

Evaluation of the She Thrives Pilot Program

GLP-1 medication as part of a community addiction recovery and transitional housing program

OpenDoors Rhode Island, April 2026

This is a preliminary program evaluation of the She Thrives GLP-1 pilot, believed to be the first social service program in the United States to offer GLP-1 medication as an addiction intervention within a community setting. Across two validated outcome measures — the WHO-5 Well-Being Index and the Penn Alcohol Craving Scale — this small group of treatment-resistant, justice-involved or recently unhoused individuals showed statistically significant improvements at 3 months and highly significant craving reductions at 8 months. This program evaluation is largely based on surveys of thirteen individuals that were conducted by OpenDoors as part of a process of trying to better understand the effectiveness of the program model, which offers transitional housing, wrap-around services, and access to GLP-1 addiction treatment. The surveys were all retrospective, all survey data is self-reported, and there is no comparison group of people that received similar services but no GLP-1 treatment, meaning the results should not be seen as scientifically measuring the impact of GLP-1 treatment.

Key Findings:

- **Program participants stayed on the medication:** Only one individual left the program, demonstrating a high level of program adherence. Even participants that left the residential, program based setting they started the program in stayed on the medication. This indicates a high level of program participation in a population that is generally difficult to engage over the long term. Four participants (20%) had nonvoluntary temporary lapses in medication due to medical procedures, lack of supply, or incarceration.
- **Participants reported a large increase in wellbeing:** There was a 119% improvement in self-reported wellbeing after three months of program participation.
- **Participants reported a large decrease in cravings for addictive substances:** There was a 48% reduction in self-reported cravings at three months and a 72% reduction in self-reported cravings at eight months.
- **More research is justified:** This program merits formal research to assess impacts on a larger scale and determine whether similar interventions could benefit justice-involved women with histories of substance use disorder.

In search of a new tool to combat the cycle of addiction and incarceration

The crisis of addiction is particularly severe and dangerous to women in Rhode Island struggling with histories of trauma and incarceration. The majority of women in the Rhode Island prison system are there in part due to substance use disorder, and the period immediately following release from prison is among the most dangerous in a person's life due to high overdose rates. Existing treatment modalities such as medication-assisted treatment, residential programs, intensive outpatient therapy, and mutual support groups have meaningful limitations for individuals whose addiction histories are long, whose diagnoses are multiple, and for whom prior treatment attempts have not achieved lasting recovery. For this population, additional tools are urgently needed.

GLP-1 receptor agonists (semaglutide, liraglutide) were developed for type 2 diabetes and obesity management, but emerging preclinical and human research suggests they reduce cravings and substance use behavior through central nervous system pathways, specifically dopamine-reward circuits involved in addiction. Despite the promising scientific evidence and a long history of safety data that justifies providing access to these medications to people with substance use disorders, there are no known other social services programs in the United States that are providing access to these medications.

In collaboration with Dr. Steve Klein from the Caron Treatment Center and with support from the Center for Addiction Science, Policy, and Treatment, OpenDoors Rhode Island's She Thrives program has piloted this intervention in a community reentry context. As part of the She Thrives program, OpenDoors provides wrap-around, intensive services to women struggling with addiction, homelessness, and incarceration. This includes access to transitional housing, emergency shelter, case management, job coaching, and peer-recovery. OpenDoors operates two transitional houses, one for women and one for women with children as well as two co-ed shelters.

Over the past year, OpenDoors paired access to GLP-1 treatment for addiction with transitional housing, trauma-informed case management, and peer recovery coaching. If individuals in recovery that were living in OpenDoors recovery housing or homeless shelters expressed interest, they were connected with Dr. Klein to discuss GLP-1 addiction treatment over telehealth. If they were prescribed GLP-1 medication, it was mailed to them at their OpenDoors residence and then self-administered.

Evaluation Protocol

This evaluation was based on retrospective surveys of program participants providing self-reported data about their experiences. The fidelity and adherence reports from the patients are all in line with what was generally corroborated by staff who stayed in contact with participants, coordinated their access to the medication, and generally observed their treatment progression.

The data consists of a total of thirteen surveys conducted with program participants. The surveys were all conducted retrospectively, meaning individuals were asked about their experiences three and in many cases eight months prior. Attempts had been made to survey participants in real time as they progressed through the program but those surveys were not conducted consistently enough to analyze so a retrospective survey was conducted at a single point in time. Verbal consents were administered as part of each survey. This evaluation has not yet received IRB approval but OpenDoors is in the process of conducting an IRB review of the protocols for this evaluation.

A total of twenty individuals have enrolled in the GLP-1 program, all of whom¹ were either living in an OpenDoors homeless shelter or transitional recovery house at the time of enrollment and

¹ In one case, the patient was not an OpenDoors participant but instead a participant of a similar program operated by the partner Rhode Island agency Amos House.

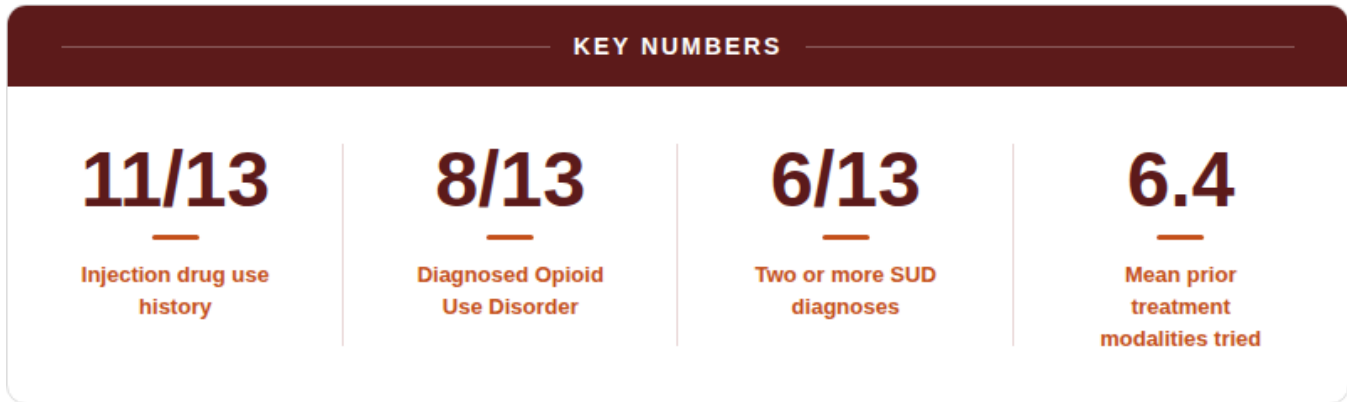
receiving case management. Three have not been in the program for three months yet, two of these individuals have not yet been surveyed and one conducted just the baseline survey. Of the seventeen individuals with at least three months in the program, fourteen stayed in contact with the program enough to be part of this evaluation and twelve of those engaged individuals took part in the survey as part of this evaluation.

Who This Pilot Serves: Treatment History and Substance Use Profile

The thirteen participants who completed at least the baseline surveys represent the intended population for this intervention: they have an average of 6.4 prior treatment modalities attempted, a majority with injection drug use histories, and more than half carrying multiple formal SUD diagnoses.

The cohort enrolled by She Thrives does not represent individuals new to the treatment system. These are people who have tried treatment repeatedly, across multiple treatment types, and for whom existing options have not been sufficient.

Prior Treatment History



Every participant had attempted at least two formal treatment modalities before enrolling in She Thrives. Across the thirteen surveyed participants:

- 8 of 13 had completed residential drug treatment at some point in their lives.
- 8 of 13 had completed or attempted detoxification.
- 9 of 13 had received inpatient hospitalization for substance use or mental health.
- 7 of 13 had been prescribed medications for addiction treatment (buprenorphine, Vivitrol, methadone, or naltrexone). Six were on some form of medical treatment for addiction at the time of enrollment in the GLP-1 program.
- All 13 had been in recovery housing or AA/NA at some point — indeed, all were residing in recovery housing or at OpenDoors at baseline.

Despite this extensive treatment engagement, none had achieved stable long-term recovery prior to enrollment. Four participants carry Opioid Use Disorder plus Stimulant Use Disorder diagnoses; two carry AUD, OUD, and Stimulant UD simultaneously. This treatment-refractory profile is precisely the population for whom new pharmacological tools have the most to offer.

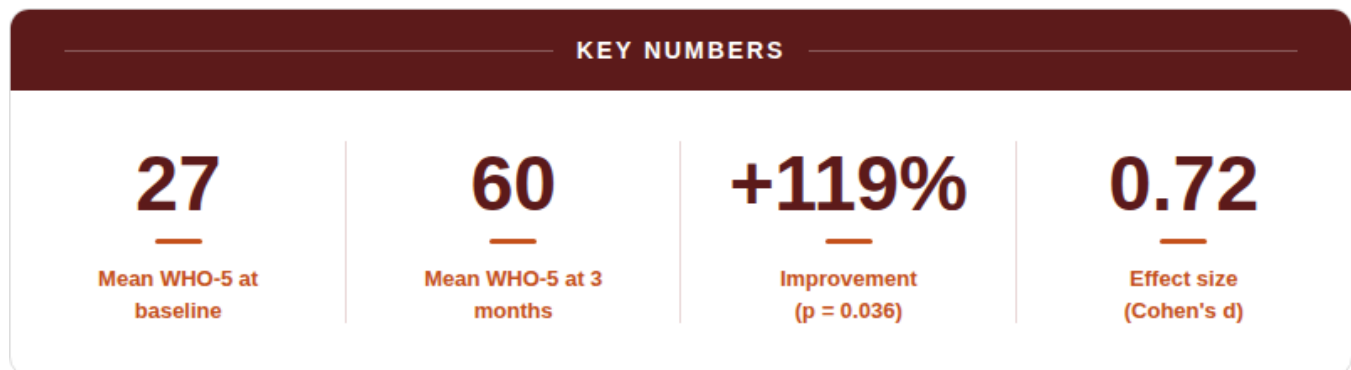
Substance Use Profile

Primary problem substances span opioids (including heroin, fentanyl, and prescription opioids not as prescribed), stimulants (crack cocaine, powder cocaine, methamphetamine), and alcohol. Several participants reported poly-substance use histories involving four or more substances. Eleven of thirteen participants reported a history of injection drug use at some point in their lives, though no participant was actively injecting during the baseline assessment period reflecting a cohort that has achieved some stabilization but remains at high risk for relapse.

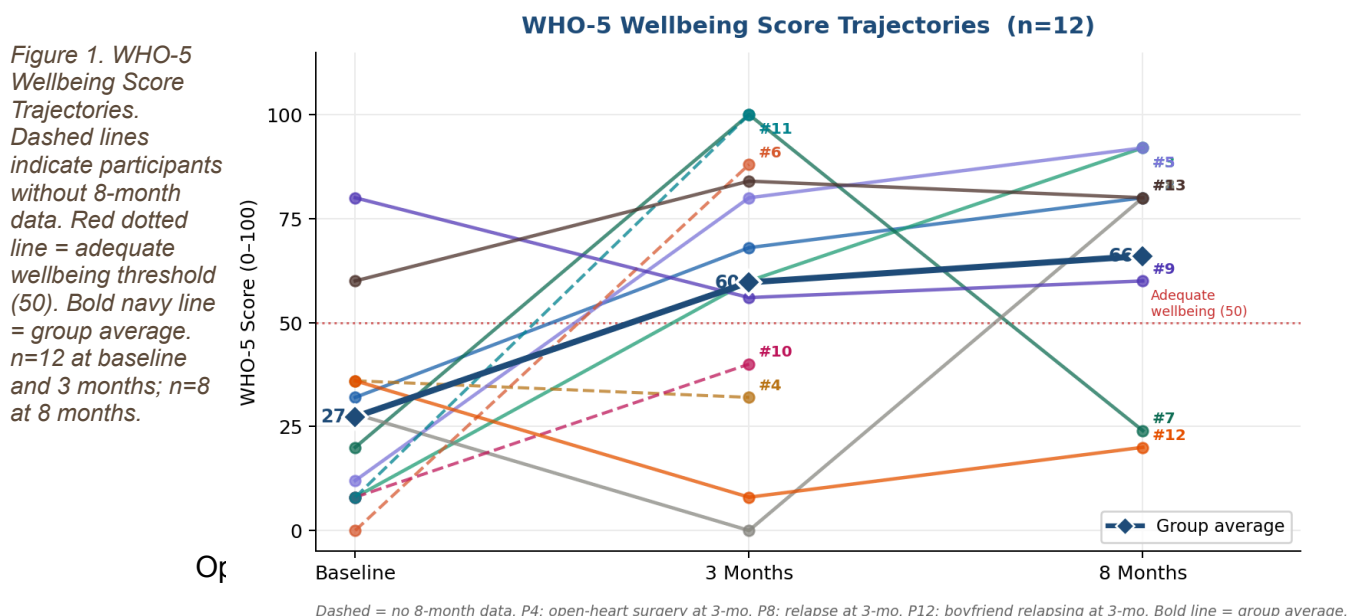
Three additional individuals enrolled in *She Thrives* but did not stay in contact with staff and did not complete baseline surveys: one left the program immediately due to medication nausea, one lost contact after leaving program housing, and one was returned to incarceration. These cases are included in total enrollment counts but excluded from outcome analyses.

Finding 1: Wellbeing Improved Significantly at 3 Months

Wellbeing was assessed using the WHO-5 Well-Being Index, a validated five-item scale scored 0–100. A score below 50 indicates poor wellbeing and serves as a clinical screening threshold for depression. At baseline, eleven of the twelve participants with follow-up data scored below that threshold. By 3 months, eight of twelve had crossed it.



A Wilcoxon signed-rank test, the appropriate non-parametric test for this sample size and distribution, confirmed the improvement is statistically significant ($W=12.5$, $p=0.036$). A paired t-test produced a consistent result ($p=0.031$). The effect size is medium-to-large (Cohen's $d=0.72$), notable for a pilot study of this size.



WHO-5 Wellbeing: Baseline vs. 8-Month (Completers, n=8)

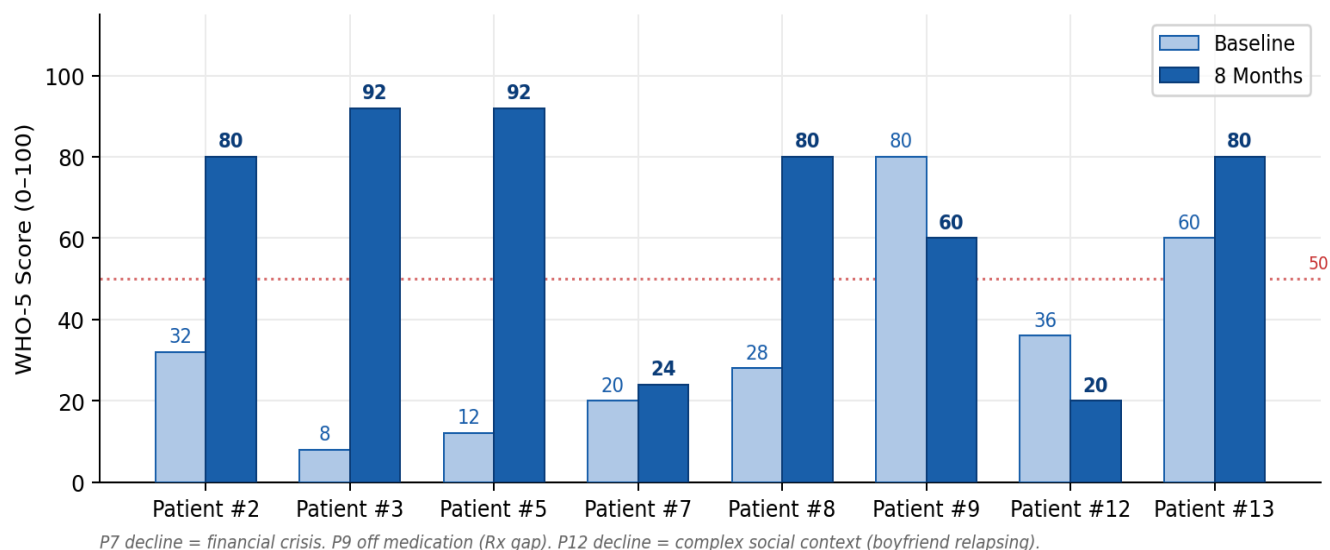
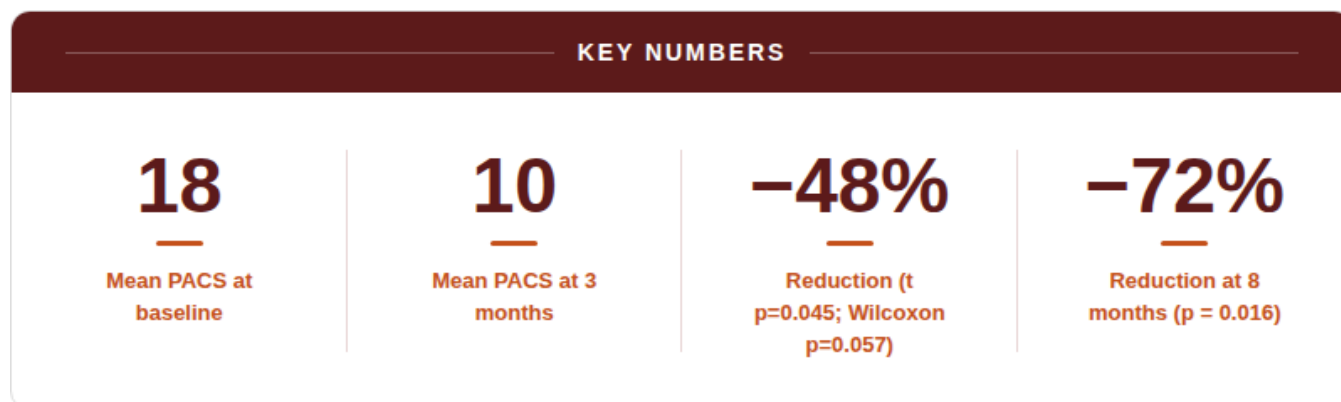


Figure 2. WHO-5 Wellbeing: Baseline vs. 8-Month comparison among completers (n=8). Patient #7's decline reflects a documented financial crisis; Patient #9 was off medication pending a prescription refill.

The 8-month wellbeing improvement (mean +31.5 points, n=8) did not reach statistical significance ($p=0.086$), almost certainly because the smaller sample at that time point reduces statistical power rather than reflecting a genuine attenuation of effect. The effect size at 8 months (Cohen's $d=0.77$) is nearly identical to the 3-month result.

Finding 2: Craving Reduction Is Large and Highly Significant



Cravings were assessed using the Penn Alcohol Craving Scale (PACS), adapted for each participant's primary problem substance. The scale runs 0–30; zero indicates no cravings across all five dimensions. Patient #9 is excluded from craving analyses since that participant scored zero at all time points and their primary substance profile falls outside the PACS construct. Patient #11, who scored 0 at baseline and 14 at 3 months, is included in the analysis. Eleven remaining participants provide the craving trajectory.

The craving reduction remains substantial even with Patient #11 included. At 3 months, the group mean fell from 18 to 10, a 48% reduction. The paired t-test reaches significance ($p=0.045$, Cohen's $d=0.69$), while the Wilcoxon signed-rank test is borderline ($W=11.5$, $p=0.057$). The more conservative Wilcoxon result reflects Patient #11's counter-trend increase in cravings from 0 to 14. Among the seven participants with complete craving data (Patient #11 has no 8-month data), the reduction reached 72% (mean $20.7 \rightarrow 5.7$), with $p=0.016$ by Wilcoxon and $p=0.0003$ by paired t-test. The 8-month effect size of $d=2.80$ is very large.

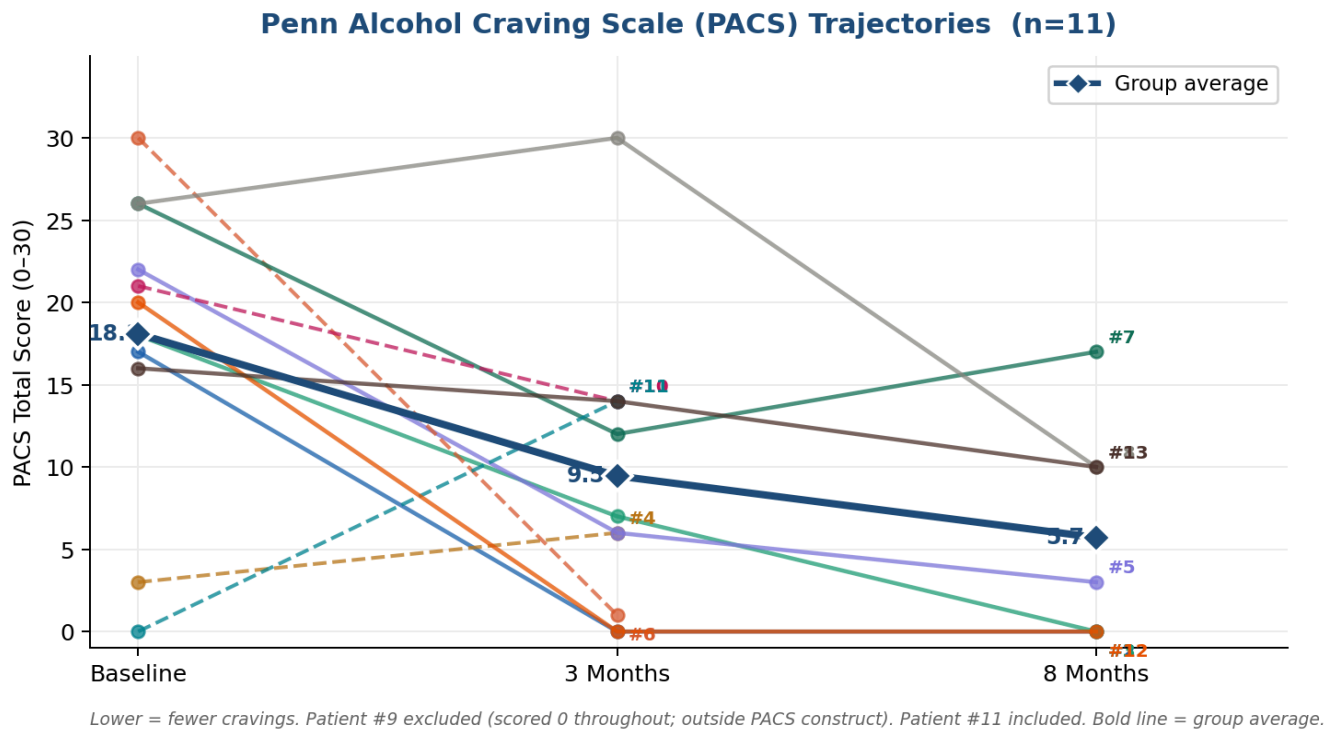


Figure 3. PACS Craving Score Trajectories. Lower = fewer cravings. $n=11$ at baseline and 3 months (Patient #9 excluded; Patient #11 included); $n=7$ at 8 months. Bold line = group average.

Several individual trajectories are particularly notable. Patient #6 entered with the maximum possible craving score (30) and fell to 1 in three months. Patients #2 and #3 both reached zero cravings by 8 months. Patient #12 reached zero cravings at the 3-month mark despite a sharp concurrent decline in wellbeing suggesting that GLP-1 effects on craving may operate independently of broader psychological wellbeing, which has significant clinical implications.

Finding 3: Both Measures Move in the Right Direction at Each Point in Time

The consistency of the directional trend across time points strengthens confidence in the signal. Neither measure reversed between 3 and 8 months at the group level. The dual-axis chart below displays mean WHO-5 and mean PACS trajectories with standard deviation bands.

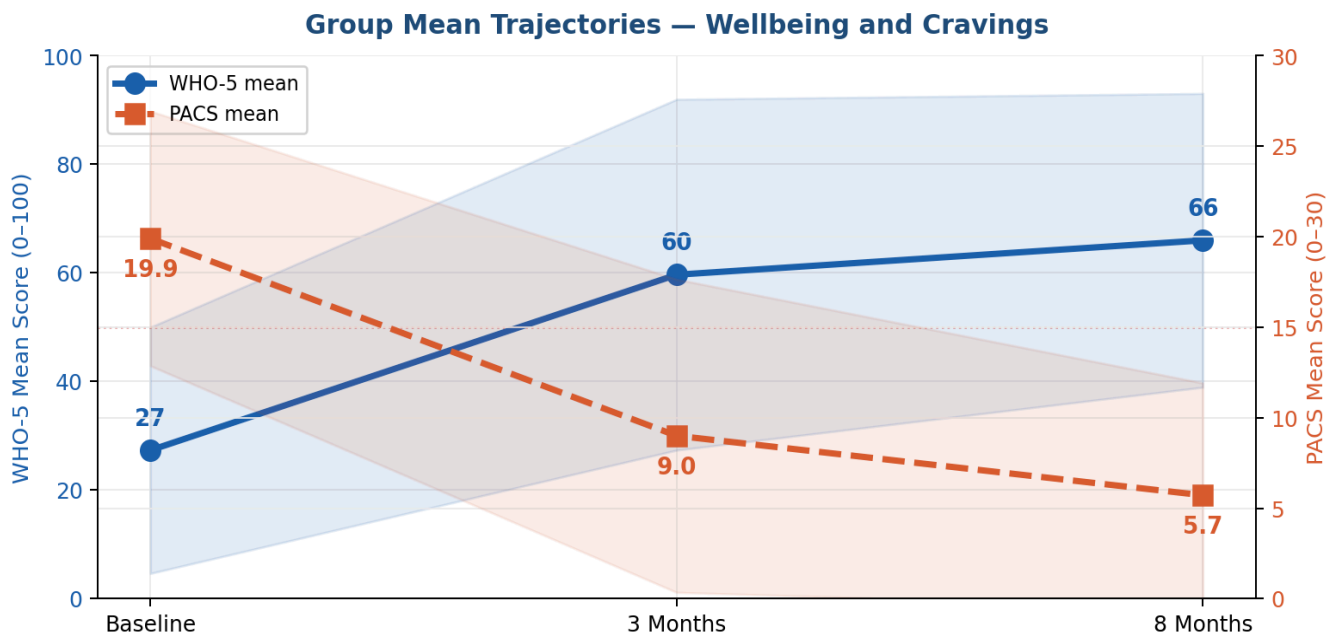


Figure 4. Group mean trajectories. WHO-5 (left axis, higher = better); PACS (right axis, lower = better). Shaded bands = ± 1 SD.

Finding 4: Consistent Medication Adherence

All twelve participants with 3-month follow-up maintained dose adherence at 1 month. For the full 3-month period, ten of twelve were fully adherent; Patient #4's reduction was medically directed ahead of surgery, and Patient #12 took most but not all doses while managing an unstable home environment. At 8 months, five of eight completers maintained every-dose adherence.

Zero voluntary discontinuations across all follow-up points: Every lapse has a documented external explanation such as surgical protocol, prescription supply gap, or complex social circumstances. This level of adherence in housing unstable and justice-involved populations is not typical of conventional modalities, and is itself a key feasibility finding.

Patient Profiles

The quantitative results above are perhaps best understood through the lives of the people behind them. Participants Regina Roberts, Jessica Massarone, and Jessica Vega illustrate both the severity of the need this program addresses and the nature of the change participants have experienced. They all granted permission to use their names and experiences as part of this evaluation. They have been profiled in national media and their accounts are drawn in part from the *Washington Post*, *Boston Globe*, *Rhode Island Monthly* and *New York Times* articles.

Regina Roberts

Regina Roberts, 42, was living in an OpenDoors facility and fighting to get her teenage son back from foster care when she enrolled in the She Thrives pilot. She had been sober since 2023, supported by 12-step programs, therapy, and life-skills classes and she faced constant reminders of her past: liquor stores, the smell of alcohol on someone's breath, cigarette smoke. When OpenDoors told her about GLP-1s, she agreed immediately. She stated, "I figured, why not try it? I'll take anything to help me stay on my road to sobriety."

At baseline, Roberts's survey scores reflected the challenges she was facing at the time. Her WHO-5 wellbeing score was 8 out of 100 and her Alcohol Use Disorder diagnosis was the framework through which years of her life had been organized. Her PACS craving score was 18 out of 30. She rated her mental health as fair with a serious problem severity. Still, every dimension of her readiness to change was at or near maximum: she scored 10, 8, 8, and 9 across the four readiness subscales. She continued to experience these well-being and cravings challenges despite having been in the OpenDoors transitional house for eight months at that point, receiving wrap around support, and having several years of sobriety.

By three months, her WHO-5 had risen to 60 and her cravings had fallen to 7. After eight months on the medication, after regaining custody of her son and moving into her own apartment her WHO-5 reached 92, and her PACS score was 0: no cravings at all. She described the medication to the *Boston Globe* as "a mental reprieve," stating "It helps slow down my thinking long enough that I can work through my problems rather than letting my worst impulses take over." She also credited the GLP-1 treatment with sharpening the focus that allowed her to complete a six-week certified nursing assistant course. She returned to the miniature house-building she had loved before her addiction consumed her, toiling for hours over tiny details, twisting paper with tweezers to fashion lifelike lilacs. "It's cathartic," she told the *Globe*. "I'm creating my dream home."

Jessica Massarone

Jessica Massarone grew up in a home where her parents struggled with drug addiction. "I was constantly worried about what I was going to come home to," she stated. Despite being diagnosed with anxiety and depression in her teens, she earned an associate degree in child development and worked for seven years at a university child care center. At 26, a boyfriend introduced her to cocaine. "The addiction part came really fast," she states. She got pregnant, got sober, and relapsed. She lost custody of her three children after nearly dying from an overdose. After 45 days in jail for possession, she agreed to an open adoption. "I love them so much that I, yeah, gave them away," she stated.

At OpenDoors, Massarone enrolled in the GLP-1 pilot in May 2025. Her baseline WHO-5 wellbeing score was 12, severely depressed by clinical standards, and her PACS craving score was 22 out of 30. She carried a Stimulant Use Disorder diagnosis, had histories of psychiatric hospitalization, residential treatment, IOP, detox, and multiple prior attempts at sustained recovery. When a representative from OpenDoors mentioned the GLP-1 pilot, she reflected on the milestones she'd missed while high or in jail and decided it was worth the chance. "My conclusion was, if I can take a drug that was literally killing me, then why not try taking a drug that could save my life?" she stated. The effects were immediate, she said. The inner voice that had long urged her to use went quiet. She began walking to work through the same parking lot where she once met dealers, and instead of the visceral, physical reaction that once triggered her, she said a prayer of gratitude and called her counselor. When a former drug friend contacted her on social media, she felt nothing. "I shut it down right away," she stated. When she saw a dealer making a sale outside her workplace, rather than being pulled toward it, she was "disgusted", stating "And I was amazed by that, because for me, it's a big deal."

By three months her WHO-5 had risen to 80 and her PACS had fallen to 6; by eight months she was living in her own apartment, promoted at work, and spending Friday nights with her three children. Her WHO-5 reached 92 and her PACS dropped to 3. The medication also helped her lose 17 pounds. "The medication has changed everything, every single thing," she stated.

Jessica Vega

Jessica Vega enrolled in January 2026 while living in an OpenDoors shelter. Her survey data at baseline reflects someone in an active crisis. Her WHO-5 wellbeing score was 0, every single item on the five-question scale scored as low as it could go, indicating she felt cheerful, calm, active, rested, and interested in daily life at no time at all. Her PACS craving score was 30, the maximum, with every dimension of craving, frequency of thoughts, duration, strength, difficulty resisting, overall intensity,

rated at its ceiling. Her mental health was rated poor, with a serious problem severity. All nine DSM-5 substance use disorder criteria were met. She was drinking daily, and had drunk four or more times per week in the two weeks before her baseline interview. Jessica indicated that at this point she was struggling with being recently homeless for the first time, chronic pain from a botched surgery, a long history of trauma, and serious damage to her relationships with her children caused in large part from her alcohol use.

Despite this, her readiness to change was high: 10 out of 10 across all five readiness subscales. She reported joining the program to reduce cravings, support her recovery, try a new treatment option, and because her case manager encouraged her.

Within three months, her transformation was among the most dramatic in the cohort. Her WHO-5 had risen to 88 from absolute zero to well above the clinical threshold for adequate wellbeing, an 88-point gain. Her PACS craving score had fallen from 30 to 1, a near-total elimination of craving: only a trace of occasional thoughts remained, with no significant urges, no difficulty resisting, and no overall craving severity. She had stopped drinking entirely, alcohol use recorded as zero at the three-month interview, compared to daily drinking at baseline. She maintained every-dose adherence throughout and was still enrolled in the GLP-1 program at the time of the survey.

Vega's case illustrates something the aggregate data alone cannot convey: that the people this program reaches are often not on the margins of recovery, but have fallen entirely through it. She arrived with no formal SUD diagnoses on record despite meeting all nine diagnostic criteria, a gap consistent with what research shows about underdiagnosis in homeless and justice-involved populations. She had no prior experience with MOUD, residential treatment or outpatient therapy. The only interventions she had ever received were psychiatric inpatient care and a prior stay in recovery housing over a decade ago. Jessica reflected that when she started the GLP-1 medication she was skeptical it would work because the doctor she saw for her chronic pain had never mentioned it. "He told me the drinking would make my pain worse, so why didn't he tell me about this medication? Maybe if he had, I wouldn't have become homeless," she stated.

Policy Implications

These preliminary findings carry several implications for addiction treatment, criminal justice diversion, and reentry services.

GLP-1 as a Complement to Existing MOUD

Seven of thirteen participants had prior experience with buprenorphine, methadone, or naltrexone, the three approved medications for opioid use disorder. The fact that these individuals subsequently enrolled in a GLP-1 pilot reflects the limitations of existing pharmacotherapy for a meaningful proportion of people with treatment-resistant addiction. GLP-1 medications appear to address a complementary mechanism, craving reduction, rather than substituting for existing MOUD. Policy frameworks should accommodate GLP-1 as an adjunct, not a replacement.

Social Service Settings Can Deliver Clinical Innovation

She Thrives is a social service program, not a clinical facility. The delivery of a novel pharmacological intervention through a community reentry organization with clinical oversight from a licensed healthcare provider through telemedicine demonstrates a model for treating hard to serve individuals who may not engage with traditional clinical settings.

Diversion Requires Robust Reentry Infrastructure

The outcomes documented here did not occur in isolation. They occurred within a program that provides transitional housing, trauma-informed case management, and peer recovery coaching

alongside the medication. The life circumstances documented across participants, including domestic violence exit, custody battles, homelessness, grief, and chronic relapse histories, underscore that effective addiction treatment at this level of complexity requires wraparound support, not medication alone. Diversion policy that sends people to community programs or to prison without adequately funding those programs sets both up to fail.

Research Pathway

These results support research into this program model. A formal pilot feasibility study could produce more rigorous data on adherence, treatment results, and obstacles to and approaches to successful implementation. A randomized controlled trial would allow for conclusions about the impact of the She Thrives program on addiction and incarceration outcomes, potentially ultimately creating support for expanding this model. OpenDoors, Dr. Klein, and researchers from Brown University have been invited to submit a full proposal to Arnold Ventures to support a larger trial and are pursuing other funding options for continuing and expanding this work.

Limitations

- Preliminary descriptive pilot data (n=13 surveyed). Statistical significance should be interpreted cautiously given sample size; results require replication in a larger controlled study.
- There was no control group. Improvements reflect within-participant change but cannot be attributed specifically to GLP-1 medication versus program participation, housing stabilization, or time.
- The survey was conducted retrospectively, meaning participants were asked about their experiences, well-being, and cravings at a later date and asked to remember previous periods of time. Most participants conducted the survey around nine months after the start of the program, meaning the baseline data was at least nine months old while the eight month data was recent. This introduces an even higher level of bias and potential inaccuracy, as individuals likely do not completely accurately remember details of their experiences months later.
- Adherence and craving measures rely on participant self-report and have not been independently verified.
- The PACS was adapted from its original alcohol-focused design; validity for the diverse primary substances represented in this cohort has not been formally established.
- Three enrolled participants exited before completing baseline surveys; four have not yet reached 8-month follow-up. Findings reflect participants who remained engaged, which may introduce positive selection bias.
- This evaluation methodology has not been approved by an Internal Review Board. All participants provided written consent and OpenDoors is in the process of pursuing IRB approval.

About She Thrives

She Thrives is a reentry and diversion program operated by OpenDoors Rhode Island serving unhoused and justice-involved women. The program provides access to transitional housing and emergency shelter, trauma-informed case management, peer recovery coaching, housing stabilization services, family reunification support, and GLP-1 medication for addiction treatment. OpenDoors is in the process of trying to expand and rigorously study the pilot program through a feasibility study and randomized controlled trial. For more information about She Thrives visit <https://opendoorsri.org/she-thrives>

De-identification Note

All participant names have been replaced with Patient #1–#13 in enrollment order to protect the names of the program participants and the patient profiles are presented with patient consent.