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Delivering a Maternal Substance Abuse Intervention Program Along the Rural Route

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Area of focus: Rural mothers/women and alcohol and other drugs.

Abstract

We sought to design and deliver an indicated-level substance abuse prevention program for lower income mothers living in rural Vermont. The Rocking Horse program employed best practices for working with rural mothers, used sensitive outreach, and built the program in the community. This 10-week psychoeducation group modality, led by a maternal/child specialist and a licensed substance abuse treatment professional, provided education about the risks of alcohol and illegal drugs for women's health during pregnancy, and for young children living in substance-abusing families. Health education was delivered in a highly supportive format that emphasized building personal competencies. The short-term results suggest that this program is increasing knowledge of the harms caused by substance abuse and bolstering personal capacity to move away from this behavior.

Introduction

According to the National Household Survey on Drug Abuse (Substance Abuse and Mental Health Services Administration, 2002), the estimated rates of problem drinking and illegal drug use for women are climbing, and rural women are included in these trends (Rural Women's Work Group, 2000). Yet getting rural mothers the help they need to move away from this harm is challenging because they often hesitate to admit problems (Boyd, 1998). For many, revealing heavy drink-

ing and drug use in the family may bring threats from close family members (Booth & McLaughlin, 2000); carry community disapproval toward them for behavior unbecoming a mother (Ettlenger, 2000); and capture attention from child welfare authorities. The limited availability of treatment services (Fortney & Boothe, 2001), the hurdles barring access to the programs, and the need for childcare and transportation (Bushey, 1997) further discourage them from seeking help early. For poor and nearly poor rural mothers involved with substance abuse firsthand

or secondhand, the rural poverty hardships they face may loom larger in their lives than the destructive nature of substance abuse. All too often, cultural norms, access barriers, and personal issues keep these women from getting help until they are in crisis. These observations, and the absence of prevention-level programs for this population, prompted a Vermont group of maternal/child professionals and substance abuse specialists to develop an alcohol and other drugs (AOD) intervention that might keep low-income mothers out of harm's way.

The Rocking Horse (RH) program attempts to intervene with these at-risk mothers before their circumstances escalate into a treatment crisis. The program was designed as an indicated-level prevention effort to interrupt the progression of risk. During the past 2 years, this Vermont program has served an estimated 225 lower income rural mothers who are at risk of substance abuse. Our evaluation suggests that this program is helping mothers build knowledge and skills to repair the personal and family harm that results from problem drinking and illegal drug use.

Getting Started: Designing the Rocking Horse Program

The RH program realizes that substance abuse is a part of our world and strives to reduce its tragic effects on maternal health by intervening early, both to decrease the vulnerability to this health threat and to increase the capacity to move away from this risky behavior. The program believes that changing risky behaviors depends on strengthening knowledge and skills through a caring approach that respects the women's culture and their traditions. The program also recognizes the harms from alcohol and illegal drug use that are specific to women's experiences (Ramlow, White, & Watson, 1997). Central to the program's framework are the concepts found in effective prevention efforts. Effective preven-

tion at the individual level is based on building mastery, self-worth, and life skills and establishing rewarding relationships (Schinke, Brounstein, & Gardner, 2002).

Four main principles guided program development. First, the RH program recognizes that these mothers are nested in a background where sets of social and cultural factors may place them at risk for substance use. RH helps them recognize risk factors and provides strategies to reduce the harm. Second, RH also understands that substance abuse has grave consequences during pregnancy, and parental substance abuse places young children at risk. The program provides education on the serious outcomes of substance abuse during pregnancy and teaches skills to bolster safe and nurturing care of the young child. Third, the program realizes that these mothers face hardship, and their support networks may not be dependable. RH underscores substance abuse as a major factor in destabilizing personal development, family strength, and reliable friendships. The program model highlights setting goals, making decisions, managing stress, and recognizing healthy, rewarding relationships. Fourth, the RH program recognizes that these mothers are cautious and guarded for many reasons. Reaching and engaging these women call for using culturally matched approaches and sensitive outreach and lowering the barriers to access.

Delivering and Managing the Program

The RH program is a group modality that follows a 10-week curriculum. The content of the weekly groups has four major domains. Guided discussion explores substance abuse and women's health, substance abuse and relationships, substance abuse and young children, and substance abuse and life troubles. A maternal/child specialist and a licensed substance abuse treatment professional lead the weekly

groups. These leaders are women who live and work in the same rural communities and have a deep understanding of the culture and lives of the women they serve. The groups are conducted in nonagency community settings, and onsite childcare and transportation are provided. A particular feature of this program is providing the mothers with a small incentive at each weekly meeting. These small gifts recognize that being a mother is hard work and reward their efforts to solve problems. Additionally, special emphasis is placed on making the climate inviting and caring. The setting is private and comfortable, and snacks are provided for the mothers and their children.

The group process is sensitive to the culture of the mothers. Group leaders are mindful of the intergenerational patterns of substance abuse in families; often, healthy role models are lacking. The leaders function as teachers, mentors, and role models. They are very supportive and encourage the women to support one another in rewarding ways. Relational approaches and thoughtfulness are the key processes in group interaction. The groups close each meeting with a ritual that emphasizes self-care.

The mainstay of the RH program is its community aspect. It is not seated in any agency, nor is it part of an outpatient or residential substance abuse treatment program. Professionals from the network of programs that serve the local population collaborate to deliver the program. Multidisciplinary community teams of maternal/child, substance abuse, early childhood, mental health, and child protection workers, as well as family visitors, manage the program in their community. The group leaders who coordinate the groups receive supervisory and administrative oversight. The supervisory level maintains program integrity and gathers feedback from the field to refine the program. The administrative level concentrates on program accountability.

Program Evaluation Methods

The RH program was piloted for 3 years (1997, 1998, and 1999) in rural Vermont locations and served an estimated 60 women. The observational data from pilot groups in two communities suggested that the program was both reaching and engaging an at-risk group of younger mothers. The group leaders' findings suggested that the women were responsive, their attitudes were changing, and their binge drinking patterns decreased. In 2000, RH groups were implemented across the State, and an objective, measurable, evaluation component was developed.

Three methods are used to evaluate the program. The women complete a preparticipation and postparticipation survey and add narrative comments, and the leaders also complete a focused questionnaire. The preprogram and postprogram surveys are self-administered at the first and last group sessions. Each survey uses forced choice questions that are scored on a Likert scale. The 23 items are measures from the Center for Substance Abuse Prevention Core Measures Initiative (1999). These measures look for shifts in perception of handling stress, managing parenting, self-esteem, and establishing supportive relationships. The measures seek changes in perception about the risks of alcohol, tobacco, and illegal drugs in relation to women's health and pregnancy as well as their effects on young children. The tool gathers demographic data from the mothers and asks questions about their personal alcohol consumption and illegal drug use and that of their partner(s).

The leaders complete a log that records the number of women served and notes the time needed for program management. This log also records the number of women referred for treatment services. The postprogram survey that leaders complete elicits leaders' impressions about conducting the program, observations of the women attending, and comments about both the program's strengths and areas for improvement.

Results from Year 1 and Year 2

The data were analyzed using a t-test for matched pairs of preprogram and post-program surveys. The following results are based on 124 completed sets of questionnaires (from a total of 167 surveys returned from the field) for groups conducted in 14 towns across the State in 2001 and 2002. Missing data reflect incomplete forms and unmatched surveys. The data suggest that 29 percent of the women do not complete the 10-week program, and more than one-third are repeating the program.

The demographic data show that the majority of the women are 22–35 years old, and two-thirds are single parents. Sixty-eight percent had their first baby during their teenage years; half of these women had not completed a high school education. More than 80 percent of the women had children under age 5, and 36 were pregnant. More than 60 percent of the mothers were not working and receiving Temporary Assistance for Needy Families benefits. About 25 percent of the women reported heavy drinking, and 40 percent reported that their partners were heavy drinkers. Almost 80 percent of the women stated that they had used illegal drugs in the past.

Data from year 1 and year 2 suggest several significant changes: a shift in perception of handling stress more effectively ($p = .008$), increased perception of risk from alcohol for women's health and during pregnancy ($p = .01$), increased perception of strong interpersonal support ($p = .003$), and an increased perception of self-worth ($p = .01$). Although not statistically significant, the data also suggest an increased perception of parenting skills and an increased understanding of substance abuse behavior patterns. The results show a reported 9 percent decline in their own binge-drinking behavior. The women's narrative comments are consistent across the 2 years with four major perceptions: The women report a very strong positive opinion of the group experi-

ence; they cite the importance of having a trusted space where they can talk about the effects of alcohol and drugs on their lives; they state that they have built new ways to manage their lives and feel more capable taking care of their babies and children; and they want to see this program continue because it is "worthwhile."

The leaders reported that they observed uninterrupted attendance; the women dressed up to come to the group; the group was referred to as "class"; dropping out was influenced more by the partner than by the attendee; the women often commented on being afraid to talk about AOD for fear of retribution; and the women had a startling lack of knowledge about sexually transmitted infections. The leaders suggested that 10 group meetings were not enough and recommended that the program be extended. The leaders also commented that this program was serving as an entry point for bridging many of the mothers into other services. The group leaders reported personal satisfaction in conducting these groups. They expressed alarm, however, about the norm of heavy drinking among these younger mothers and their great vulnerability to the mounting presence of drugs in the rural towns.

Despite the data suggesting that this program is having positive results, the findings must be viewed with caution. The evaluation design is empirically weak with only a preprogram and postprogram survey of the attending women. The results may be biased because the women are alerted to the postprogram survey questions by taking the initial questionnaire. No control of confounding variables was attempted. Additionally, missing data may have affected the results.

Discussion

Although the evaluation process has weaknesses, we nonetheless believe that the RH

program is leaving an imprint. The program is reaching and engaging a population that is at increased risk for substance abuse. The findings from this prevention effort suggest that the program is effectively delivering health education about the risks of substance abuse and helping the mothers increase their awareness about how AOD jeopardizes themselves, their pregnancies, and their young children. The women in the program also appear to be building coping skills and gaining self-confidence to manage their lives. The experience of genuine support also seems to help them identify healthy, rewarding relationships.

The group leaders and other professionals involved with the program view the program as greatly needed by this population of mothers. Until this program was launched, prevention efforts were absent. The treatment network stepped in when the women were in crisis—a demanding and often unfriendly entry point for treatment. The community teams note that early intervention may have interrupted a crisis situation for some of the mothers; for others, the program sparked recognition that they needed treatment. The community teams commented positively on their personal satisfaction in delivering this program. As well, the community teams have found that the structure of the program (not nested within an agency) has promoted shared ownership among the service providers.

Program Lessons Learned and Recommendations

We set out to address a profound maternal health risk for a population that usually keeps this risk well hidden. We discovered that “country mothers” are at risk of AOD and in need of prevention programming. We also learned that matching approaches to the intended population is an important key to engage people in helper programs. We believe that the strength and followthrough in the RH program rests with the collabora-

tive efforts of the community teams. This program was based on grassroots participation of the many providers who work with these mothers. As this program was developed and discussed, these professionals came forward to head up implementation in their communities. It is clear that involving others from the beginning is a critical part of a program’s success.

All programs need to be evaluated, and the methods and processes of the evaluation must be sound and objective. We have come to realize that field evaluation processes must be stringent. During the past 2 years, approximately 48 groups have been conducted in 14 communities by 11 teams of group leaders. Data accuracy problems have prompted a more structured and monitored data gathering process. Additionally, a strong evaluation design is needed to better determine the effectiveness of a program. Presently, we are moving ahead with a stronger experimental design that will include a comparison group and measure results of the comparison group against results of the intervention group. Without such a comparison, program outcomes are questioned.

Summary

Poor and nearly poor rural mothers face a collection of health threats. We encourage all professionals who work with these women not to overlook the possible presence of substance abuse in their lives. During the past 2 years we have found that we are drawing to the attention of the service system the issues of substance abuse among this population. The program is gaining recognition, and the referrals are growing.

Is the RH program making a difference? The short-term outcomes support the conclusion that we are engaging our intended population and helping these mothers increase their knowledge of AOD abuse and build skills to move away from AOD.

Equally important, the program is highlighting, at both program and system levels in our State, the presence of substance abuse for this group.

Finally, our findings support the need for both substance abuse treatment programs for rural mothers and further research into the strategies that will provide effective interventions for this population. We advance the notion that all efforts, from prevention to treatment, recognize that AOD is interwoven in the life fabric of these women. Therefore, addressing this problem must include attention to all the background influences that place these women at risk. Additionally, initiatives must recognize the strengths that these women possess as well as their attachments to their families. We also suggest that incorporating treatment programs into various community provider teams may create a spirit of engagement and promote shared ownership. These collaborations are often the key to a program's sustainability and growth.

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