

2009 Innovations Awards Program APPLICATION

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ID# (assigned by CSG): 09-E-16VT

Please provide the following information, adding space as necessary:

State: Vermont

Assign Program Category (applicant): Health & Human Services

1. Program Name: Rocking Horse Circle of Support
2. Administering Agency: VT Department of Health, Division of Alcohol & Drug Programs & VT Department of Corrections
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9. Please provide a two-sentence description of the program.

The Rocking Horse program (RH) is an indicated-level substance abuse group intervention designed for low income rural childbearing age women at high risk for progression of alcohol and other drug use. The program uses health education and experiential life skills building within a socially and instrumentally supportive process.

10. How long has this program been operational (month and year)?

Full operational capacity was established in state fiscal year 2004.

The RH program was purposefully, slowly and strategically implemented. We limited our initial reach with the pilot phase of the program to assess potential obstacles, refine delivery approaches, and submit for timely external reviews before expending public dollars on an effort that may have little return in addressing the problem.

The following is the chronological order from initial limited pilot phase to full operational capacity.

September 2001- June 2002: Initial limited pilot

September 2002-June 2003: Expanded pilot

July 2003: Program Design & Evaluation reviewed by Center for Substance Abuse Prevention (SAMHSA) and recognized with the Exemplary Award for Innovative Programs in Substance Abuse Prevention

September-December 2003: Increasing operational delivery and program availability

March 2004: Establishing full operational capacity and processes

August 2004: Program reviewed by National Rural Institute on Alcohol and Drug Abuse and receives award for Excellence in Rural and Frontier Alcohol Intervention.

January 2006-April 2007: Program awarded Service to Science Academy (CSAT) participation yielding increased capacity for program evaluation of effectiveness and efficacy.

11. Why was the program created? What problem(s) or issue(s) was it designed to address?

We observed several disturbing trends in substance use in the lower income pregnant and parenting women living in our rural communities. The Behavioral Risk Factor Surveillance Survey supported these observations. The data estimated 32% of lower income women ages 25-34 years were drinking daily and 14% of this group reported heavy drinking. We also observed a surge in young women entering the correctional system with an estimated 75% having alcohol and other drug abuse behaviors. Despite the problem being in the data lens, these women were often invisible until their plight escalated into a treatment and/or a criminal crisis.

We discovered that sets of factors hinder help-seeking by this at-risk rural group of women. Their reluctance arises from the stigma associated with family and community disapproval for behavior unbecoming the “cherished” maternal role and the more severe consequences with investigation by child protection services. We found that the limited availability of substance-use target programs, access hurdles, and the need for transportation and childcare further discourage getting help.

We also found yet other issues that were influencing the rates of substance use in these women. Individual-level factors such as school drop out, early pregnancy, unstable social support, and no employment placed many of these young mothers in the path of substance use. These personal factors and long standing rural Vermont community norms where heavy drinking and marijuana use are accepted, play a significant role in progressive substance use. Taken together the host of factors- looming difficulties accessing help fear of stigma from not meeting the traditional motherhood expectations, socio-economic distress, and community norms placed this group clearly in harm's way.

The most pressing factor in the development of the program was the absence of substance use prevention programming for this population in our state. Albeit treatment services for these women were available, but no prevention-level efforts existed. The Rocking Horse program realizes that substance abuse is part of our world and attempts to intervene early to deter the tragic health, family, and social outcomes associated with the behavior. Central to the program's framework are the concepts found in effective prevention efforts. We developed, implemented, and continue to evaluate a community-based indicated-level alcohol and other drug prevention program for low income childbearing-age women questioning their own substance use behaviors and/or experiencing the first-hand effects of another's substance use.

12. Describe the specific activities and operations of the program in chronological order.

The development and delivery of the Rocking Horse program followed a disciplined process. A working group of substance abuse clinicians, maternal child professionals, a public health researcher, and substance abuse prevention specialist was formed to explore the feasibility of a prevention effort for this population. The diverse group of professional colleagues from a variety of human services settings decided to take action to address the conditions they coped with in their daily practice with these women.

The following outlines the operational processes and activities undertaken in this program initiative in chronological order.

Operational Phase I:

A) Program Development:

Development Activities: The following are the detailed components of the programs development.

1. Needs Assessment:

The first task of the working group was to conduct an extensive needs assessment of the problem. Clinical observations, statistical prevalence data, and maternal-child program findings were used to determine the scope and severity of substance use among this population.

2. Establish a Theoretical Framework and Logic Model:

The next step examined substance use prevention best practices and prevention science research literature. This foundation was used to develop the program's theoretical framework (Stages of Change Theory) and guided the Logic Model from which the design of the program was outlined.

3. Development of Program Goals:

The working group addressed the question "What prevention activities do we want to achieve?" From this question the program goals were defined:

1. Reduce substance use among a target population of low income pregnant and parenting women
2. Increase capacity to manage personal and family life more effectively
3. Develop and sustain rewarding social, peer, and family relationships

4. Development of Program Objectives:

Next, quantifiable measures of the program's effectiveness were determined. These objective measures serve to evaluate the program.

- 1) Increase perception of risk to women's health from risky substance use
- 2) Increase in self-efficacy
- 3) Decrease substance use (alcohol consumption and drug use)
- 4) Increase perception of social support

5. Program Design:

The Rocking Horse program is a 10 week psycho-educational community-based substance use prevention program delivered by a substance abuse professional and a maternal child specialist. The program uses a dedicated session curriculum that combines health education about the harm of alcohol and other drugs and skills building to build self efficacy. The process is supportive, the program provides weekly incentives, childcare care and transportation, and is no cost to the participant. The program receives referrals from the network of services involved with these women and by the correctional system.

B) Program Delivery Structure and Management

With a defined program design template the next stage involved careful consideration of **program structure and its administration**. Building the program structure was directed by these questions:

- a) Who would deliver the program?
- b) Where would the program be delivered?
- c) How would the program be managed?

The Rocking Horse Program would be delivered by two human service professional women; one with expertise in substance abuse and one with expertise in maternal and child health. The group leaders would be contracted to coordinate all activities to establish the group in their community and deliver the group sessions. The program called for the groups to be offered in community settings and not human services agency sites. The local group leaders would be required to secure settings, such as family centers, churches, schools, to conduct the groups.

They would also be required to procure incentives, arrange for childcare and transportation, and provide group refreshments. The program promoted local governance in establishing the groups.

Program management would be accomplished in a three tier model structure. The three tiers are Program Administration, Field Management, and Clinical Supervision. The Program Administration level concentrates on program accountability and grants management. A staff person at the VT Dept. of Health in the Division of Alcohol & Drug Abuse Programs would conduct these activities. The Field Management level concentrates on program implementation and management at the community level. A fiscal agent in collaboration with a community team including the group leaders share the tasks involved in the delivery of the program. The purpose of the Clinical Supervision level is to monitor program integrity and fidelity, gather feedback from the field to refine the program, conduct evaluation and deliver the RH curriculum training.

Operational Phase II- Pilot Implementation:

With program design, delivery, and management in place, the next stage was implementing the program. The program was piloted from 2001-2003 with the intent of evaluating a limited roll out for any non anticipated problems. The pilot results suggested that we were attracting and engaging the intended population, suggested that we were positively influencing substance use attitudes and behaviors, and coping capacity. The qualitative data from participant comments suggested positive program regard. Additionally, we evaluated the leader's feedback with a formal questionnaire and monitored program reach with attendance logs. The leader's reported the program attracted these women, and that they observed distinct shifts in the attitudes and behaviors regarding substance use with the attending women.

The pilot experience with the program and the evaluation data suggested that the program was potentially effective. We then decided to submit the program design and evaluation results for an external review. We submitted our program findings to Center for Substance Abuse Prevention and the program was recognized with the Exemplary Award for Innovative Programs.

Operational Phase III - Full Program Implementation:

Strategic program expansion was undertaken in 2004. In the early months of 2004 we began to recruit for more group leaders, refined our marketing and advertising materials, provided formal presentations at staff meetings at a number of programs and services involved with these women, and talked with potential funders about the program. By March 2004 we had established a network of nineteen leaders who in turn had developed local capacity to deliver the program (site, childcare, transportation, incentives, & referrals). The program was fully operational at this time.

Operational Phase IV- Program Evaluation:

Ongoing program evaluation has been maintained beginning with program inception. We evaluated the pilot implementation and continue to evaluate the program annually. Refined evaluation measures were implemented in 2007 and program fidelity evaluation was conducted. The findings from the participant data measures suggest significant and consistent positive outcomes to intervene with alcohol and other drug behaviors in this group. The fidelity monitoring finds that the program concepts have not drifted from the origination of the model.

We have disseminated our program results for external review since the program began. We pursued this activity to both gather feedback from established experts and to inform others of our initiative. The program received recognition from the National Rural Institute of Alcohol and Drug Abuse and published in the TAP Series #28 Center for Substance Abuse Treatment. The program findings have also been presented at the annual conferences of the American Public Health Association, the National Commission on Correctional Health Care, and the National Child Welfare League of America.

13. Why is the program a new and creative approach or method?

While the arena of substance abuse prevention has devoted heroic efforts to address substance use in our youth, fewer initiatives have been implemented for prevention-levels of programming across the life years. We discovered a group of pregnant and parenting women for whom no prevention efforts were in place to interrupt their potential progression of risk from alcohol and other drugs. We implemented and have evaluated an evidence-informed culturally acceptable model program where the locus of delivery is in the community, have established the program on the service continuum, and mobilized awareness of the plight of these women affected by alcohol and other drugs. We believe that the strongest aspect of the program is the local leader governance of all activities from group establishment to delivery. These collective contributions although not unique, we believe them to be contributory to addressing the jeopardy of substance use for our select population.

14. What were the program's start-up costs?

Consultation/Training/Evaluation: \$14,000.
Program Administration: \$5,808. (in-kind equivalent to .10 FTE)
Materials/Operating/Training: \$13,000.
Field Management Level: \$71,840.

Total: \$104,648.

15. What are the program's annual operational costs?

Consultant/Evaluator: \$14,000.

Research Assistant: \$3,400.

Program Administration: \$8,174. (in-kind equivalent to .10 FTE)

Materials/Operating/Training: \$9,600

Field Management Level: \$89,424.

(supports leader fees, transportation, food, incentives, materials)

Total: \$124,598.

16. How is the program funded?

SAMHSA Federal Block Grant

In-kind from churches, local businesses, service clubs and other community groups

17. Did the program require passage of legislation, executive order, or regulations?

No legislation, executive order or regulations were required for the program.

18. What equipment, technology, or software is used to operate and administer the program?

No special equipment is required to operate or administer the program.

19. To the best of your knowledge, did the program originate in your state?

Yes, the program developer is the contact person listed in the application (Item 3-7)

20. Are you aware of similar programs in other states?

We are unaware of similar programs in other states.

21. Has the program been fully implemented?

The RH program has been fully operational since 2004. The program continues to expand with the training of new leaders, implementation in more communities, and attended by increasing numbers of women involved with the Dept. of Corrections. The demographic data find 27% of the participants report involvement with the Dept. of Corrections.

22. Briefly evaluate the program's effectiveness in addressing the defined problems or issues.

We set out to create a program that would address a profound maternal health risk for a population that often keeps the risk profile well hidden.

We found that the substance abuse treatment network stepped in when these women were in crisis- a demanding and often unfriendly entry point into care. For all of us involved with the program we have asked the question “Is the Rocking Horse program making a difference?” The leaders’ observations, the women’s comments, the evaluation data from the focused surveys (using valid and reliable measures), and feedback from our network colleagues support the conclusion that we are helping these women move away from heavy drinking and other drug use.

The data from the pre and post surveys suggest:

1. Increased risk perception of alcohol for women’s health
2. Decreased heavy drinking patterns of consumption over the course of the program
3. No onset of new consequences for risky drinking
4. Increased perception of risk from marijuana

The key strength of the program is in its community-based structure. The program is not delivered in an agency setting but in a community setting (church, family center, etc) and led by a professional team of women leaders who contract to conduct the groups. As such, the leaders often work for different agencies in a collaborative relationship in delivering the program.

We believe that the Rocking Horse program is making a meaningful impact on the substance use risk observed in a number of low income rural Vermont mothers. From the early pilot groups to fully operational status the program has served an estimated 700 women in 176 group replications. We also believe that the model, structure, and delivery of the program have not only attracted and engaged these women, but sustained the viability and legitimacy of the program in the service continuum.

23. How has the program grown and/or changed since its inception?

The RH program has been steadily gaining as a prevention effort since its inception. We are offering the program in more communities, have delivered the program in our two correctional facilities for women, developed a work book to compliment the Program Curriculum Guide, and provide required annual training for group leaders. As mentioned we are conducting program fidelity monitoring, and now are implementing a time-series evaluation component. The early results of the time-series data suggest that the imprint of harm from alcohol and other drugs is sustained and that heavy drinking has not rebounded.

Currently we are in the process of re-branding the program and are conducting focus groups with the attending women to gather feedback from the new marketing slogan and materials. This effort is aimed at clarifying the intent of the program as a maternal substance abuse prevention program and not a parenting program. At times the first impression of the program has been interpreted as a parent/child program which has been a disadvantage. However, the trademark logo and program name will remain as they are widely recognized.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt the program?

The most important component for success of helping programs is the “grass roots” observations and design contributions by frontline providers. It is these professionals who know best about the groups they work with and are key informants in program development. Involving these professionals from the beginning and asking them to take the lead in implementation is a sound approach. The result is that the program developers and the program delivery agents share ownership of the program.

We were able to build this collaborative relationship because of our “rural smallness”. We are a small state community of substance abuse and maternal child professionals and we are privileged to have access to our agency-level leadership. The challenge facing other states may be both program development and agency distance from program delivery. All too often programs are created, funded, and put into motion by assignment on professional staff that are not involved in the first steps. Frequently these programs are perceived as burdensome on already filled workloads.

Another challenge is the importance of program evaluation and the need for data to evaluate the efforts. Bridging the research component and clinical practice (program delivery) can be difficult. Helping the group leaders understand the need to measure the program’s outcomes called for changes in the way many conducted their clinical practice. In our experience stressing the importance of distributing the survey tools, completing the logs, and forwarding the leader questionnaire at the outset is now seamlessly incorporated into group delivery.

We saw a problem, did the background research to get the facts, incorporated best practices into a program design, and then paid close attention to our community and the strategies needed to have the program accepted for whom it was intended. The RH program could be transferred to other states. The concepts in our design are universal however delivery approaches and management must be adapted to the other unique conditions found in different settings.