in that they all have experienced a mental illness, their perceived physical and emotional safety in the program, and new social connections with the other participants and the community. The extrinsic factors include: affordability, community environment, skills and personality of the instructors, the weekly draw and transportation support. The women suggested that they felt equal to the instructors rather than “below” them, which they had experienced in other groups. This suggests that the role of the recreation therapist at this stage is one of a partnership with the women.

The third stage of the model is the 4 categories of benefits of participation: emotional, social, physical, and cognitive. Emotional outcomes include increases in: laughter and fun, sense of purpose, and a perceived control over their mental illness. The social category includes major decreases in feelings of isolation, in combination with increased connectedness both to the other participants as well as their environment, increased support and understanding from each other and the establishment of meaningful relationships. Physical benefits include decreased pain and increases in physical functioning, interactions with others, eye contact, endurance and muscle tone. Increased knowledge about community resources and healthy living factors were seen as benefits in the cognitive category.

### **Discussion and Application**

This program is an example of a positive partnership between four very different agencies. While the initial incentive to attend the program was access to an affordable physical activity program, the addition of a leisure education and healthy lifestyle component allowed the women to get to know each other better and to expand their knowledge about the opportunities available to them in their community. The initial motivation for all the women was improved health and fitness. However, the data suggests that the primary benefits are emotional and social, followed by physical and cognitive. Through the group and camaraderie, they developed a support network in their new group. The women felt that they have common challenges in that they were female and poor, but that they also have “the stigma of mental illness”. The self-referral process helped the women to be intrinsically motivated to take charge of their health and was a major factor in encouraging the women to commit to attend the program regularly. These women needed to be self-determined in their decision to attend. The women stated that it was extremely important to have the support and encouragement of the Recreation therapist. One participant stated: “The [name] recreation therapist believes in us and in our recovery which helps us to believe in ourselves”. The women as a group have taken group ownership and feel empowered to share their experiences. They are hopeful that their positive experiences will help other communities and mental health providers see the benefits of establishing similar programs. Two of the women commented that this was the first fall season in several years, when they did not have to be rehospitalized. This was solely credited to participation in the “Woman Alive” program. One of the

individuals stated: “if a program like this had been available twenty years ago, I would never have attempted suicide”.

## **References**

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