A Model of Effective Case Management Intervention with High-Risk Families

Parent-Child Assistance Program (PCAP)

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Section One

The Parent-Child Assistance Program: An Introduction
Addressing the Problem of Maternal Alcohol and Drug Abuse

Maternal alcohol and drug abuse during pregnancy is a serious public health concern that incurs risk for both mother and child. For the mother, substance abuse is associated with increased risk of prenatal complications, sexually transmitted diseases, depression, and domestic violence. For the child, prenatal alcohol and drug exposure adversely affects growth and development of the fetus and may put an exposed child at risk for a range of physical, neurodevelopmental, and behavioral problems that persist across the lifespan (Mattson & Riley, 1998; Nolan et al., 2005; Singer et al., 2002; Streissguth et al., 2004; Thompson, Levitt, & Stanwood, 2009).

Postnatally, a birth mother with an untreated substance abuse disorder is likely to provide a home environment compromised by the kinds of problems associated with addiction, including domestic violence, poor nutrition, and health and safety issues among others (Conners et al., 2004; Grant et al., 2011; Lustbader, Mayes, McGee, Jatlow, & Roberts, 1998; Marsh, Ryan, Choi, & Testa, 2006).

Of equal concern is the quality of mother-child attachment and interaction. A baby learns to develop healthy emotional attachments with others by interacting with a mother who notices, understands, and responds to the baby's signals and ways of communicating. Successful mother-baby attachment requires back-and-forth, two-way interaction. However, if the infant's brain function has been affected by prenatal drug or alcohol exposure, the baby may not be able to read the mother's expressions and signals accurately, or be able to respond appropriately. He or she may have difficulty focusing and keeping attention, or may become overstimulated, irritated, and hard to console. At the same time, when a mother uses alcohol or drugs to relax or relieve pain, her ability to be mentally and emotionally available to her baby may be compromised.

In other words, whether a baby's neurologic system is impaired by prenatal substance exposure, or the mother's attention and functioning are affected by ongoing substance use, the critical work of mother-baby attachment and emotional development may be impaired.

An Intergenerational Cycle

Pregnant and parenting women who abuse alcohol and drugs are typically vilified and blamed as bad mothers. They have been labeled “unmotivated”, “difficult to reach”, and
“hopeless.” Yet many women in this high-risk population were themselves the abused and neglected children in our communities just a decade or two ago, growing up in settings where no one noticed or intervened. PCAP data illustrate this intergenerational cycle:

<table>
<thead>
<tr>
<th>Childhood History of PCAP Mothers</th>
<th>N = 1160</th>
</tr>
</thead>
<tbody>
<tr>
<td>One/both parents abused alcohol/drugs</td>
<td>89%</td>
</tr>
<tr>
<td>Physically/sexually abused as a child</td>
<td>63%</td>
</tr>
<tr>
<td>In foster care system as child</td>
<td>23%</td>
</tr>
<tr>
<td>Ran away as a child</td>
<td>58%</td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>37%</td>
</tr>
</tbody>
</table>

These children grew into young women who used alcohol and drugs (often self-medicating), became pregnant, and delivered babies born into the same circumstances as they themselves had been. They parent their babies the same way they were parented because they don’t know another way. Not surprisingly, mothers with substance abuse problems become distrustful of “helping” agencies, and this alienation from community resources only exacerbates the problem. The result is that those women at highest risk for having children with serious medical, developmental and behavioral problems are the least likely to seek and receive assistance from community resources designed to help them.

Turning our backs on mothers or “kicking them out” of programs because they are difficult to work with does not make their problems go away. It does ensure that they will continue to experience a host of problems associated with intergenerational substance abuse, and continue to bear children who suffer in turn.

PCAP undertook the challenge to find a way to connect with this population.

There are no “throw away” people. Substance-abusing mothers have often been labeled “difficult to reach” and “hopeless”. Turning our backs on them because they are difficult to work with does not make their problems go away. PCAP undertook the challenge to find a way to connect with this population.
PCAP Background and Primary Goals

PCAP began in 1991 at the University of Washington as a federally funded research demonstration designed to test an intensive, three-year advocacy/case management model with high-risk mothers and their children. The primary aim of the model was to prevent subsequent alcohol and drug exposed births among birth mothers who abused alcohol and/or drugs during an index pregnancy. Research findings demonstrated the model’s effectiveness, and the Washington State legislature subsequently funded PCAP to develop sites throughout the state. The model has been replicated at dozens of other sites in the United States and Canada.

Primary Goals

The primary goals of PCAP are to help mothers with substance abuse disorders

- Achieve and maintain recovery
- Build healthy family lives
- Prevent the births of subsequent alcohol/drug exposed infants

We do this by building trusting relationships with mothers, connecting clients with comprehensive, relevant community services, and teaching them to believe in themselves.

The PCAP Evidence-Base: Intervention Outcomes

PCAP is based on the widely accepted tenet that effective intervention programs for high-risk mothers take into account the complex nature of the women’s problems, and provide services that are multidisciplinary, comprehensive, coordinated, and include the children. Therefore PCAP evaluation examines multidimensional outcomes, improved overall social functioning, and reduction of risk to the mother and target child, rather than focusing solely on the traditional treatment goal of complete abstinence. Since 1991, PCAP has served over 2,000 families in Washington State. The program has been evaluated using blended evaluation designs and outcomes have been published in peer-reviewed journals.

“Results shown are the only test.”

Florence Nightingale (1894) on demonstrating the effectiveness of home visiting programs.

Hospitalized postpartum women were screened for eligibility and randomly assigned to home visitation intervention (n=30) or the community standard of care control group (n=31). Referrals meeting the same eligibility criteria were also accepted from community service providers and assigned to the intervention group (n = 35). Data from community-referred clients was analyzed separately. Participants were interviewed pre and post-intervention using a structured interview adapted from instruments used by the authors in prior studies (Grant et al., 1994; Streissguth et al., 1981, 1993).

To measure overall effectiveness of the program, two composite variables were created: a baseline (intake) score, and an endpoint score to assess status at 36 months. Each of these composite variables incorporates five domains theorized a priori to be most affected by the intervention:

1. Utilization of alcohol/drug treatment
2. Abstinence from alcohol and drugs
3. Family planning (use of birth control, subsequent pregnancies)
4. Health and well-being of target child (health care, custody)
5. Appropriate connection with community services at 36 months

Each domain is comprised of items on which a subject was scored on a 5-point scale. Item scores were summed to compute domain scores and domain scores summed to compute the total summary score. Cronbach’s alpha (computed from the five component domain scores) was .91 for the baseline score and .82 for the endpoint score.

Data from the 36-month post-intervention interview indicated that hospital-recruited clients (n=28) scored significantly higher than hospital-recruited controls (n=25) on the endpoint score (endpoint mean: clients = 17.1 vs. control = 10.1, t = -2.11, p < .04). Adjusting for the baseline scores (baseline mean: clients = -21.8; controls = -18.5) we found a stronger intervention effect (p < .02). Three-group analysis of covariance (hospital-recruited clients, community referred clients, and hospital-recruited controls) indicated positive intervention effects among both client groups compared to controls (p<.05).


Study 2 was a post-program follow-up of Study 1 intervention group subjects who were located for interview 1.6 to 3.6 years after exit from the 3-year PCAP intervention. A total of 48 intervention group subjects were located. Among the 45 mothers on whom we had interview data at the three measurement points (PCAP enrollment, PCAP exit, and follow-up), we found statistically significant improvements as follows.
Between PCAP exit and post-program follow-up:
- Increase in abstinence from alcohol and drugs for at least 6 months at the time of interview (31% at exit vs. 51% at follow-up, \( p < .05 \))
- Decrease in mothers with a subsequent pregnancy (51% during program vs. 29% during follow-up, \( p < .05 \)) and with a subsequent birth (27% during program vs. 9% during follow-up, \( p < .05 \))
- Increase in stable, permanent housing (58% at exit vs. 80% at follow-up, \( p < .01 \))
- Decrease in mothers incarcerated during the interval (67% during program vs. 39% during follow-up, \( p < .01 \))


In 1996 PCAP obtained state funding to replicate the intervention in Seattle and Tacoma, the two largest cities in Washington State. Funds were not made available to enroll a control group. Study 3 is a cohort study, pretest–posttest comparison examining 36-month outcomes from: the original demonstration (OD) (described in Study 1 above), the Seattle replication site (SR) (1996–2003), and the Tacoma replication site (TR) (1996–2003). Subjects enrolled after 1996 (n=84) were interviewed using the 5th edition Addiction Severity Index (ASI), a widely used standardized instrument demonstrating good reliability and validity.

Comparing data across the OD (n=60), SR (n=76), and TR (n=80), slopes for the regression of endpoint score on baseline score were similar across the groups. Each of the replication samples performed significantly better than the OD (\( p < .02 \)), adjusting for baseline score.

Compared to the OD, at exit from the intervention a higher proportion of SR and TR subjects:
- Completed inpatient or outpatient treatment (OD= 52%; SR= 76%; TR= 73%)
- Were abstinent from alcohol and drugs at exit for \( \geq 6 \) months (OD= 28%; SR=43%; TR=39%)
- Were abstinent from alcohol and drugs at exit for \( \geq 1 \) year (OD=17%; SR=34%; TR=33%)
- Were abstinent from alcohol and drugs for any \( \geq 1 \) year period while in the program (OD=37%; SR=59%; TR=46%)
- Were employed as the primary source of income (OD=12%; SR=29%; TR=29%)
Compared to the OD, at exit from the intervention a lower proportion of SR and TR subjects:

- Had public assistance as the primary source of income (OD= 50%; SR = 26%; TR = 26%)
- Index children were in the state foster care system (OR=26%; SR=17%; TR=9%)


**Study 4. Maternal substance abuse and disrupted parenting**

Women with substance abuse disorders typically have psychosocial characteristics that put them at risk for disrupted parenting. Prior research indicates that comprehensive, accessible services tailored to the mothers' needs can contribute to family stability. This study further explores the complicated interplay of how maternal risk and protective characteristics and service elements are associated with reunification. The study contributes to existing literature by following mothers for three years; examining service needs as identified by the mother herself; using a summary proportion score to reflect the totality of services received to matched service needs identified; and using logistic regression to examine interactions of services received with critical maternal characteristics. The sample is comprised of 458 substance-abusing mothers enrolled during pregnancy or postpartum in the Washington State Parent–Child Assistance Program (PCAP), an evidence-informed case management intervention.

Participants' custody status was well distributed among four categories based on continuity of parenting. Findings indicate that at program exit 60% of the mothers were caring for their index child. These mothers had more treatment and mental health service needs met, had more time abstinent from alcohol and drugs, secure housing, higher income, and support for staying clean and sober. Among women with multiple psychiatric diagnoses, the odds of regaining custody were increased when they completed substance abuse treatment and also had a supportive partner. Mothers who lost and did not regain custody had more serious psychiatric problems and had fewer service needs met. We discuss implications of our findings for child welfare policy and practices.
Study 5. Factors associated with subsequent alcohol and drug exposed births

Parental alcohol and drug abuse is a factor in approximately 15% of the cases investigated by the child welfare system and in approximately one quarter of cases with substantiated maltreatment. While substance abuse treatment is generally an essential component of child welfare family plans, a relatively low proportion of substance abusing mothers involved in the child welfare system complete treatment, which typically results in placement of their children in substitute care and the beginning of a new generation of adaptive problems.

This longitudinal study explores whether loss of an index child due to substance abuse is associated with risk of a subsequent alcohol/drug-exposed birth in a sample of 795 substance-abusing mothers enrolled in the Washington State Parent–Child Assistance Program (PCAP). Results indicate that at program exit, over one-fifth of these women had a subsequent birth (SB) after the birth of their index child. Among these women, over half (i.e., 56.3% or 12.3% of the entire sample) used alcohol and/or drugs during the subsequent pregnancy.

Consistent with our main hypothesis, the adjusted odds of having a SB were increased nearly two-fold for women who had the index child removed from their care. Furthermore, among mothers with subsequent births, the adjusted odds of having an exposed SB were increased three-fold if the index child had been removed from the mother’s care. We discuss implications of our findings for child welfare policy and practices.


Fetal Alcohol Spectrum Disorders (FASD) Intervention and Prevention

Approximately 50% of PCAP clients in Washington State report that their mothers abused alcohol, and approximately 20% report that they themselves were exposed to high levels of alcohol prenatally. Although few of these clients have a formal medical diagnosis of fetal alcohol spectrum disorders (FASD), many are suspected of having FASD based on their exposure history, their psychosocial profile, and their behavior.

See below for publications on intervention with mothers who have or may have FASD, screening for FASD in treatment facilities, suicidality, and other topics.

See Section Six of this manual for PCAP strategies for working with mothers who have neurocognitive impairments, including FASD.
Sources


Section Two – Overview of the PCAP Model

Section Two

Overview of the PCAP Model
A Two-pronged Approach

The PCAP approach is two-pronged. Advocate/case managers:

- Work closely with clients and their families to offer outreach and engagement, provide structured goal setting, problem-solving, practical assistance, and consistent coaching; and
- Work closely with community service providers to assure that clients and families receive the comprehensive, multidisciplinary services they need, and to help providers understand how to work more effectively with this population.

1. Between the Case Manager and the Client

The goal is to help the client move along a continuum, from dependence on the case manager, to interdependence with the case manager, to independence and strength on her own.

PCAP case management is not delivered according to a specific model of behavioral intervention. Instead, case managers develop a positive, empathic relationship with their clients, offer regular home visitation, and help the women address a wide range of environmental problems. Case managers use concrete, explicit methods to help clients identify personal goals and the incremental steps that must be taken to meet those goals. The client is closely involved in every plan and decision as the intervention proceeds. The process allows for a client’s gradual transition from initial dependence on the case manager’s assistance and support, to interdependence as they work together to accomplish steps toward goals, to independence as the client begins to trust in herself as a worthwhile and capable person, and learns the skills necessary to manage her life.

2. Between the Case Manager and Community Service Providers

One of the most important components of PCAP is the development of working relationships between PCAP case managers and community service providers. A multidisciplinary, coordinated team approach is the ideal. However, most community service providers do not have the time to connect in a productive, meaningful way with the other providers working with a client.

The PCAP case manager has this role. She:

- Is a liaison for communication among the client’s provider network.
- Facilitates the group in developing a service plan that addresses both the service providers’ concerns and the client’s goals.
- Assures that service plans do not create unrealistic expectations of the client.
In addition, professional and agency effectiveness increase when a case manager tackles the barriers (e.g., lack of housing, and/or child care) that could otherwise hinder or defeat a service provider’s aims for a client. For example, a primary care physician can more fully focus on a family’s health care needs when the PCAP case managers helps with scheduling, provides transportation, and assists the mother with the paperwork involved. The skills that service professionals and case managers contribute are distinctly different, but they are complementary.

**Overarching Principles**

**Case management.** The PCAP model incorporates fundamental and well-known components of effective case management (Case Management Society of America 2010). It is individually tailored, promotes the competence of the client, is community-based and multidisciplinary, and considers the dynamics of the family. The following elements characterize effective case management and home visitation programs:

- **Individually tailored:** is responsive to the particular needs of each woman
- **Promotes competency of the individual:** strengths-based approach
- **Uses a relational approach** to build rapport and deliver intervention
- **Family-centered:** attends to the dynamics of the whole family
- **Community-based:** utilizes the existing resources within a community
- **Multidisciplinary:** recognizes the need for a comprehensive approach

**Long-term intervention.** As a three-year intervention, PCAP offers a realistic length of time during which a woman can form a therapeutic alliance with her case manager and undergo the developmental process of making gradual behavioral changes. The beginning of this process is slow and tentative for most clients, who have never known the steady presence of a trusted parent or other individual in their lives (in fact, many clients state that their own mother first introduced them to drugs). The three-year duration also provides a clear time frame during which clients know they’ll have assistance; in this way it serves as an external motivator to completing their goals.

**Developmental perspective.** The PCAP model embraces a developmental approach at multiple levels: the development of the mother as an individual and as a parent; the development of the child; and the professional development of the PCAP case manager. Mothers who grew up with substance-abusing parents experienced insensitive and unreliable caregiving at best. They knew the emotional pain of having a mother and/or father who did not respond to their distress, and this childhood environment contributes to their persisting beliefs that relationships cannot be trusted. Their ability to recognize healthy relationships continues to be compromised. As mothers, this trajectory is evident in their difficulty responding in a developmentally appropriate manner to their own child’s emotional cues and distress signals, and in their difficulty identifying and connecting with healthy individuals who will not pose a threat to the family. PCAP offers these mothers,
perhaps for the first time, the opportunity to develop a different kind of relationship. Over the three years, as the case manager works closely with the mother and implements intervention strategies, the woman begins to make positive strides and gradually recognizes that this relationship is a healthy one that allows her to grow. As she trusts the case manager and experiences the reliability of the relationship, she becomes more capable of offering consistent attention and care to her child.

Parallel process. The attention, care, and support that case managers give to their clients is expected to be reflected in the way the mothers interact with their children. Accepting and supporting the mother not only helps her engage in treatment and avoid relapse, but may also gradually enhance her capacity to care for her child physically, emotionally, and socially. Similarly, the PCAP case managers receive close attention, care, and support from their clinical supervisors as described below.

Structured implementation. The intervention has a well-defined, structured, and manualized protocol for implementation. At the same time the PCAP model involves the practice of supervisors and evaluators meeting regularly (every three months) to examine and reflect on what works and what doesn’t. The manual and structure insure that the principles of the intervention are delivered in practice at a ‘dose level’ that is sufficiently strong.

Theoretical Components

Three theoretical bases—Relational Theory, Stages of Change, and Harm Reduction—guide the PCAP intervention. A thorough understanding of these theoretical underpinnings helps PCAP staff develop effective practices and contributes to positive program outcomes.

1. A Relational Approach

Relational constructs inform the therapeutic approach with clients and shape the day-to-day case management practices.

- **Relational theory** underscores the importance of interpersonal relationships to women as they grow, develop, and define themselves (Miller 1991; Surrey 1991).
- **Therapeutic alliance** - the process through which a mental health professional builds rapport and engages with a patient in order to help the person achieve desired change (Orlinsky et al. 2004) – is also considered vital.

Relational theory and therapeutic alliance have been well-studied by addiction researchers and practitioners. Findings tell us that a sense of positive connectedness to others:

- Is critical to successful outcomes among women with substance abuse disorders who are in intervention, treatment, and recovery settings (Amaro and Hardy-Fanta 1995; Finkelstein 1993).
Section Two – Overview of the PCAP Model

- Determines the extent of client compliance and retention in an intervention (Barnard et al. 1988), and may be more important to treatment outcomes than concrete services received (Pharis and Levin 1991).

The relationship between PCAP case manager and client is an important path through which change occurs throughout the intervention.

Theory into Practice.
The PCAP model puts concepts of relational theory and therapeutic alliance into practice by offering personalized, knowledgeable and compassionate support from a single case manager who works consistently with her clients for three years, a period of time long enough for the process of gradual and realistic change to occur.

PCAP values hiring case managers who have successfully overcome difficult personal, family, or community life circumstances similar to those experienced by their clients (e.g., substance abuse, single parenting, and poverty). Case managers who have undergone difficult change processes and achieved successes (e.g. in education, employment and relationships) are realistic role models who share their experience of recovery with clients and inspire the hope that it is possible to overcome obstacles.

PCAP clients often present defensively at the start of the intervention; most are ashamed of their substance use in pregnancy and know they have poor parenting skills. Case managers’ shared history allows them to literally ‘get in the door’ on home visits—because they are more easily perceived as understanding and empathetic with the client’s situation, allowing them to more easily build rapport with those who might be unapproachable. The case managers’ sustained empathetic “peer” guidance, offered in the context of teaching and role modeling, promotes the client’s social and emotional development as she learns to trust others, build practical skills, and gradually trust in her own self.

“I do this work in large part because I am the biological mother of a fetal alcohol affected son. I’d like to be part of the process by which other women can make changes in their lives, and prevent more of these kids from being born. I really do love my job. Women do get their lives turned around, and when a woman gets her life turned around, it affects everybody in the circle of her life. So, we’re breaking a life cycle for these kids. These kids are not going to have to grow up and do exactly what their mothers are doing, who are generally doing exactly what their mothers did.”

—PCAP Case Manager
2. Stages of Change and Self-Efficacy

Stages of Change theory recognizes that women enrolled in PCAP will be at different stages of readiness for change at different times. Ambivalence about changing addictive and other behaviors (e.g., parenting) is normal and should be expected (Prochaska and DiClemente 1986). Motivational interviewing (MI) is a corresponding conversation style developed by Miller and colleagues (1991) that helps clients examine and resolve ambivalence about change and increase their internal motivation to change.

PCAP case managers and supervisors should be trained on MI principles and the use of MI strategies from professionals in their communities as soon after hire as possible. Supervisors are expected to provide MI practice and reinforcement during supervision sessions and group staffing. A helpful resource used by all PCAP sites is:

*Treatment Improvement Protocol (TIP) 35*

“Enhancing Motivation for Change in Substance Abuse Treatment”

To order, call 1-877-SAMHSA (1-877-726-4727)

Or go online: [http://store.samhsa.gov/home](http://store.samhsa.gov/home) and enter TIP 35 in the search box.

Staff should receive periodic refresher training as it is available.

Motivational Interviewing (MI)

- Is built on the principle that people do not respond well to a demand for change or an attack on current behavior.
- Is an approach that inspires people to examine their behavior, think about ways in which they are uncomfortable with what they are currently doing, and get motivated to make changes.
- Instead, change can occur by listening very carefully for the patient’s own statements about the desire to change and building the interview around the individual’s perspective.

MI strategies are based on four basic principles: expressing empathy, developing discrepancy, accommodating to resistance, and supporting self-efficacy. Self-efficacy is the belief in one’s ability to perform in ways that will produce desired outcomes; a person’s expectations about self-efficacy are influenced *most powerfully* by his or her own past accomplishments (Bandura 1977).

Theory into Practice.

The principles embodied in MI naturally complement PCAP’s relational theory basis because they call for case managers to be empathetic and nonjudgmental, to listen closely and respectfully to their clients, and to accept and trust in the client’s perception and judgment about her own life. In practice, the most important way in which a PCAP case manager has a positive effect on her client’s self-efficacy is by listening carefully to her about what is important and how she thinks about her problems, and valuing this self-expression. Case
PCAP case managers understand that for clients who have never experienced competence and accomplishment, each small step a woman takes deserves attention and encouragement. Acceptance and understanding of the client’s situation, and trust in the client’s perception and judgment, are critical. Case managers can have a positive influence on clients’ self-efficacy expectations, motivational states, and, ultimately, behavior by:

- Providing clients with concrete, practical opportunities to accomplish goals of relapse prevention, recovery, and social adjustment.
- Helping clients recognize and celebrate each step toward performance achievements.
- Offering ongoing verbal and emotional encouragement regardless of temporary setbacks or relapse.
- Role modeling, as someone who has achieved personal goals similar to those the client may be aiming toward.

A PCAP client’s self-efficacy will determine whether she will begin a behavior, put the required effort into it, maintain her efforts, and thus progress to another stage of change.

**Harm Reduction**

PCAP intervention strategies are based on harm-reduction principles positing that alcohol and drug addiction and associated risks can be placed along a continuum, with the goals of:

- Helping clients move along this continuum from excess to moderation or abstinence.
- Reducing the harmful consequences associated with substance use (Marlatt & Tapert, 1993; Marlatt, Somers & Tapert, 1993).

PCAP participants are not asked to leave the program due to relapse or setbacks. Instead, case managers work with them to examine factors (“triggers”) that led to relapse and take steps to eliminate or minimize such triggers in the future. In this view “any steps toward decreased risk are steps in the right direction” (Marlatt et al. 1993).

Given that substance dependence is a chronic relapsing disorder, rather than using an all-or-nothing approach to interventions that require abstinence of participants, intervention programs based on harm-reduction principles may reduce some of the negative consequences associated with substance use while at the same time keeping greater
numbers of women involved in treatment (Burns & Breen, 2013; Centre for Epidemiology and Evidence, 2014).

Parents who struggle with chronic substance use disorders are motivated to participate in interventions for a number of reasons. For example, primary concerns for substance-using mothers are loss of child custody (Ondersma et al. 2000; Young et al., 2007), recurrent births of substance-exposed infants (Grant et al. 2014; Ryan et al., 2008; Kissin et al. 2001), housing instability (Bassuk et al 1997; Bassuk et al., 1998; Caton et al., 2000; North et al., 2004; Vangeest & Johnson, 2002), and financial insecurity (Boardman et al., 2001; Mulia et al., 2008; Rhodes, 2009). The PCAP harm reduction approach has the capacity to reduce such negative consequences for women enrolled.

Theory into Practice.

With regard to the maternal concerns mentioned above, at PCAP exit approximately 80% of children are living with their own families, 75% of mothers did not have a subsequent birth during the three-year intervention, 70% are living in stable housing or in a treatment facility (compared to about 40% at intake), 30% were getting their main source of income through employment versus welfare (compared to 7% at intake), and 60% attended or completed GED, college, or work training (Grant & Ernst, 2016). In addition, approximately 90% completed alcohol/drug treatment or were in progress, and 80% had been abstinent from alcohol and drugs for six months or more during the program.

In practice, PCAP case managers focus attention not simply on reducing alcohol and drug use, but on reducing other risk behaviors that affect the health and social well-being of the clients and their children.

Examples

- **Family planning.** Family planning means determining the number of children one wants to have, and the spacing of the children, through the use of birth control. An important PCAP program goal is to reduce the risk of births of future alcohol- and drug-affected children. Not every woman will be able to become abstinent from alcohol and drugs during her pregnancies. PCAP works with clients to choose effective family planning methods in order to avoid having unwanted or unintended pregnancies.

- **Safety planning.** A safety plan is a written agreement between a mother and the PCAP case manager, or between the mother and her child welfare worker, describing how potential threats to the family and to child safety will be managed. Safety plans should be 1) solution focused; 2) family-centered; and 3) collaborative.
They should clearly describe the specific actions and responsibilities of all plan participants. A parental safety plan can include the following elements:

- Identify a friend, family member, or other supportive person who can check on the parent(s) regularly. It should be someone who is trusted, knows the signs of stress in the parent(s), and agrees to act to protect the children, including talking to professionals.

- Keep a list of community resources and phone numbers, including resources such as rental assistance, support help-lines (e.g., parenting support, 12-step), and food assistance. Laminate this list and keep it accessible.

If client is in recovery and she is planning to go on a date, ask: “Are you ready for the weekend? How can you enjoy yourself without threatening everything you’ve accomplished? Let’s make a plan.” Include specific details about:
- a safe babysitter; food and diapers for children; contact information, other resources; condoms or other birth control for mom; phone charged with numbers entered.

- **Relapse prevention and planning.** Preventing an alcohol or drug relapse is more than just saying “no” in the face of temptation. Prevention needs to start early and before there is a temptation. A comprehensive relapse prevention plan takes into account:
  - social interactions
  - emotional triggers
  - the development of positive coping mechanisms

  See [http://www.recovery.org/topics/relapse-prevention/](http://www.recovery.org/topics/relapse-prevention/)

- Without giving the parent(s) “permission” to relapse, or promising immunity from all consequences, it is realistic to plan for it. Help the parent(s) take responsibility and think about potential consequences by creating a written agreement including the following:
  - **In the event of relapse…**
    - *My children must be somewhere safe, with someone safe. Here are the names and phone numbers of safe people who will be able to come and get my children, or who I will be able to take them to, if I have used or know I am going to use. (These names and phone numbers should be on the resource list.)*
    - *I have a bag of supplies set aside with food, diapers, extra cloths and toys to make sure the children have their basic needs met.*
    - *After relapse, I will take steps to regain sobriety and make the home safe for the children. (Parent(s) should identify the steps and names of people who need to be included in that plan.)*

- Work with the mother to develop a list of reasons to stay clean and sober, including both the **risks** to their children and the **joys** of parenting.
Help the parent create a visual representation of these concepts and action steps that can be displayed in the home (e.g., a collage or vision board) or can be carried with them (e.g., on a laminated key chain with the “number one reason” and a picture of the child).

Develop a list of people who are not allowed in the home when the children are present. This list should be developed with the help of someone such as the chemical dependency counselor. Laminate this list and keep it accessible.

Help the mother to identify and plan for how she can attend recovery support meetings, such as a 12-step group, on a regular basis.

Note: Physicians working with parents affected by substance use problems have found harm-reduction approaches to be valuable. In a study conducted at pediatric primary care clinics sites with 879 parents who brought children for medical care, Wilson and colleagues (2008) found that parents who screened positive for substance use were amenable to pediatrician-initiated interventions involving discussions of substance use and its negative effects on children, relevant educational materials, and options for evaluation and treatment. Smith and Wilson (2016) encouraged pediatricians to address these topics with parents, suggesting that while some parents might be willing to enter drug treatment for the sake of their children, others would choose harm-reduction measures such as decreasing substance use, even if not abstaining, or reducing use of more harmful drugs while increasing marijuana or tobacco use.

The PCAP harm reduction approach is consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of recovery from substance use disorders as a “process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (2012).
Section Three

Program Start-up

![Image of a family with a baby and children]
PCAP Staffing and Job Descriptions

Core PCAP staff qualifications and job descriptions:

- Clinical Supervisor Job Description
- Case Manager Job Description
- Office Assistant Job Description
- Exit Interviewer Job Description

The Role of the Clinical Supervisor

A key element of PCAP has been the development and institutionalization of excellent supervision practices. Close, regular, interactive supervision is critical because the work can be emotionally and physically draining. PCAP supervisors are ideally master’s level clinicians who meet individually with case managers for at least an hour, ideally every week and at a minimum twice each month. They are available for consultation throughout the week either by phone or in person.

In the Program and in the Community

PCAP clinical supervisors have dual roles. They provide direction and supervision within PCAP and at the same time play a central role in building PCAP’s identity and maintaining an excellent reputation in the community. These two dimensions are essential components of the PCAP model and a clinical supervisor must be actively engaged in both roles for the intervention to reach full potential.

<table>
<thead>
<tr>
<th>Role of Clinical Supervisor in the Program</th>
<th>Role of Clinical Supervisor in the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screens referrals</td>
<td>Establishes PCAP identity</td>
</tr>
<tr>
<td>Assigns new clients to case managers</td>
<td>Solicits referrals</td>
</tr>
<tr>
<td>Administers consent/client service agreement</td>
<td>Facilitates communication among providers</td>
</tr>
<tr>
<td>Conducts ASI intake interview</td>
<td>Identifies service barriers</td>
</tr>
<tr>
<td>Supervises individual case managers weekly</td>
<td>Interacts with agencies to resolve barriers</td>
</tr>
<tr>
<td>Facilitates weekly group staffing meeting</td>
<td>Participates on task forces, work groups</td>
</tr>
<tr>
<td>Accompanies/observes case managers on home visits</td>
<td>Provides feedback data to community</td>
</tr>
<tr>
<td>Identifies training needs and arranges trainings</td>
<td></td>
</tr>
</tbody>
</table>
Within the Program

The supervisor has diverse roles. As an administrator, she discusses each client’s status and reviews paperwork, case notes, and how the case manager allocates her time. As a teacher, she explores with the case manager how case activities are related to client goals and helps her to differentiate between crises that need the case manager’s intervention versus those the client may be ready to handle by herself. As a mentor and guide, the supervisor helps the case manager examine and process how activities on the cases may be affecting her; she discusses areas of growth the case manager would like to see for herself and opportunities for additional training.

The supervisor is in a leadership position that allows her to create a positive, healthy work environment in which case managers can give attention and care to their clients. When the parallel process functions well, the supervisor’s support of the case manager is reflected in the case manager’s attention to the mother, which is in turn reflected in the mother’s care for her child. The words of Jeree Pawl come to mind: “Do unto others as you would have others do unto others” (Pawl and St. John 1998).

Disappointment and frustration are common among service providers who work with high-risk, unpredictable populations. It is critical for the PCAP clinical supervisor to assist case managers in recognizing and understanding these normal responses, rather than reacting to clients in counterproductive ways or ignoring the feelings and increasing the risk of burnout. In a model like PCAP that is based on maintaining long-term trusting relationships between case managers and clients, staff turnover must be kept to minimum. If burnout results in a case manager leaving, the transfer of a caseload to different staff disrupts the relationship not only with the case manager but also in some case with the program, and can lead to setbacks for the client.

Balancing time among a caseload of 16 high-risk women can be difficult. Supervisors must continually pay close attention to how the case manager is balancing her time among clients, and whether she is persistent in trying to find ways to connect and build relationship with every client. This is particularly challenging if a client is rude to the case manager, or continually no-shows for appointments. On the other hand, clients who are doing well are easier to be with, and it’s a natural tendency for case managers to schedule more time with these women. Don't let this happen. The supervisor’s role is to help the case manager avoid extremes, monitor the balance of time, and assure that she is spending time with each client. Otherwise, some clients will end the 3-year intervention having received a relatively small intervention “dose”, and having poor outcomes to show for it.
Fostering client independence. Supervisors must be attuned to the potential problem of a case manager’s over-efficiency interfering with the goal of helping women develop self-efficacy and achieve healthy independence. For example, a case manager may become frustrated with a struggling client and do the client’s work for her, instead of guiding the client in a process that will result in the client developing skills and competency. Every mother who has agreed to be in PCAP hopes on some level for a better life, and for some women it will take a great deal of time and persistence before progress can be observed. Alternatively, a case manager may be tempted to leave a “star” client to her own devices, failing to remember the importance of her continued support in helping the client sustain her progress.

Individual, one-on-one weekly supervision with each case manager
During each supervision meeting, clinical supervisors:
- Review each clients’ status with the case manager, with reference to the Weekly Time Summary sheet to check for accuracy.
- Discuss what the individual case manager wants to accomplish with each case by next week.
- Discuss how focus can be redirected to the client goals.
- Discuss individual case manager training needs.

Review of Weekly Time Summary Forms

PCAP data demonstrate that in general, client outcomes are better among clients who spend more time with their case managers. In order to monitor case manager time, maintain fidelity to the PCAP model, and ultimately achieve better PCAP outcomes, supervisors are required to:
- Review Weekly Time Summary forms every week, ideally during supervision with the case manager.
- Run data reports and monitor to assure that on average 55% of time each week (22 hours in a 40 hour week) is spent working directly on the client caseload (face to face time and time on behalf of client).
- Note that realistically, case managers will not be able to see, or even talk to, every client every week. The amount of time spent with clients depends on many factors, and will naturally vary.

Field accompaniment. In addition to weekly supervision sessions, successful clinical supervisors also periodically accompany case managers on home visits to observe and consult.

Client File Reviews/Chart Audits
Supervisors are required to read and sign off on case manager case notes approximately every three months, using the PCAP Client File Review form to document that client files are up to date, complete, and accurate.
Advocate-Client Relationship Inventory
The Advocate-Client Relationship Inventory is a 27–item questionnaire that was adapted for PCAP (with permission) from an instrument developed for the Memphis New Mothers Project (Barnard, 1998). The Inventory assesses a client’s perception of the quality of her relationship with her PCAP case manager, and it includes four constructs: 1) “caring” (being emotionally involved, being present, doing for, and giving hope); 2) “coaching” (being supportive as a coach who helps the client reach her potential); 3) “ongoing developmental” (assisting clients with the developmental issues of a mother learning and growing in her various roles); and 4) “harmony” (promoting harmony among the mother, her family, and the case manager).

The Inventory:
- Is completed by the PCAP client (not by the case manager).
- Is voluntary (the client must be willing to complete it).
- May be given by clinical supervisors to clients at any time during the 3-year intervention (in person or as a mailed survey) to assess program quality and client satisfaction or as a tool to help the supervisor assess personnel problems (e.g. validity of a case manager’s reported time spent with clients).
- Is always completed after the final PCAP exit interview.

Weekly Staff Meetings
PCAP sites have weekly, two-hour group staffing/problem-solving meetings where case managers share the highlights of the prior week, examine challenging cases, share community resources, and mentally prepare for the week ahead. This is the only time case managers come together as a team during the week.

The clinical supervisor can use this valuable time to best advantage by:
1. Listening for, and noticing common themes in individual supervision sessions with the case managers.
2. Then asking case managers to discuss specific clients or situations as case study illustrations at the weekly group meeting in order to stimulate brainstorming and discussion.
   a. Other case managers offer ideas and support, and reflect on experiences with their own clients.
3. Subsequent staffing meetings provide continuity when case managers give updates on client status and on how others’ suggestions have worked.
Effective clinical supervisors ensure weekly group staff meetings are brainstorming, problem-solving sessions that leave case managers in a positive frame of mind for the challenges they face.

A continuing challenge faced by supervisors is maintaining a balance between spontaneity (keeping meetings flexible and interesting) and structure (covering essential business items within time limitations).

Weekly staff meeting expectations:

- Meetings are held once a week for two hours.
- Clinical supervisor makes an agenda through the week (business, discussion items).
- Use a sign-in sheet. Take brief minutes and keep on file.
- It is critical that all staff be present and arrive on time.
- Staff members do not make or answer phones calls, text messages, or do paperwork at staff meetings.
- Periodically, guests from the local service provider community are invited (local police, Planned Parenthood, child welfare).
- Periodically, supervisors may arrange to meet outside the office for a change of scene; the venue must be private enough so that case discussions cannot be overheard.
- To increase interest and variety, supervisors may ask case managers to take turns leading the meetings.

“I look forward to the staff meetings when I'm stuck on a particular client. I get a lot of positive reinforcement at the staff meetings.”

— PCAP Case manager

“Weekly staff meetings are very, very helpful. They give me a chance to know about other people's clients and how they're doing. They allow me to get feedback and fresh views on challenges from the other case managers and from the supervisor. They are just essential.”

— PCAP Case manager

PCAP Site Newsletter

Some PCAP supervisors create PCAP site newsletters. General ideas on content for these newsletters include:

- Informational articles (e.g., health, child development)
- Fun and free things to do (e.g., library story times)
- Client poetry, testimonials
- Recipes (easy, nutritious, fun to make with children)
- Clean and sober birthdays (e.g., Nicole – 6 months)
- Target child birthdays (e.g., Monty – 1 year old)
Newsletter suggestions: Keep at 8th grade reading level; no last names, no client photos.

**Letter to Client at Exit/Graduation**

At PCAP exit, clinical supervisors write a brief letter to each client who has participated, personally thanking her for her time and participation in the program. PCAP letters are handwritten on program stationery.

*Example:*

> Dear -----,

> We would like to extend our warmest thanks to you for your time and energy over the past three years in PCAP. You have taught us, and others, a great deal about how we can help make a positive difference in women’s lives. We wish you the very best in the future!

> Sincerely,
The Role of the Case Manager

PCAP case managers are required to have:

- a minimum of a BA degree, preferably in a social services field; and
- at least four years of community-based experience working with high-risk populations or the equivalent combination of education and experience; and
- If in recovery from substance abuse, must have at least five of continuous years in recovery.

PCAP case managers understand the high-risk circumstances in which clients live. PCAP values hiring case managers who have faced challenges (e.g. domestic violence, poverty, single parenting, an alcoholic parent, personal alcohol or drug abuse), and most importantly, who have overcome these obstacles and achieved success in important ways — for example, by finishing a degree in school or by maintaining steady and meaningful employment. Their own struggles and successes enable PCAP case managers to be positive and credible role models, offering their clients hope and motivation from a realistic perspective. While they may have some history in common with their clients, they are able to form healthy relationships with clients because they have accrued the time and the achievements that confer a level of competency and emotional objectivity. This allows for relationships that are more therapeutic than sympathetic, more professional than peer.

Other key characteristics of PCAP case managers include:

- Excellent problem-solving skills and creativity
- Experience as mothers is helpful
- Tenacity, persistence
- Work experience and understanding of professional behaviors expected in an office culture

Advertising for The Case Manager Position

In advertising for the case manager position, administrators ensure that notification of job openings reaches diverse populations. The most successful case manager recruitment has occurred through word-of-mouth by service providers who understand the scope of the role
and through recommendations of current case managers who know what the position requires. Some of our successful case managers have come from programs they found frustrating because they permitted only short-term contact with clients who clearly needed more consistent, long-term support in order to achieve positive outcomes.

**Case Manager: Physical Elements/Requirements of the Position**

Estimate of PCAP case manager time spent in physical activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td>5.5 plus hrs/day</td>
</tr>
<tr>
<td>Standing in one place</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Walking</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Lifting</td>
<td>30 lbs</td>
</tr>
<tr>
<td>Lifting frequency</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Carrying</td>
<td>30 lbs</td>
</tr>
<tr>
<td>Carrying frequency</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Pushing/pulling (file drawers, carts, strollers)</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Bending</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Squatting</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Climbing</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Reaching</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Driving</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Simple grasping/fine motor</td>
<td>0-2.5 hrs/day</td>
</tr>
<tr>
<td>Keyboarding or typing</td>
<td>0-2.5 hrs/day</td>
</tr>
</tbody>
</table>

**Driving**

**Essential:**
- Transport clients and their children
- Provide outreach services to connect clients with community agencies
  Provide outreach services to locate missing clients

**Details:**
Must have a valid driver’s license and be able to drive a vehicle/travel on a daily basis (approximately 25-33% of the time, or 2 to 3 hours in a day); on some occasions may need to transport clients to treatment or court, so the distance may be up to 200 miles at time. Case managers need to assist clients (many of whom are pregnant) with transporting children, which can include lifting a baby or baby in car seat; case manager should be able to lift up to 30 pounds.
Communication, Accountability, and Safety

Most of the case managers’ time is spent in the field with clients; therefore mechanisms are in place for purposes of safety and accountability. If they are leaving the office for a home visit or work in the field, case managers are required to leave information indicating their destination (e.g. name, current address, current phone number of client) and expected return time. This information may be conveyed/retained using an agreed-upon smart phone application, or logged on a daily tracking sheet and updated during the day along with any messages the case manager has for her incoming callers.

‘Flex’ Time

Whether or not flex time is allowed depends on your PCAP host agency policy, including whether PCAP staff are hired as hourly or exempt/ salaried employees, and whether there are insurance considerations (i.e., is flex time activity covered by the agency insurance policy). Clinical supervisors are expected to know the flex time policy at the agency where they are employed, and adhere to it.

At agencies where flex time is permitted, PCAP guidelines are below:

- Case managers have flexible hours because important client events and crises do not necessarily occur on weekdays between the hours of eight and five o’clock.

   Essential:
   - Conduct two home visits/month per client
   - Provide housing support/ case management services
   - Obtain and maintain current CPR, Infant CPR Certification

   Details:
   Home visits require case manager to access homes that are not ADA compliant, so case managers may need to climb stairs to access clients’ homes. Case managers must wear clothing and shoes which are both professional as well as conducive to walking some distances to homes and/or community provider offices. Case managers must be able to respond to emergencies and/or danger quickly.

   Essential:
   - Complete required paperwork
   - Demonstrate cognitive/ organizational abilities to keep track of up to 16 clients, their families and their service providers
   - Document all activities accurately and in a timely manner

   Details:
   PCAP paperwork requires approximately 8-10 hours per week at a desk writing, making phone calls, typing, and computer data entry.
Case managers must get prior approval from the clinical supervisor and/or the appropriate agency staff person if a situation requires the case manager to work outside of regular work hours, and case managers must identify the clinical purpose for the work.

- Full time staff (40 hours per week) are expected and encouraged to complete their work week within 40 hours, and are discouraged from working more than 40 hours per week.
- If staff do work over 40 hours in a week, they must record the hours on the Weekly Time Summary Form and take the extra flex hours off within the next week or as soon as possible.
- Staff are never permitted to accrue more than 10 hours in additional flex time.

**Telecommuting Recommendations**

Administrators may want to allow telecommuting under certain circumstances, after staff are experienced and familiar with the PCAP model.

There are times when case managers call clients or service providers from home, using their work cell phone. Appropriate examples include: when a case manager needs to stay in touch with clients who work full time during the week, to trace missing clients, when there is severe weather preventing case managers to travel, or when case managers have a sick child. Case managers intending to telecommute are required to:

1. Discuss telecommuting with supervisor and get agency approval first.
2. Have a clear plan for the work she'll be doing.
3. Deliver the "product" when she gets back to the office (e.g., case notes completed; biannual forms data-entered, case note documentation of tracing calls or provider contacts, etc.).

Case managers may work with clients on the weekend or evening if the situation warrants and there is a therapeutic goal (e.g., a client calls because she is suicidal; a baby is due). **Working outside of work hours must be approved by the host agency (with consideration for insurance coverage), and by the clinical supervisor.**

**PCAP Client files are never to be taken out of the office.** When the case manager is not working with a file it should be kept in the PCAP office locked filing cabinet designated for that purpose. Supervisors should be able to locate any case manager’s client files quickly and access information easily.
Lessons Learned About Hiring

Case manager turnover and the resulting transfer of clients to different case managers can compromise program outcomes because the intervention is based on the development of a consistent, trusting relationship between case manager and client. When a case manager leaves the program, her clients may take months to re-engage with someone new, or some may drop out of PCAP entirely.

Successful Case Managers
Case managers have varied styles and approaches to working with clients. Successful case managers share the following characteristics:

• A direct, honest, and nonjudgmental manner.
• A strong belief in the essential dignity, worth, and promise of each client.
• An understanding that each small step clients take toward rebuilding their lives deserves attention and encouragement.
• A sense of excitement in the challenge of working with clients who may be difficult or manipulative.
• A commitment to working with women for a period of time long enough to allow for the process of realistic and gradual change to occur.

Case Managers who have left PCAP have taught administrators important lessons:

• Case managers in recovery from substance abuse must be in recovery for a minimum of five years and, equally important, must be maintaining a stable, recovery-oriented lifestyle with a solid support system. They must have moved well beyond the circumstances associated with the former lifestyle.
• The case manager/home visitor position is not a desk job. It is an outreach position, meaning that the case managers go to the clients; the clients are not expected to make appointments to see their case managers in the office.
• Case managers who are unable to flexibly manage multiple issues and prioritize quickly as crises arise find the work stressful and unproductive.
• A judgmental or apprehensive attitude on the part of the home visitor is detrimental to building an open relationship with the client.

PCAP Training

Comprehensive, ongoing training is an essential component of the PCAP model. Four types of training occur in PCAP: pre-service training, ongoing training on relevant topics from outside sources, and ongoing in-service training with local
providers, and annual 2-day refresher training on the PCAP model.

1. **Supervisor and Case Manager Pre-Service Training:**
   See [Training Requirements for Supervisors](#) and [Training Requirements for Case Managers](#).

2. **Ongoing Training on Relevant Topics from Outside, Professional Sources**

   These in-depth trainings may be specifically arranged by the clinical supervisor for PCAP staff, or they may be trainings offered in the community through the health department, local university, or other source. Because PCAP staff at hire have prior experience in social service settings working with high-risk populations, case managers do not need to receive training in all the topics listed below before they begin working with a caseload. Clinical supervisors determine the timeline for assigning clients to case managers while they train concurrently on topics below.

   Critical training topics include:

   - Motivational Interviewing
   - Alcohol and drug abuse (behavior, treatment and recovery, relapse prevention)
   - Co-occurring mental health disorders
   - Family planning (methods, contraindications, side effects)
   - Domestic violence
   - Infant developmental stages and care giving techniques with emphasis on alcohol/drug exposed children
   - Fetal Alcohol Spectrum Disorders (FASD)
   - Car seat safety for infants and children
   - Cardiopulmonary resuscitation certification (CPR)

3. **Ongoing In-Service Training with Local Providers**

   The PCAP Clinical Supervisor arranges for local service providers to train PCAP staff on the dynamics and roles of their agency, what they can offer to PCAP clients, and tips on how to work successfully with their agency. These opportunities also give community partners an introduction to and personal connection with PCAP. This familiarity does three things: it builds positive relationships between PCAP and other providers that ultimately benefit the clients; it helps to prevent future service barriers; and it is invaluable in addressing and resolving service barriers and misunderstandings that may arise between PCAP and the agency. In-service trainings may be held during regular PCAP staff meetings. Local providers typically invited to provide in-service training include:

   - Child welfare social workers
   - Welfare/social security benefits social workers
• Family Planning
• Local police department
• Local substance abuse treatment agency

4. Annual 2-Day Refresher Training on the PCAP Model

Annual 2-day refresher training is conducted by the PCAP state director and an experienced PCAP clinical supervisor. Training is held at a central location with supervisors, case managers, and office assistants from multiple sites attending.

Example of PCAP In-Service Training with Local Providers

“We invited staff from a local family planning agency to attend a staff meeting to talk with us about problems we were having with clients who were not making their appointments for Depo-Provera shots on time (women on Depo Provera receive injections every three months). If a woman missed her appointment she typically had to start all over again with a pregnancy test, she would sometimes miss that appointment or want to reschedule, and in the interim might become pregnant unintentionally. In meeting with us, agency personnel gained an understanding of the high-risk clientele we work with, and they recommended an idea for ‘fast-tracking’ these clients in their system. The idea worked.

It comes down to developing good relationships with service providers. This means not just having names in our roldexes, but knowing who they are and what they look like, inviting them to our offices, and spending time with them so we understand each other’s work.”

Content includes the basic tenets of the PCAP model, case manager and supervisor roles and best practices, boundaries, safety issues, small group practice on realistic goal setting with the client. Refresher training is interactive and dynamic, with group discussion about the realities of the work and the importance of supportive supervision and self-care.
Safety Guidelines

PCAP staff members are home visitors who may find themselves in situations in which their personal safety is at risk. PCAP highly values the personal safety of every staff member, and PCAP Safety Guidelines were developed to help staff avoid risky situations, and respond to problems if they arise.

PCAP staff members should never enter into a situation she/he thinks may be dangerous. If a staff member senses a problem, she/he is expected to leave the setting and consult with the supervisor or get assistance from law enforcement. PCAP staff members are not expected to perform the roles or functions of law enforcement. Personal safety begins with common sense, attention to risks, and prevention.

Some of the details in the Safety Guidelines are specific to Washington State PCAP, but the information and recommendations can be generalized to PCAP sites elsewhere. PCAP sites affiliated with local, individual agencies or institutions should, in addition, seek guidance and assistance from their own risk management or law enforcement agencies.

PCAP safety protocols are updated on a regular basis, and are reviewed with staff annually as part of refresher training.

Topics addressed in the Safety Protocol include:

- Safety Training
- Special Equipment
- Opioid Overdose Response
- Health Risks and Precautions
- Field Safety: before you leave, at the home, when protective custody is anticipated, dogs, meth labs
- Office and Building Safety
- Active Shooter
- Domestic Violence
- Weapons
- Threats Against Employees
- Emergency Calls from Clients
Section Four

Enrolling Clients
Client Eligibility

The PCAP supervisor determines whether or not a woman who has been referred is eligible for the program. Women are eligible to enroll in PCAP who meet three criteria.

1. **Pregnant or up to twelve months postpartum, and up to twenty four months postpartum if space is available.**
   
   Note: If a woman enrolls in PCAP then terminates the pregnancy, has a miscarriage, or the target child dies, she is still a client and remains in PCAP unless she decides to withdraw.

   and

2. **Self-report of alcohol and/or drug abuse during the pregnancy.**
   
   The woman must self-report heavy or problematic alcohol or drug use during the index pregnancy. Underreporting is common at the initial referral stage, and should be expected.
   
   If the following information is available, it may be helpful in determining whether or not a client meets this criterion:
   
   • Any positive maternal/infant toxicology screens during pregnancy or at delivery?
   • Any previous alcohol or drug exposed pregnancies?
   • Any previous children removed from custody due to alcohol/drug abuse?
   • Any history of alcohol/drug treatment?

   and

3. **Ineffectively engaged with community service providers.**
   
   A woman referred to PCAP may already have several providers or case managers, such as a Child Protective Services (CPS) social worker, a public health nurse, or a probation officer. The fact that she has providers does not mean that the client is effectively engaged with them, and the fact that she is pregnant and abusing substances is an indicator that she may need additional or a different kind of help.

   A woman referred to PCAP may currently be in substance abuse inpatient or outpatient treatment. This does not make her ineligible—the questions to consider are these: when she leaves treatment what is her long-term support system? Who will support her in relapse prevention? Who will coach her in taking the next steps toward recovery and an improved quality of life? Enrolling women in PCAP who are also in treatment is not a duplication of services.
Special Considerations: Mental Health Conditions

An important consideration at enrollment is a woman’s mental health status. At intake, about 50% of Washington PCAP clients report that they have co-occurring mental health and substance abuse disorders, with the most frequent mental health diagnoses being mood disorders (depression, bipolar disorder), and stress/panic/anxiety disorders (including post-traumatic stress disorder).

The clinical supervisor usually does not learn about a client’s mental health issues during the referral process. More typically, she will learn this during the intake process as she administers the psychological status section of the intake interview.

If a woman is referred who has a profound mental health problem such as a psychotic disorder or schizophrenia, the clinical supervisor must consider whether or not PCAP case management is an appropriate service for her, or if the woman needs instead a referral to a psychiatrist and treatment facility where she can obtain long term therapy and medication management. The question to ask is whether PCAP is enough to address the needs of the woman.

“We enrolled a client in PCAP who had schizophrenia. The referring mental health treatment provider wanted the woman enrolled in PCAP because of our case management services. The client was accepted on the condition that her mental health provider work hand-in-hand with the PCAP case manager for the duration of the program. It required a real commitment from the mental health provider, and it was an important condition of acceptance into PCAP so that the client could receive the full range of essential services that she really needed”.

The clinical supervisor should consult whenever possible with other PCAP clinical supervisors and/or professionals to determine 1) how the woman would benefit from our services; 2) which additional comprehensive mental health and other services the woman will need in order to recover and/or stabilize; and 3) the mental health providers who are available and who will commit to work as a team with PCAP on this case throughout the 3 year intervention.

Women are also eligible for PCAP who meet the following criteria, although fewer than 5% of our clients are enrolled this way:

1. Women who have delivered a child with a diagnosis of FASD
   and
2. Who are still drinking
   and
3. Who are capable of bearing children

Research indicates that when mothers who have delivered a child with FASD continue to drink heavily and bear more children, each subsequent child born suffers increasingly severe alcohol effects. It is therefore important to intervene with any mother who has delivered a child with FASD in order to prevent future heavily exposed and damaged children.
Client Recruitment

“PCAP’s best recruitment strategy is to have a good reputation in the community...positive word of mouth is what really matters.”

– PCAP Supervisor

Generating Referrals

Clients may be referred to PCAP through self-referral, family or friends, but it is more typical to receive referrals from local community health and social service agencies, such as:

- Substance abuse and mental health treatment providers
- Hospital social workers (especially prenatal clinics, post-partum hospital units, neonatal units)
- Welfare workers
- Child Protective Services social workers
- Prosecutors, public defenders

The PCAP clinical supervisor is responsible for:

- Introducing PCAP to potential referral sources in the community.
- Developing relationships with agencies and individuals who will make referrals to PCAP.
- Maintaining rapport and a good reputation with these agencies.

Strategies for generating referrals:

1. Develop a PCAP brochure that briefly describes the intervention, the eligibility criteria, outcomes to date, and contact information. See Washington State PCAP Brochure example.
2. DO NOT send a mass mailing to community providers.
3. Do schedule brief, in-person meetings with supervisors or administrators at the agencies most likely to come into contact with eligible women.
4. Do ask if you can attend one of their staff meetings to briefly introduce PCAP and explain how we can enhance the work of their agency by providing mutual clients with long-term, comprehensive case management and recovery support.
5. Do invite the agency supervisor and/or agency staff to attend a PCAP staff meeting to learn more and meet the case managers.
6. Do emphasize that PCAP is a best practices model, and distribute a list of PCAP articles published in peer-reviewed journals.
7. Do follow up on these meetings.
8. DO send a personalized thank you note.
9. When an agency begins to make referrals, stay in close touch and keep them aware of PCAP updates.

NOTE: It may take months for PCAP to establish itself and for referrals to start coming in on a regular basis. Don’t despair, be consistent and professional, and most importantly-- listen to the service providers so you can determine if there are concerns about referring to PCAP so you can then address those concerns.
Section Four – Enrolling Clients

Screening and Accepting Referrals

PCAP staff members, including the supervisor, case managers, and office assistant, are trained on how to take information from referral sources using the Community Referral Screening Questionnaire (CRSQ, see below). Staff members may need to make follow-up calls to the referral source to obtain more information about eligibility. If the referral source doesn’t have enough information, the PCAP supervisor may have to talk to the woman (the potential client) herself. Ask the referral source to ask the potential client if it’s okay for someone from PCAP to contact her. PCAP does not make ‘cold calls’ to women who have been referred by someone else.

The supervisor (not the case manager) is responsible for:

- Making final decisions about eligibility and determining who will be enrolled in PCAP. Supervisors often consult with other supervisors if they are unsure about whether or not a potential client meets the enrollment criteria.
- Contacting the eligible client to invite her to participate, ask her to come to the office for an intake interview, and inform her about the data collection and evaluation component of PCAP.
- Assigning the new referral to a case manager who will contact client and transport her to the PCAP office do the intake interview with the clinical supervisor.

The Community Referral Screening Questionnaire (CRSQ)

The Community Referral Screening Questionnaire (CRSQ) is used to standardize the referral process.

It may take time to obtain enough information to determine whether the woman is eligible. Throughout this time, it is critical to communicate clearly with referral sources regarding the woman’s status (e.g., whether she’s eligible; has refused PCAP; is missing and we haven’t been able to contact her, etc.) If a woman cannot be located or refuses to participate, the referral source must be informed so he/she will not assume the client (and child) are being monitored by PCAP.

For eligible, consenting women:
Inform the referral source of enrollment and name of case manager assigned to woman.

For eligible women who refuse or can’t be located:
Document all procedures used to contact the potential client and keep copies of all correspondence. Keep referral source informed as to the status of the referral and document this.

For ineligible women:
Refer to alternative, appropriate service provider.
If that assumption is incorrectly made, the child could be at high risk.

**Documenting Referrals**

Document all procedures used to contact the potential client and keep copies of all correspondence. Keep the referral source informed as to the status of the referral and document all contact.

**Referral documentation system:**

- Keep separate file folders for each year (e.g. 2017, 2016).
- Within these, keep files labeled:
  1. Pending eligibility decision
     (Note: this is for CRSQs that are in process and don’t have enough information yet to determine eligibility.)
  2. Eligible and enrolled
  3. Eligible but refused
  4. Eligible but not located
  5. Not eligible

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**A 3-year old child who was not in PCAP died in a tragic child abuse case. In the course of the investigation, local authorities questioned PCAP about why the mother had not been enrolled in PCAP at the time of the child’s delivery.**

**Because PCAP keeps careful documentation of every referral (not just the referrals that are enrolled), the clinical supervisor was able to go back to her referral records for the birth year, and find clear documentation that the mother had been referred to PCAP but ultimately did not enroll. At the delivery hospital, the Child Protective Services (CPS) worker had told the mother that she could take her baby home with her if she enrolled in PCAP. The mother said she would and the referral paperwork went to the PCAP site. The PCAP staff attempted to follow up with the woman, going to her home, phoning, and sending multiple letters. Eventually, the mother was located and told the PCAP staff member that she refused to enroll. PCAP had stayed in close contact with CPS throughout this process, and informed them immediately of the mother’s refusal to enroll. Documentation was clear that the mother and child were on the CPS caseload alone.**
Addressing Common Recruitment Challenges

Challenge: Community misconceptions about PCAP.

Nearly every new PCAP site has experienced some community providers initially misunderstanding or questioning our approach. Here are some examples:

- **PCAP enables women because you drive them and their children around and you don’t kick them out when they relapse.**
- **PCAP puts the focus on women who are clearly very bad mothers. The focus should be on the kids, who are the real victims here.**
- **PCAP doesn’t play by the rules. Your case manager called around and found a treatment bed that day for the client—that was my job (it’s just that I had a back log and wasn’t going to be able to get to it).**
- **PCAP expects clients to get special treatment just because they’re enrolled in your program.**

**Addressing the Challenge:**

**First**, reassure community providers that PCAP workers are mandated to report child abuse and neglect. At PCAP exit about 60% of clients have custody of/are living with their child. An important part of PCAP work is helping child welfare workers assure that the children are in safe, stable home environments.

**Second**, explain that most of the mothers in PCAP were themselves abused and neglected children just a decade or two ago. Most were born to substance-abusing parents, most were physically or sexually abused, and most didn’t finish school. No one intervened then, and these girls grew into women who have no template for what a “normal” home or healthy parenting looks like. Now they’re parenting the way they were parented. PCAP’s job is to show our clients another way and break this cycle of intergenerational substance abuse and dysfunction.

**Third**, a major part of PCAP’s role is to collaborate closely with other service providers and connect clients to services. In dealing with providers who have concerns about PCAP, case managers should enlist the help of PCAP clinical supervisors if necessary, in organizing case consultation meetings with service providers (after Releases of information are signed). Be
patient, professional, transparent, and consistent. As the work proceeds, stay in close touch and keep the provider aware of progress the client is making.

**Fourth**, inform providers that PCAP does not expect clients to get special treatment simply because they are enrolled in our program. While it’s true that PCAP does intervene on clients’ behalf when they don’t yet have the skills to solve their own problems, our larger aim in doing this is to address service barrier problems from the point of view of any woman going through that system, not just women fortunate enough to have a PCAP case manager.

**Challenge: How can you enroll a woman if – at the time of referral--she denies or seriously underreports her substance abuse?**

If the referral source says the woman used alcohol and drugs heavily during pregnancy but the woman completely denies use, we don’t enroll her in PCAP. The women enrolled in PCAP must **self-report some level of substance abuse during pregnancy**. Why? There are two reasons. First, if we enroll women who deny substance abuse at intake, then at program exit we will not be able to measure a reduction in substance abuse, which is a key outcome indicator of success in the PCAP intervention. Secondly, women who deny having an alcohol or drug problem **have no reason to be involved in PCAP**, a program whose primary aim is to help women address their addiction disorders and build healthy families.

**Addressing the Challenge:**
At referral, in order to know whether a woman is eligible the clinical supervisor must attempt to gain some trust with her so she will more accurately disclose her pregnancy alcohol and drug use. To gain a woman’s initial trust, the supervisor should do these things:

- Talk with the woman **directly**.
- Assure her of confidentiality, and assure her that we are not part of child welfare services.
- Describe the services PCAP offers and let her know that if she is eligible the case manager will work with her to help turn her life around; many of our case managers had life histories like hers.
- DO NOT try to persuade her by offering inducements (e.g. the possibility of housing); her interest in PCAP should be because she wants to stop substance use and make changes in her life.
- If she appears to feel shame or guilt because of using substances during pregnancy, tell her that especially in early pregnancy most women don’t know
they’re pregnant, and so they have no pregnancy-related reason to stop. If a woman is addicted, it is very hard to stop without help.

• If a woman continues to deny substantial alcohol or drug use, tell her: “It sounds like substance abuse isn’t a problem for you. That’s good. But it does mean you aren’t eligible for PCAP because PCAP is for women who do have a problem with alcohol or drugs and would like our help getting their lives together. Please feel free to give me a call if you’d like to talk more about this.” In many cases, a woman will call back a day or two later and tell the supervisor, “Okay I’ve got more to tell you…”

**Challenge:** Community providers may refer a woman to PCAP primarily because the woman needs housing or transportation services.

**Addressing the Challenge:**
PCAP is not a transportation broker or a housing agency, and we do not enroll women who are referred primarily for these or other specific services. Women are only enrolled in PCAP if they meet all eligibility criteria.

“When I get a call from a referring agency and hear, ‘She really needs housing; can you help?’ –that’s my first clue that this woman may not fit PCAP eligibility criteria. I give the caller housing resource phone numbers.”

―PCAP Clinical Supervisor

**Challenge:** How long do we look for a woman who has been referred, and can’t be located?

**Addressing the Challenge:**
Women are eligible for PCAP until the baby is 6 months old, and we continue to look for difficult-to-locate referrals until that time. If a client who was referred earlier responds to outreach efforts after 6 months postpartum, and there are open slots on the PCAP caseload, we will enroll up to 12 months postpartum.
Challenge: How much time and energy should PCAP staff spend locating difficult to find referrals?

Addressing the Challenge:
Clinical supervisors determine this depending on the capacity of the site.
- If the PCAP site is close to full capacity and has steady incoming referrals, or if the site has a waiting list already, then locating missing referrals has a lower priority.
- If the PCAP site is new or has many openings, and is in the process of establishing an identity in the community, then the staff has more time to pursue these referrals (up to 12 months postpartum).

Challenge: In order to look for a woman who has been referred but can’t be located, do we need releases of information signed by her?

Addressing the Challenge:
PCAP sites use all the information provided by the referral source to locate and engage someone who has been referred but not yet enrolled, including all telephone contacts. The information provided by referral sources is ‘protected’ that is, we may use this information to try and locate her. The responsibility for proper disclosure procedures is on the referring party, not the PCAP site. The referral source is responsible for letting the woman know that they have referred her to PCAP, and asking her if it’s alright if someone from PCAP contacts her to talk with her about PCAP.

Challenge: What is the best time to enroll a client (in relation to delivery of the target child)?

Addressing the Challenge:
The ideal is to enroll a woman as early as possible during pregnancy in order to reduce the extent of alcohol and drug exposure to the baby. However, most women are not ready to accept intervention during the first and second trimesters because the pregnancy is not a reality for them; they have not begun to plan for the baby, or may simply want to continue to “party” until the baby is born. If a woman is enrolled too early in her pregnancy it can work against efforts to engage her in PCAP because she may not be ready.

The closer a woman is to the birth of the baby, the easier it usually is to engage her in PCAP. Women who are beyond 6 months postpartum often feel they can handle taking care of their child without any extra help. Additionally, women this far postpartum may have already had their children taken away. If she hasn’t enrolled earlier, enrolling near the time of delivery is a good time because a mother is more likely to want and need extra help at that time.
Challenge: Are women ever enrolled in PCAP for a second round of intervention?

Addressing the Challenge:
PCAP has enrolled women for a second round. For example, a woman who completes PCAP but did not do well, or whose recovery was not stable, may be referred one, two or three years later because she is again pregnant and using. In order to be enrolled again, the woman must meet all three eligibility criteria. In addition, when considering enrolling a client for a second time the supervisor must have a frank and honest conversation with the client about why she thinks she would benefit from PCAP for an additional three years, i.e., what has changed, why should PCAP give her a slot in the program when she has already demonstrated that she did not want or could not use our help? Based on this information from the client, and consultation with other supervisors if necessary, supervisors may enroll former clients for a second round of PCAP. In our experience, about half of the clients re-enrolled succeed in the program.

Client Intake Process

The PCAP intake interview process:

- Is a thoughtful, nonjudgmental dialogue with the clinical supervisor that is the client’s first welcome and introduction to PCAP.
- Provides important clinical information about a client’s history and her current condition that the supervisor will use to help the case manager develop an individualized intervention plan.
- Provides the important baseline evaluation information.
- Is an ideal time for the case manager to transport the client, create a welcoming introduction to PCAP, and begin to get to know her.

PCAP Clinical Supervisor Role

1. Welcome the client and explain PCAP.
2. Tell the client that if she relapses or has setbacks she will not be asked to leave the program; she should call her case manager for help.
3. Review in detail, and have the client sign and date the Client Services Agreement and research Consent Form (in Washington State).
4. Administer PCAP Addiction Severity Index (ASI) intake interview.
Case Manager Role

1. Schedule interview with the clinical supervisor and the client.
   a. The ideal interview location is the PCAP office. If the client is in a
treatment or hospital facility, the interview may be conducted there only if
there is a private setting where they will not be overheard.
2. Inform client that the consent and interview process will take about 2 hours.
3. Transport client to the PCAP office for the interview. If a client offers to drive
herself, thank her and tell her we cannot do that (over 90% of these are no-
shows).
4. Provide childcare at the PCAP office if the client brings her children.

Frequently Asked Questions about Client Intake

Q: Why can’t the intake interview be done in the client’s home?
A: At intake, the client’s home situation is unknown and therefore unpredictable. In addition, the
client’s privacy may be violated within the home, as the interview may be overheard by children or
other adults. PCAP interviews need to be conducted under standardized conditions in a calm and
private setting. The ideal location for the intake interview is a private room in the PCAP office.

The intake interview must be completed before a client starts receiving PCAP case management
services.

Q: What if a client demands case management services (e.g., food, diapers, transportation) before
she has done her intake interview?
A: Remind clients that our system is similar to going to a doctor’s office—before she can go into an
exam room for physician services, she has to fill out the paperwork in the waiting room.

Q: What if a client can’t complete the intake interview in one appointment?
A: If a client becomes exhausted or stressed, if it becomes apparent that she is under the influence,
or if she has another commitment, the intake interview can be completed at another time,
scheduled as soon as possible. The interviewer should stop at the end of a section, so when they
resume the interview it will start with a new topic.

Staying Organized: The PCAP Client File

The purpose of the client file is to hold and organize information the case manager collects
and uses during the course of the intervention. Each client has a separate file. Information
in the client file should be kept up to date at all times so that it is relevant and useful to the
case manager and her supervisor. The office assistant assembles new files so case
managers have a clean file ready to start with each new client assigned.

Client files are never to be taken out of the office. When the case manager is not working
with a file it should be kept in the locked filing cabinet designated for that purpose. Files
should not be kept in the case manager’s desk. Supervisors should be able to locate any
case manager’s client files quickly and access information easily should a case manager not be available when action needs to be taken on a case.

1st Section:

Client ID Sheet (top sheet)

- Based on information collected from the client by the clinical supervisor during the ASI intake interview, the office assistant enters new client ID data into the client database and prints out the ID sheet for that client’s file.

- As the intervention proceeds, case managers will write updated addresses, phone numbers, references, etc., on the Tracing Update Log, and give the information to the office assistant, who will update the client database and print out a new ID sheet for the client file.

- Case managers should keep all previous ID sheets in this section of the file, and never discard old information as it may be valuable in tracing.

- Note: Client database content should never be deleted. When a client graduates or leaves the program for any reason, the office assistant should move client information from the “mom/baby” table to the “graduated clients” table.

Tracing Information Update Log

Use this form to record any new contact information you have for the client. For example, if she calls you from an unfamiliar phone number, or asks you to drop her off at an unfamiliar address, or mentions a favorite bar or restaurant where she goes, note this information on the Tracing Information Update Log as soon as you learn it. This information will help you locate the client if you lose contact with her, and having it in this specific place in the client file will save you hours of time (versus poring through last year’s case notes to find an address). Another idea for collecting information for the Tracing Information Update Log is to ask the client, “This is a special form. If we get in a car accident, and you have to go to the hospital, and I have your baby, who could I call?”

Client Services Agreement

Keep a copy of the Client Services Agreement (signed by the client and supervisor at the intake interview).
Section Four – Enrolling Clients

2nd Section:

Service Coordination Form
Every client has different community service providers with whom she works. The Service Coordination Form is used to organize this information.

Case manager Service Coordination tasks:
- At enrollment, using input from the supervisor (based on information obtained on the ASI intake interview) and input from the client, the case manager records the names and complete contact information for service providers with whom the client is already working.
- In addition, based on PCAP assessments done with the client (e.g. Difference Game, Goals, DLC), the case manager identifies new service providers she will be linking the client with to help her meet personal and program goals. The case manager records all provider contact information here.
- Before contacting service providers, the case manager obtains signed Release of Information (ROI) forms from the client that allow PCAP and the agency to share information regarding this case (see below). Signed ROIs are kept in the Service Coordination section (section 2) of the client file.
- Contacts service providers on the list and introduces herself, explains PCAP and her role as a case manager. Explains that case managers help their clients manage multiple life problems that might otherwise complicate and interfere with service provision by the professionals.
- The service provider may ask the case manager to scan/fax the ROI before they talk.
- As necessary, and with permission of the client, links providers with each other by organizing case consultations or conference calls, and acts as a liaison for communication within this network in order to avoid duplication of services or working at cross-purposes, and to alleviate manipulation by the client. Supervisors are often involved in these case consultation conferences.
- Continually updates Service Coordination forms so that another case manager or supervisor could pick up the client file and make important contacts if necessary; dates all new entries.
- Maintains a color-coded “dot” or other system to indicate which providers are current and actively working with the client (green dot), and which providers the client is longer involved with (red dot).
- Keeps prior Service Coordination contact pages in this section of the files, and never discards old information as it may be valuable in tracing.
Note: Clients’ service networks change over time. Early in the intervention, services commonly include alcohol/drug assessment and treatment, Children’s Protective Services (CPS), legal services including management of child custody issues, family healthcare, housing, family planning services, and basic needs. Later, clients in recovery begin to utilize education and vocational training resources in the community.

Releases of Information (ROI)
The purpose of ROIs is to give permission for the PCAP case manager to exchange information with the client’s other service providers, and to coordinate the efforts of the client’s service providers in order to help the client meet her goals.

- Before asking a client to sign a ROI, read it carefully to her and answer her questions.
- Introduce the ROI to the client by saying, “I’m asking you to sign this so I can talk to your other providers about how to better help you. It does not mean that I tell them everything. But without it I can’t let them know what you need, or tell them how well you’re doing!”
- Ask for ROIs as soon as you can after enrollment.
- Supervisors: consider asking client to sign basic ROIs at intake interview.
- Clients are not required to sign ROIs. If no ROI is signed for a provider, the case manager should note this on the Service Coordination form.

Filling out the ROI:
- Never have a client sign blank ROIs.
- Complete every blank on the form before asking a client to sign.
- It is OK to strike out a certain topic if a client doesn’t want you to discuss it with another provider (have client initial the strike out).
- Enter only one agency per ROI. Entering more than one agency on a ROI is a breach of confidentiality—providers will learn who else the client is working with.
- Generalize: for example, write “King County PCAP Staff” instead of one case manager’s name. Write “Evergreen Treatment Staff,” instead of a specific treatment provider’s name. Write “DCFS” instead of “CPS” because it covers the region. In addition, put the name and phone number of the specific agency provider on the back of the ROI.
- A ROI can be filled out for a period prior to, during, and up to a month or so after PCAP participation time.
• Keep ROIs up to date. Develop a good system for checking to ensure that they haven’t expired. Get new ROIs signed before they expire.

3rd Section:

Mother and Target Child Medications

Mother Medications:
Case managers record detailed information about medications the client is taking or has been prescribed, in order to:

• Help clients comply with taking their medications as prescribed.
• Remind clients when prescriptions need to be refilled.
• Have information readily available in the event that the client or medical providers need to know exactly what medications a client is on (for example, before a new medication is prescribed, prior to a surgical procedure, at an emergency room admission, etc.).
• Ask clients for medication information beginning at enrollment, and if possible, look at actual containers to determine name and dosage. Include medications for physical and mental problems, and family planning.
• Record this information on the Section 3 medications form.
• Update information as necessary, and date every update.
• More than one form may be used over the course of three years. Keep all previous forms in chronological order in the client file.

Target Child Medications:
Case managers

• Ask the client or foster parent for information about medications the child is taking or that have been prescribed for the child (for physical and/or mental health problems).
• Note any allergies the child has.
• Record immunizations the target child has received and when. In Washington State, this information can be obtained from the Washington State Immunization Information System.

See: http://www.doh.wa.gov/Portals/1/Documents/Pubs/348-367-IISAuthorizationForm.pdf or contact the WA State Immunization Information System at 1-866-397-0337 or email: WAIISRecords@doh.wa.gov
Section Four – Enrolling Clients

4th Section:

Assessments and Goals

Assessments

- Include copies of these assessment forms: Difference Game score form, Goals (updated/new forms every 4-months) Family Strengths and Needs, Difficult Life Circumstances (DLC), last page of ASI (profile of client needs).
- Note: Complete these initial assessments within six weeks after client enrollment. Review as soon as possible in supervision.

Client Goals

Goals and “baby steps” are evaluated and reestablished every four months because this amount of time allows clients to 1) Accomplish short-term, concrete tasks (e.g., complete paperwork for housing waiting lists or enroll in a neighborhood parenting class; and 2) Make progress on long-term goals requiring gradual life changes (e.g., staying in recovery or avoiding contact with former abusive partner).
(See details in Section Five: The Difference Games and Setting Goals)

Case managers:

- Complete goals/baby steps form with each client at enrollment (after administering the Difference Game) and every 4 months after that.
- Keep copies in the client file, most recent on top. Keep all previous forms in chronological order.
- Give a copy of the completed form to the client if she has a private place to keep it at home.
- Supervisors keep a copy of client goals forms to review progress with case managers on a regular basis during supervision.

5th Section:

Case Notes

Case notes serve as a narrative version of a case manager’s activity and a clients’ progress. If an auditor, other case manager, or supervisor picks up a file, she needs to be able to get a clear picture of who the client is, what has been done, what is working, what areas need attention.

Case notes could be important in an investigation. An accurate, truthful record of what has happened is important.

You don’t want a file that reads as if you did next to nothing with a client and providers. All attempts at contact with clients and service providers need to be documented. If a client refuses services, or is a no-show, it needs to be recorded. If a service provider doesn’t
respond to phone calls or email, or is a no-show for meetings, it needs to be recorded. You may need this documentation later to strengthen a case.

**Case Notes: Do’s and Don’ts**

- **DO** write case notes neatly, in ink. If you type case notes, they must be kept up to date, printed out weekly, signed, and put in client file.
- **DO** sign each case note entry with full signature (not just initials), date (including year), and put in client file.
- Use plain English. Avoid technical terms, jargon, and acronyms. If you use a new or unusual acronym, define it the first time you use it. [e.g., significant other (SO)].
- Avoid speculation and do not use subjective, judgmental statements.
- Do not discuss what you think the client or provider’s actions mean. Instead use direct quotes, or describe actual behavior you observed, e.g., “Concerned that the client may be seeing her old boyfriend as evidenced by....”
- **DO** keep case notes up to date, completing them by the end of each week.
- **DO** write notes that are useful to you.
- **DO** strike through mistakes and write above. Don’t use ‘White-Out’.
- **DO** record volatile situations, but also notify your supervisor immediately of these situations.

**Format for Writing PCAP Case Notes**

Charting good notes requires discipline. Keep case notes up to date. It is critical that you get in the habit of jotting down a few notes after every action or interaction. Complete case notes by the end of each week.

**Use the Description, Assessment, Plan “D.A.P.” system:**

**DESCRIPTION:** An objective description of pertinent information

- **WHEN:** Note ACTUAL DATE contact happened: month, day, and YEAR, and time of day if it was outside normal work hours.
- **WHERE:** Note location where contact occurred. Note the specific address if it’s a new location.
- **WHO:** Note EVERYONE who was present. If it is a new provider, add to Service Coordination form. It is okay to use names in your case notes, except for other PCAP client names. If referring to a PCAP client, just use her first name.
- **WHAT:** Note what happened (client, child’s care-giver, service provider)? Note purpose of visit, topics discussed, reactions, and outcome.

**ASSESSMENT:**

How is the client doing? Describe status, progress. Is she working toward her goals?

**PLAN:**

Make a plan for next step; a date for next visit. What needs to be done? When and by whom? Note any upcoming major changes/issues.
Electronic Case Note Security
Case managers may write their case notes on the computer. If they do they should follow these security protocols:

- Client and target child names or other identifiable information are never put into an electronic case note; instead, use the client ID # at the top of the page. Full names of others should not be in the case notes. Use initials or descriptor (e.g., “landlord” or “older sister”).
- Case notes must be printed out weekly, signed, and filed in the chart.
- The computer used or the case note file should be password protected.
- Notes may temporarily be saved on a thumb drive; they should never be saved to the hard drive.
- Case notes should be deleted from the thumb drive after they are printed out and filed.
- Because deleted files can easily be recovered, it is more secure to delete the text from the file before the final save (i.e., save an empty file). Then delete the file.
- Thumb drives should ideally have the capacity to be password protected and to have the data encrypted in case the thumb drive is lost.

6th Section:

Correspondence

- File correspondence in chronological order. **DO NOT PUT RECORDS FROM TREATMENT, MENTAL HEALTH, MEDICAL, etc. in the client file, or in a separate “dummy” file (there is no such thing).**
- All PCAP files can be subpoenaed. Paperwork from other agencies should only exist in a client file if you have a valid, up-to-date release of information for it. Otherwise do not keep outside agency records in any of your files. Doing so has the potential to put PCAP at legal risk. Instead, in client case notes, record relevant information from the outside agency document. For example, for documents from treatment agencies (e.g., monthly or other regular reports, discharge summaries) or from hospitals, doctors, or clinics: document that you received the report; the name and date of the report; diagnoses; recommendations (including meds prescribed); facts such as admission date and discharge date.
- Then shred document or return it to the owner. Do not assume the document or report belongs to the client. Whoever created the document (e.g. the physician, the therapist, etc.) is the only one who can authorize its release and re-release.
- **It is okay to keep a copy of dependency court orders.** This is public record and you are working with child welfare, the courts, and the client to work toward compliance. You do need a signed release of information for this and any other reports, correspondence, or letters in your file.
Best Practices: “Carry File”
- Create a “Carry File” containing blank pages of the forms you usually need in the field (e.g., ROIs, Service Coordination forms, Tracing Information Update form, Goals forms, Case Note pages, Medications Information forms, CRSQ).
- Biannual Assessment time is a good time to update everything in the client’s file.

Client File Supervisor Responsibilities
- The supervisor is ultimately responsible for content and quality of client files.
- Supervisors are required by contract to complete Client File Reviews (audits) every 3 months. (See Section Three: The Role of the Clinical Supervisor)
- Client file audit results may be used in personnel actions.
Section Five

Delivering the Intervention
The Intervention Part I: The Case Manager and the Client

Components of the Intervention

In brief, over the course of the intervention the case manager’s primary tasks are to:

- Assist clients in obtaining alcohol and drug treatment and staying in recovery.
- Connect women and their families with relevant community services.
- Coordinate services among this multidisciplinary network.
- Assist clients in following through with provider recommendations.
- Monitor cases to see that the children are in safe home environments and receiving appropriate health care.
- Teach clients the skills necessary to manage their lives successfully, including how to access community services themselves.

Establishing a Relationship

PCAP is a relational model, which means that the case manager’s first step is to create a bond and develop a positive, trusting relationship with her client. Many clients state that they have never trusted anyone before in their lives (including their own mothers, many of whom first introduced the client to drugs and alcohol), so this process may take months. Throughout PCAP, the case manager continues this ongoing process of developing the supportive interpersonal relationship.

Successful case managers are persistent and find unique, sincere ways to build trust without being pushy with the client. They:

- Tell clients a little about themselves, why they chose to do this work.
- Treat clients with respect and dignity.
- Role model honesty and integrity.
- Are not judgmental.
- Stop, breathe deeply, pay attention, and respond thoughtfully in problematic situations (versus reacting quickly).
- Act as a role model in all their activities with the client: basic skills, social behavior, parenting skills, household management, interactions with service providers, etc.
- Keep the client confidentiality; use Releases of Information.
- Uphold promises they make (e.g., household items, appointments, phone calls)
- Do not promise things that are unrealistic.
- Do not act as expert in situations where they are not, and instead connect clients to appropriate service providers.
- Do not make assumptions about how the client feels.

“There were times when I felt like I was going to relapse and my advocate would be there for me, and she’d keep checking on me and I’d get through it. I’ve learned so much about myself and being responsible again and being a good mother. It was all what she taught me—she changed my life for me.”

—PCAP Client

“My case manager never gave up on me. She kept believing in me until I finally started to believe in myself.”

—PCAP client
• Engage the family/friends involved in the client’s life.
• Stay in contact with clients: regular home visits (twice/month minimum), and in addition calls, texts, emails, and letters.
• Trace clients who disappear: make weekly attempts; continually obtain updated contact information.
• Continue to work with the client after an unpleasant incident, examine their own behavior and help client examine her behavior so both can learn to respond in ways that are more appropriate and effective.
• Understand that relapse is part of addictive behavior; tell the client that she will not be asked to leave the program because of relapse or setbacks.

Maintaining Healthy Boundaries

PCAP work involves close working relationships with clients over a long period of time, in home and community settings. Having healthy relationships between case managers and clients requires that boundaries be articulated and maintained. Early in the development of the PCAP model, we used a focus group process with case managers to identify essential home visitor boundaries. We require that these guidelines be followed (they are not suggestions) and we continue to refine them based on case managers’ field experiences, both good and bad. The boundaries touch not only on the content of conversations (e.g. “Case managers will role model/discuss aspects of their personal lives they believe are beneficial/relevant to a client’s progress and well-being, but will not discuss other aspects of their own personal lives. Ask yourself ‘Whose needs are being met?’”), but also on situations that arise in the course of the work (e.g., “Case managers will not buy goods or services from clients. PCAP staff will not hire clients for any service.”).

See PCAP Boundaries and Standards. PCAP case managers and supervisors are required annually to review, discuss, and sign this document.

It can be tempting for a case manager to rationalize an action (e.g., lending a client $15 so she can meet her rent payment deadline) that results in an unanticipated, poor outcome and a breakdown of the relationship. When case managers are at all uncertain about an action to take with a client, they are trained 1) to think about the potential “worst case scenario” (because worst case scenarios do happen); and 2) to consult with their supervisor prior to taking action.

If a case manager thinks she may have overstepped her boundaries, she is trained to talk to her supervisor to reduce potential consequences and prevent future boundary issues.
The First Home Visit

The first home visit takes place shortly after the client has completed the intake interview with the supervisor (thus the case manager may have already been to the home once before to pick the client up for that interview).

PCAP case managers are frequent home visitors (at least twice per month) who begin their work by building trust with the client and establishing an alliance with her family and social support system. It is important for case managers to be well prepared and thoughtful throughout the first home visit with a new client, as it will set the stage for the development of their relationship over time.

Before you go:

- Start the client file.
- Do a thorough briefing with supervisor about client, based on content of the intake interview.
- Take a gift, if available and appropriate (something for the new baby, photo album, a day planner or calendar).
- Take your business cards and give her several to distribute to her providers, put the cards in her purse, her refrigerator, the diaper bag, etc.

At the home:

- Discuss the purpose of PCAP and your role as case manager.
- Tell the client a little about yourself and why you chose to do this work.
- Assure client of confidentiality; remind her you are a mandated reporter, but you are not a child welfare worker.

Remind the client that she will not be asked to leave the program because of noncompliance, setbacks, or relapse. See Section One under Harm Reduction. Any undertaking that requires a person to make fundamental changes in long established behavior patterns (for example, losing weight or quitting smoking) will entail setbacks. Relapse should not be a surprise in the recovery process, particularly among clients with a long history of drug or alcohol abuse.

Instead, case managers work with clients to learn from their mistakes, identify triggers, and practice new behaviors and patterns. This policy has resulted in clients’ increased likelihood of overcoming shame after relapse, contacting the case manager quickly, resuming recovery (or treatment), and repairing the damage done. Case managers use
relapse experiences to help clients examine events that triggered the setback, and to develop resiliency strategies. When a client is able to successfully rebound from a relapse event, she develops self-efficacy as she observes herself coping, overcoming a crisis, and moving on.

Before you leave:
Make a plan for your next home visit including date and time, and what you both plan to do before then. Help the client put it on her calendar and/or in her phone, and give her a to-do list.

Establishing Ground Rules with Clients

As part of introducing the PCAP process, at the start of the intervention case managers review and discuss the Ground Rules with clients. **PCAP Ground Rules are not friendly suggestions for PCAP staff; they are an essential part of the model.** Clinical supervisors review essential ground rules with clients during the intake interview as part of the Client Services Agreement, and case managers remind clients of them as often as necessary during the intervention.

It is helpful to give clients a copy of the **Ground Rules**, and keep a copy in the client file to review if necessary.

**The Ground Rules**

At the beginning of the 3-year intervention, and periodically throughout the intervention, case managers review the ground rules with clients in order to clarify the nature of the relationship.

They let the client know:

1. “I’ll always be truthful with you. I won’t lie to you, or for you.”
2. “If you are high when we meet, I may decide to meet with you at a later time.”
3. “You can trust that I will be with you through ups and downs: there will be times you don’t like me. It’s okay if you disagree with me, but we have to keep communication open.”
4. “Please stay in touch with me and respond to my calls and texts, even if you’re using or not ready to meet with me in person, so I know that you’re okay.”
5. “I have other clients and there may be times when someone else’s emergency becomes the day’s priority.”
6. “My role is not to continually respond to your crises, but to help you move beyond crisis and toward achieving your goals.”
7. “I’ll be on time or will call you if I’m running late. Please call me if you are running late or have to cancel.”
8. “When possible, I will let you know ahead of time if I have to call CPS.”

(See **Section Five: Interfacing with the Child Welfare System**)

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“PCAP works with women for three years in their homes and communities and a lot of things can happen under those circumstances. We have opportunities for both close relationships and misunderstandings to develop. Case managers use ground rules from the very beginning to prevent misunderstandings that can mushroom into bigger problems that undermine the intervention.”

—PCAP Supervisor
9. “We’ll have a three-year working relationship, not a three-year friendship.”
   a. [Friendship: a reciprocal relationship with a close associate to whom secrets are confided or with whom private matters and problems are discussed.]

10. “Advocacy is a two-way street: “If you take one step, I’ll take three. You’ll get as much out of the program as you put into it.”

11. “I’ll let you know when you’re giving me too much information (TMI) about something I don’t need to know.”

12. “Here are my communication preferences/limits (e.g. with the cell phone)...”
   a. Explain these. For example, some case managers set a specific day/time to call certain clients twice a week.
   b. Discuss when to call ‘911’ vs. when to call the PCAP case manager.

13. “I don’t work ‘24-7’.”

14. “If we run into each other in public, I will ignore you unless you acknowledge me; in that case it’s okay to introduce me as a friend.”

15. “Let me know right away if I say or do something that offends you so I’ll know not to do it again.”

**Within the First Six Weeks**

Three important priorities in the first six weeks of the PCAP intervention are these:

1. Address the client’s major physical and mental health issues.
2. Use the ‘Difference Game’ instrument to help clients define initial goals and “baby steps” and begin to develop an individualized intervention plan.
3. Begin the practice of role modeling and teaching in all encounters with the client.

Other priorities in the first six weeks depend on the client’s unique situation. They may include, for example, helping a client arrange for housing or public assistance.

**1. Address Health Issues Early in PCAP**

Helping a client address her physical and mental health problems early in the intervention paves the way for a far more successful PCAP experience. When clients have unresolved physical and mental health problems, they are less likely to be able to take advantage of the services and support that a PCAP case manager offers. Alternatively, when case managers help clients identify and treat health problems, and regulate or stabilize physical and mental states, clients are far more likely to have the energy and ability to work on their goals. The earlier physical and mental health problems are addressed in PCAP, the more fully the 3-year intervention will be utilized.

*Case managers should avoid the mistake of waiting for a year or more into the intervention to realize that the client’s lack of motivation and action may be related to a treatable physical or mental health problem.*
Case managers should take the following steps with each client as soon as possible after enrollment in PCAP:

1. Locate key providers in the community who understand the kinds of clients we work with, and who are willing to work with them in a respectful, nonjudgmental manner. There may be only one general practice physician in your community who fits this description; if so, introduce him/her to PCAP, develop a good rapport, and send PCAP clients to him/her.

2. Obtain physical, dental, and mental health assessments at the start of PCAP.

3. Don’t assume that what you hear from clients and others is correct. Get releases of information so you can verify important health information (e.g., immunization status, birth control status, recommended medications).

4. Accompany clients to important appointments to help them communicate their symptoms and problems, and to help them understand what the provider says.

5. Help clients learn to keep a notebook and write down what the physician tells them.

6. Help clients get prescriptions filled.

7. Work with clients to develop a way to remember to take medications as prescribed and comply with recommendations for diet, activity, etc.

2. Difference Game and Setting Goals

Before you can begin to help a client set goals, you must learn what matters to her. In PCAP, advocates learn the client’s story by using the Difference Game (Grant, et al. 1997).

In the process of establishing a trusting relationship and conducting assessments, it is critical for case managers to engage clients in a meaningful way so the client has a voice and the assessment represents her reality. The more individualized and accurate the

Examples of Client Health Issues:

- If a client is suffering from an undiagnosed or untreated depressive disorder, it may render her not only incapable of working on self-improvement or court-ordered activities, but on a more basic level it may make it nearly impossible for her to get out of bed in the morning, or return phone calls.

- If a woman is suffering from a low-grade infection or chronic pain, she may have a very low energy level that makes it difficult for her to accomplish even the most rudimentary daily activities, much less take on the challenges of treatment, or job training.

- If a woman is suffering from tooth decay, other serious dental problems, or missing teeth she may be in chronic pain and/or be embarrassed to talk or appear in public.
assessment, the more useful it will be to the client and the worker as they create a service plan and monitor progress.

The Difference Game is a hands-on card sort assessment adapted from a scale developed by Dunst, et al. (1988). It consists of 31 laminated cards, on each of which is written a possible client need (e.g., housing, treatment). Clients who are uncommunicative, tense in a face-to-face interview, or uncomfortable with eye contact, can focus on the Difference Game cards and consider them at their own pace.

The Difference Game

- Helps clients put into words concepts that may be difficult for them to verbalize.
- Helps them consider domains of their life they may not have thought important or worth expressing.
- Allows the client to choose the most meaningful priorities on which to work, rather than having a professional determine what needs to be done. The client is therefore more likely to be honest with herself, mobilize resources, and utilize personal strengths.
- The emphasis is on client strengths, possibilities and desired outcomes.

How to do the Difference Game

Clients may not understand the word “Goal”. Here are other ways advocates use to describe the concept:

- What would you like your life to look like in the next few months, or in the next year, or in three years?
- What are your dreams for yourself and for your children?
- What do you want your life to look like?

Allow at least 30 minutes to administer the Game. First, ask the client if she would like for you to read the cards aloud. Next, ask the client to:

1. Sort the 31 cards into two piles --“yes” cards would make a difference in her life; “no” cards would not make a difference.
2. Choose from the “yes” pile the 5 cards that are the most important to her.
3. Rank order these 5 cards (1 to 5) according to what matters most to her at this time.
4. Now use these top 5 cards as the basis for a conversation to learn more about the client’s situation, discuss her needs, and plan goals/next steps you can take together. Pick up each card and ask the client, “Please tell me about this...”

“My case manager came to my house and we set goals that I wanted. That was a change. Usually when you screw up so much stuff you have to follow everyone else’s guidelines and what they think is right for you. I set the goal to enroll in college and also decided to get on birth control. My case manager helped me learn how to help myself. She taught me that I am worth it.”

—PCAP Client
Setting the Goals You’ll Work on Together & “Baby Steps” to get there

The Goals you set need to be SMART

- S = Specific
- M = Measurable
- A = Achievable
- R = Realistic (must take into account client’s intellectual & functional capacity)
- T = Timely

Talk about what you learned in the Difference Game

- Use the top five cards as discussion topics; they DO NOT necessarily become Goals.
- Based on your discussion, identify one or two goals that are realistic, manageable; and identify one “maintenance goal” (see definition below).
- Break the goal(s) into very explicit “baby” steps that are detailed, realistic and yet attainable and that you both will take. Identify who will do which baby steps.
- Record the goals and baby steps on the form.

- Turn “baby steps” into Weekly Goals (e.g., things you’ll each do in the next week and before the next home visit).
- End each home visit with a review of Weekly Goals.
• Update Weekly Goals at each home visit.
• Review and evaluate Goals and baby steps progress as needed, and every four months for the PCAP database.
• Re-establish next set of Goals and baby steps as needed and every four months.

**Maintenance goals:** When a client is making steady progress in an aspect(s) of her life, advocates reinforce this by helping clients identify a goal and baby steps that will help her maintain that success. Examples: If a woman is alcohol and drug free (even if only for 30 days), a maintenance goal might be to “Stay clean and sober”. Baby steps might be: “Go to my AA meetings 3 times each week; call my AA sponsor on Saturdays; stay away from my old drug dealing friends; take walks outside with my baby on Tuesdays and Thursdays and once on the weekend”.

If a woman is living in a stable and affordable apartment, a maintenance goal might be, “Stay in my current housing.” Baby steps might be: “Set aside my rent money at the beginning of the month and don’t spend it on anything else; pay my rent on time; do not allow anyone to spend the night whose name isn’t on the lease.”

**Difference Game Strategies**

• **Ask the client,** “*What’s been holding you back from doing that goal or that baby step?*” Help the client identify her barriers and take steps to address them so they will no longer hold her back.
• Don’t let a client crisis disrupt your work with her. **Use the crisis as an opportunity.** Teach the client to help herself by turning the crisis resolution into a Goal, with appropriate baby steps that need to be taken to resolve the problem.
• Based on client’s situation and goals, give her a personalized Resource List (names, phone numbers of her support people and providers) to have on hand so she can solve problems herself when they arise.

**Difference Game Reminders**

• First goals are often too lofty; they get more realistic over time.
• Clients will only be able to work on 1 or 2 main goals at a time.
• Maintaining progress: client can keep some of the same goals and baby steps for the 3 years (maintenance goals), e.g. staying clean and sober.
• Be flexible! Modify/add goals and steps as client’s needs change.
• At the end of every visit make a plan for your next visit, including appointment time. Do you each have a “to do” list? Does the client understand how to successfully complete the items on the “to do” list? How will the next visit relate to client/agency goals?
Section Five – Delivering the Intervention

• Expectation: Minimum twice/month face to face home visits.

“'She helped me establish goals; she's helped me achieve my goals. She's taught me responsibility, dependability. After three years of working with her, I see myself as a strong, independent woman.”

—PCAP Client

“Before PCAP I never thought about goals. They showed me the right direction. They showed me that I am responsible. That no matter who I am or what I do, I am somebody. It is never too late.”

—PCAP Client

Difference Game Example:
A client selected as her top card: “Time to get enough sleep.” As they discussed this and the client’s story emerged, the advocate learned that she and her two children were “couch surfing” The client did not sleep well because she was (appropriately) worried that one of the people in the temporary household (a registered sex offender) would abuse her four-year old daughter. In this example, although the top card selected was “Time to get enough sleep,” after discussion about what the card actually meant the goal became finding safe, stable, and affordable housing. Baby steps included the advocate finding an acceptable temporary housing option while they looked for a more permanent solution. At the same time, the advocate obtained and helped the client complete lengthy applications required for more permanent housing. As they dealt pragmatically with the housing issues, the client confided to the advocate that she had been sexually abused as a child. The advocate helped the client understand the value of talking with a mental health therapist about it, and about the opportunity she had to respond differently to the potential threat to her own child.

Using a Strength- Based Approach.
A critical strategy in helping a PCAP client succeed is to identify her strengths and abilities. Often an individual and those around her have difficulty identifying strengths. The PCAP case manager’s task is to discover what those are.

Ask:
What do you do well?
What do you like to do?
What do your friends and family like best about you?
What are your best qualities?
What are the strengths:
• In your family?
• In your community (including cultural strengths)?
• In developing goals and action plans, focus on using and building on strengths and abilities.
• Find ways to consistently tell the client what she does well and is good at.
3. Role Modeling and Teaching

Most PCAP clients simply don’t have the skills “their mothers should have taught them.” They rarely have a vision or mental template for what healthy adult life or parenting might look like, and their bleak backgrounds have done little to prepare them for these responsibilities. In addition, they typically have poor emotional regulation and interpersonal skills, and may respond to problems with other adults and with their own children with anger or withdrawal. The PCAP strategy of consistent support and role modeling is a powerful one that has the potential to help women change entrenched family patterns.

PCAP clients need help and guidance in understanding what healthy adult life and good parenting look like. Whether they seem to or not, clients pay attention to everything their advocates do. This requires that PCAP advocates behave as exemplary role models in all their activities with clients, including telephone etiquette, grooming, social behavior, interacting with children, soothing babies, household management, food choices, driving, etc.

Many clients may have neurocognitive impairments or lower levels of functioning than you would expect for their age level. “Telling” clients verbally is never enough.

PCAP teaching and role modeling includes the following components, done on a regular basis throughout the three-year intervention:

- Provide explicit “how to” direction and instruction, using multiple modes and simple step-by-step instructions (written and/or with pictures).
- Act as a role model in everything you do.
- Demonstrate skills you would like the client to learn.
- Ask the client to demonstrate and practice the skill so you can observe her.
- Always check for true understanding. Ask “What does this mean? How would you follow this? How would you complete this?”
- Praise the client for what she has done well.
- Offer constructive feedback in areas that need improvement.

“My advocate handled a lot of situations, and I learned through her how to deal with and talk to people.”
–PCAP client

“My advocate had a big influence on me and how I deal with things in my life.”
–PCAP client
Supporting Clients in Substance Abuse Treatment Programs and Recovery

The Challenge
Substance use disorder is a chronic illness, but only 11% of the 24 million Americans with a substance use disorder receive treatment. All of the women enrolled in PCAP have substance abuse problems, and most (nearly 85%) have been in inpatient or outpatient treatment in the past (an average of 2.8 times).

Stigma is a significant barrier to treatment, particularly for pregnant women. Other barriers to treatment for women include:
- Lack of access to gender-specific care
- Limited child-care availability at treatment facilities
- Few providers with obstetrics and addiction treatment expertise
- Fear of criminal or child welfare consequences

Among women in the U.S. who do receive treatment, treatment completion rates are low, ranging from 32% (SAMHSA, 2009a) or outpatient treatment to 52% (SAMHSA, 2009b) for short-term inpatient. Among substance abusing mothers involved in the child welfare system, treatment completion rates are even lower, from 22% (Choi & Ryan, 2006) to 26.5% (Gregoire & Schultz, 2001) including all treatment requirements, e.g., detoxification, inpatient, and intensive outpatient. Rates are higher (56.5%) for completion of only one treatment episode (Choi, Huang, & Ryan, 2012).

Why are completion rates low, and what are the risks?
One reason for low rates of treatment completion may be that women with substance use disorders commonly have co-occurring psychological or neurological disorders (Choi & Ryan, 2007; Miles, Svikis, Kulstad, & Haug, 2001; Minnes, Singer, Humphrey-Wall, & Satayatham, 2008; Zilberman, Tavares, Blume, & el-Guebaly, 2003). This not only increases the likelihood of treatment dropout (Bernstein, 2000) but also puts them at risk for poor or disrupted parenting (Grant et al., 2011). When a mother who has delivered a substance-exposed infant fails to comply with her alcohol and drug treatment regimen she is at risk for two things:
- Relapse or ongoing substance abuse.
- Risk that if she becomes pregnant she will have a subsequent substance-exposed infant.

Demystifying Substance Abuse Treatment.
Substance abuse treatment services may include:
- Assessment – An interview by a health provider to decide the services a client needs.
- Brief Intervention and Referral to Treatment – Time limited, to reduce problem use.
• Withdrawal Management (Detoxification) – Help with decreasing use of alcohol or other drugs over time, until it is safe to stop using. (This service does not include hospital treatment.)

• Outpatient Treatment - Individual and group counseling sessions in the community.

• Intensive Outpatient Treatment – More frequent individual and group counseling sessions.

• Inpatient Residential Treatment – A comprehensive program of individual counseling, group counseling, and education, provided in a 24 hour-a-day supervised facility.

• Opiate Substitution Treatment Services – Provides outpatient assessment and treatment for opiate dependency. Includes approved medication and counseling.

• Case Management – Help with finding medical, social, education, and other services.

(Source: www.dshs.wa.gov)

Before Treatment: What to Consider

1. Mandated treatment may be necessary.
   a. For a case manager to tell a client “You need treatment” and for a client to say “I need treatment” are two very different things. The ideal situation is obviously for a woman to decide for herself that she needs and wants this help. However, many clients are unwilling to acknowledge their substance abuse as the major stumbling block that it is, and take steps only after they are mandated to do so by a regulatory authority such as Child Welfare or the courts. Even those clients who do recognized that drug and alcohol abuse are having a severe impact on their lives may be hesitant to take the major step of beginning treatment.

2. Drug Court and Family Treatment Court are beneficial.

3. Seek treatment where children can stay with the mother in order to reduce the likelihood of the mother leaving treatment.

4. Seek women-only treatment settings.
   a. The most successful treatment programs our clients are involved in are those which provide long-term inpatient care for women only and allow children. These programs provide not only drug/alcohol treatment, but a safe place for women to begin working through the complex issues in their lives and a place where they can talk about difficult topics such as sexual abuse and domestic violence. Women who are in treatment with their children are in a protected environment where they can practice their parenting skills under the watchful guidance of staff.
   b. Most of our clients have lived in an atmosphere of chaos and trauma, growing up in substance abusing homes, experiencing abuse (sexual, physical, emotional), and not feeling safe and nurtured as children. These conditions have had a severe impact on their ability to trust and to parent their own children. Long-term inpatient programs give the women time to begin to examine these issues, and to learn and practice parenting skills.
During Treatment: What to Consider
1. Arrange for consistent child visitation (for children who are not with the mother).
2. Connect clients with service providers who can help her meet other needs (e.g. mental and physical health) and future needs (housing applications, etc.)
3. Help to arrange for post-treatment, transitional housing.
4. Stay in close touch; send notes of encouragement and cheer.

After Treatment: What to Consider
1. Relapse is part of the disease; be explicit and honest in discussing consequences with client. Develop a Relapse Prevention plan with the client. (See Section One under Harm Reduction).
2. Help client identify relapse triggers (e.g. people, places, special events).
3. Make specific safety plans for how to resist triggers and how to manage relapse if it occurs. This might include the client carrying with her a list of alternative things to do, and a list of names and phone numbers (including the case manager’s).
4. Introduce client to relevant support groups.
5. Remind the client that she will not be asked to leave PCAP because of relapse or setbacks. She should call the advocate if she relapses to help mitigate potential problems associated with the relapse.

Additional Strategies for Supporting Clients in Treatment, Aftercare, and Recovery
1. Be consistent in appointment days and times, routines.
2. Prepare the client in advance for any changes in appointment times or personnel.
3. Give the client a reminder call or text the day before an appointment (there’s a reason doctor’s offices do this – it improves compliance!)
4. Work with the client to set reminders of when they need to leave for their appointments (not the appointment time) on their cell phone or other device.
5. Give the client a small notebook to carry with her so providers can write down appointments, instructions, etc.
6. Help set up structure. Designate or help the client identify a trusted point person/mentor/treatment buddy for the client to call whenever she has a question or a problem or does not know what to do.

Supporting Clients in Recovery: Impulse Control
1. Help the client identify signs that she is beginning to get stressed or anxious (nervous jiggling, sweating, red face, clenched muscles.)
2. Help the client identify one or two things that help her calm down when she gets upset (taking a walk or run, ice cubes on face or wrist, deep breathing, doodling, soothing music.)
3. Talk with the client about the importance of using those techniques at the moment she is beginning to get upset.  
   a. This can reduce aggression and getting thrown out of programs.

**Supporting Clients in Recovery: Parenting Classes**

Parenting classes should always include the parent and child together. (Parent-only classes are like trying to teach someone to ride a bicycle without using a bicycle.)

Working one-on-one with the parent-child is preferable to group classes. Why?

- In this way the teaching is individualized and tailored to the mother’s learning style.
- There are many opportunities for role modeling, hands-on practice by the mother.
- Feedback is personalized and less threatening for the mother.
- The work is in realistic settings (in the home and in community); this decreases problems generalizing.

**Supporting Clients in Family Planning**

Helping women who cannot stop drinking or drugging to avoid becoming pregnant is one way to prevent future alcohol or drug-exposed births. The family planning objectives of PCAP are to reduce the incidence of future alcohol and drug-exposed pregnancies, and to reduce the incidence of unintended pregnancies among mothers who are in recovery. Clients who achieve a safe, stable, and sober lifestyle often choose to become pregnant because for the first time they will experience a healthy pregnancy and the opportunity to raise a child without the fear of having to relinquish the baby.

Family planning requires more than connecting women with services. PCAP staff must also take an active role in education and follow-up on family planning methods.

**PCAP 3-Year Outcomes**

Among 907 clients, during PCAP:

- 78.1% of mothers had no subsequent birth
- 9.6% had a subsequent birth not exposed to alcohol or drugs
- 12.3% had a subsequent birth exposed to alcohol or drugs

"Unplanned pregnancies can wreak havoc on every other aspect of clients getting their lives together."
- PCAP Case Manager

"Don’t expect that clients understand birth control even when they say they do. Small group discussions work very well. The women bounce ideas off one another; they realize that they are not alone, and that others have a lot of questions too."
- PCAP Case Manager
When a case manager introduces the topic of family planning, she often discovers that a client has already been thinking about it, or has tried a method previously. We may hear comments like these:

- “I am not sexually active now, so I don’t think I need to use birth control.”
- “I haven’t gotten pregnant for the last 2 years and I haven’t been using birth control, so why would I need it now?”
- “I tried it, but it made me gain weight, so I’m not interested.”
- “I don’t like to put chemicals in my body.”
- “I’m afraid of shots.”

**Case Manager Strategies for Family Planning:**

- Encourage clients to discuss previous family planning experiences they have had, or that they’ve heard about from sisters and girlfriends. If you don’t understand their fears, biases, and misinformation, you won’t be able to address these issues with clients.
- Help client identify pros and cons of having another child, revisit this topic.
- When reestablishing client goals every 4 months if the client is not using a family planning method, ask her: *How will having another child affect achieving these goals?*

**Supervisor Strategies for Family Planning:**

- In supervision, ask about each client’s family planning method.
- Note each client’s family planning method during chart reviews (every 3 months).
  - If a case manager has a problem discussing this issue with clients, ask her to accompany another case manager in the field who is more comfortable with the topic and whose clients are using family planning.

**Lesson from the field: Do not assume clients know how to use family planning methods**

In Washington State, approximately 40% of all women who have an unintended pregnancy are using a contraceptive method at the time they become pregnant. It is critical that case managers help their clients understand how to use family planning methods correctly, because medical providers do not always check that patients have true understanding. Even seemingly simple family planning methods, like the birth control pill, can be confusing to use. Clients have reported trouble taking pills correctly, e.g., missing pills and ‘doubling up a few days later’, or putting pills in her vagina. One client became seriously ill after using the NuvaRing incorrectly.
The Importance of Using Language the Client Can Understand

The extent to which clients are able to plan their lives, make better decisions, and take responsibility for what they do every day depends on their cognitive and functional capacities. A powerful advocate strategy for helping clients at all levels succeed is to communicate effectively.

Clients’ verbal expressive language skills (talking) are often at a much higher level than their verbal receptive language skills (listening and understanding). Yet verbal receptive language (listening) is the basis of most of our interactions with people in the social services system.

“Think Younger.” Adjust your expectations to be more in line with the client’s developmental level of functioning. Remember that it may be a case of “can’t” vs. “won’t” (Diane Malbin, FASCETS).

- Use short sentences, concrete examples, and avoid analogies and metaphors.
- Present information using multiple modes (written, illustrations, audio).
- Use simple step-by-step instructions (written and/or with pictures).
- Role-play.
- Ask client to demonstrate skills (don’t rely solely on verbal responses).

Always check for true understanding

- What does this mean? How would you follow this? How would you complete this?
- Revisit important points during each meeting/session.
- Avoid abstract (difficult to understand) language; instead use concrete (understandable) language.

Examples: Abstract vs. Concrete Language

<table>
<thead>
<tr>
<th>Abstract/Difficult to Understand</th>
<th>Concrete/Understandable</th>
</tr>
</thead>
</table>
| We have concerns about your parenting skills. | Please set up a daily schedule for your child that includes:  
1) When he eats,  
2) When he takes naps,  
3) When he goes to bed.  
Let’s write it down together. |
| What makes it hard for you to keep a schedule? Let’s make a plan to fix that. |
| Who can you call to ask for help? Where should we put their numbers? In your phone or on a paper for the refrigerator? Then help client based on answer. |
You need to find an appropriate way to discipline your child.

- It’s not OK to swear or yell at your child.
- It’s not OK to spank your child.

Let’s practice some things you can do when you are upset or frustrated with your son.

What are some things you would like to try the next time your son gets crabby?
Let’s make a list of those things.
Where can you keep the list so it is handy?

You need to check in regularly with your probation officer.

You need to call Diane’s office every Tuesday by 10 a.m. Here’s the phone number. Let’s program it into your phone to help you remember.

Where else should we write this down, in case you lose your phone?

I am going to call you the day before to remind you until you can remember on your own.

### Using Hands-on, Concrete Strategies

Advocates’ most effective teaching techniques are hands-on, concrete, and experiential.

**Laminated check lists.** “To do” and “reminder” checklists are strategies used by most people to organize their lives. Work with clients to create laminated lists that are visible, durable. Post in a prominent place (perhaps on the back of the front door so it’s a visible reminder before the client leaves the house). Possible checklists:

- What needs to be done every day before the kids leave for school?
- Who is not allowed in my house?
- What things need to be done to call my kitchen “cleaned up”?

This concrete checklist approach can be used in many situations.

1. Use a checklist with each step broken down and described in some detail (use photos of each step if possible).
2. Show the person how to put a check next to each step as it is done - they can see that when all the checks are competed the task is done.
3. Check in with the client on consistent days and times. Over time the person will be able to do more and more of the tasks herself.

**Vision boards, collages.** Crafts projects are popular with clients, and vision boards can be made with simple materials, e.g., tag board or cardboard, magazines, scissors, glue. Vision boards can be made in conjunction with goal-setting so the client can visually depict her
hopes and dreams for herself and her family. Vision boards/timelines can depict how a client’s life has changed through the PCAP intervention or how they want their life to change.

**Circle and Fence Activity.** This helpful, interactive activity should be used often throughout PCAP as clients evolve in their self-awareness and recovery. It is a clinical activity conducted by case managers during home visits.

*How it works:*
First, the case manager draws a large circle. Then she discusses with the client who is “in her circle”, that is, who are the people who are good for her, who help her stay on track and out of trouble, who are positive role models or friends. They write these names inside the circle. Case managers should accept all client contributions and record them. If the case manager disagrees with a client’s choice, she should use motivational interviewing strategies to discuss the person (e.g., develop discrepancy).

Next, on the same piece of paper the case manager draws a fence (or brick wall or other barrier). She brainstorms with the client about who should “stay behind the fence”, that is, who is not good for the client, who leads her into trouble, harms her, or is a bad influence. They write these names outside the fence.

Case managers keep this piece of paper so they can revisit the topic. As the client’s understanding about her relationships changes, or as events occur that might affect the client’s choice of friends, the case manager does a new Circle and Fence activity with her. This hands-on tool:
- Helps to remind clients who they should stay away from.
- Helps to reinforce the idea that the client has a choice about who to allow into her life, and that over time she can distance herself from dysfunctional relationships.
- Helps clients identify healthy people in her life who can be trusted and who might potentially become friends.
Pros and Cons Activity. This motivational interviewing strategy helps clients explore the positive and negative aspects of a decision they are trying to make. Record the client’s actual words so that it’s clear to her that that these are her own thoughts about important life decisions, not someone else’s recommendations. Keep this worksheet, review it later and add to it as the client continues to work through the decision process.

Motivational Interviewing “Readiness Ruler” Activity. The Readiness Ruler is an activity that asks a client to consider how she feels about changing her current behavior (e.g., substance use, going to parenting classes, whether to use a family planning method). It examines three aspects of change:

- **Importance** – The willingness to change/how important is it to the client
- **Confidence** – How confident is she in her ability to change
- **Readiness** – A matter of priorities/is she ready to make changes

**Advocate:**
1) Asks client to imagine there’s a long ruler on the floor marked from 0 to 10.
2) Asks the client questions below about the issue under discussion.
3) Asks client to stand on the number she selects.

**Example:**
On a scale of 1 to 10, how would you say you’re doing with those parenting classes CPS asked you to take? Advocate responses:
- You say you’re at a 5. Why a 5, and not just a 3? (Repeat her responses to her as she describes the positive steps she’s taking, and “defends” her progress.)
- What would need to happen for you to get to a 6 or 7?
- How could I help you in getting to a 6 or 7?

**Example:**
**Importance**: On a scale of 1 to 10, how important is it for you to make these changes?
You say you’re at a 6. Why a 6, and not a 4? (Repeat her responses to her)

**Confidence**: On a scale of 1 to 10, how confident are you that you could make a change if you wanted to?
You say you’re at a 5. Why a 5, and not a 3? (Repeat her responses to her)
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**Readiness:** On a scale of 1 to 10, how ready are you to make a change?  
*You say you’re at a 5. Why a 5, and not a 3? (Repeat her responses to her)*

In discussion with the client:
- Review past successes.
- Help client identify small steps that can lead to success.
- Problem-solve to address barriers.
- Provide tools, strategies, resources, and teach skills.
- Focus on the positive steps, the progress, on the strengths.
- Use setbacks as opportunities to problem-solve and examine how to avoid triggers.


**Working with Clients within a Family Context**

Effective case management is done within the context of a client’s family. To whatever extent possible, PCAP case managers establish rapport with the older children, the husband or significant other, extended family members, and close friends. Everyone in this network is involved in some way with the client’s substance abuse and related problems, and they will be affected as well as she attempts to break long established behavioral patterns. Family members may have a powerful influence over the woman. Gaining their trust (and hopefully their support for her recovery process) is a preliminary step that allows the case manager access and the opportunity to communicate with this important group throughout the intervention. It is important to remember, though, that the family’s support is not guaranteed and they may resent and resist PCAP’s ‘intrusion’ as case managers slowly help the client disrupt dysfunctional patterns and relationships.

The client will not be able to get well if her family members are not well. In the process of helping clients develop a stable home life and support system, case managers often provide referrals and service linkages for the client’s family members. For example, for the older children they may obtain summer day camp scholarships or arrange for school psychologist services; for a partner or a sister they may make referrals to treatment or job training classes; for the elderly grandmother who cares for the client’s children they may arrange for a neighborhood volunteer chore service.

Clients sometimes disappear for weeks or months at a time, leaving the children with family members. Having a close relationship with the family allows the case manager to continue to provide services on behalf of the children, as well as to learn the whereabouts of the missing client.
Case Manager Best Practices

Help Clients Clear Up Legal Warrants Early.
Case managers help clients clear up warrants early on in order to allow PCAP work not to be disrupted or hampered by a client’s arrest or fear of arrest. Case managers must be clear on the best strategy for clearing up warrants given a client’s particular circumstances.

• Do background research. The client may have outstanding warrants in many counties that she isn’t aware of or warrants for things she forgot about.

• Talk to the prosecutor or other appropriate personnel, clarify your understanding, and double-check!

• Collect documentation/support letters from treatment counselors, employers, schools, etc. regarding progress the client has made, and her commitment to recovery. Encourage the client to write her own letter explaining her progress and future plans, and why she is asking for leniency from the court.

• Have a well thought out plan that takes into consideration questions such as: if they arrest the client on the spot, what is the plan for her children? Who is available and willing to care for them, and for how long?

• Never take a client to court for old warrants on a Friday; if she is arrested she’ll be there for the weekend, with no arrangements made at home.

• Case managers have been successful in having all warrants quashed.

• Case managers have been successful in having 6 month sentences reduced to 3 days.

• Case managers have been successful in asking judge to allow the client a week to get affairs in order before appearing at the jail to do her time.

Have a Plan in the Event of Relapse.
Case managers let clients know that if they relapse, they should call PCAP as soon as they possibly can in order to get support in stopping the relapse and in dealing with consequences of the relapse. By doing this over time PCAP has seen longer periods of time between relapses, and shorter time in relapse. See Section One under Harm Reduction for details on Relapse Prevention and Safety Planning with clients.

Accompany Clients to First Classes, Meetings, Etc.
Accompanying clients to their first parenting class or AA meeting is a small way in which case managers can help clients overcome initial hurdles and nervousness that may prevent clients from getting started. Case managers use these opportunities to model behaviors such as how to take the correct bus route to a meeting, how to dress, and how to conduct themselves at a meeting.

Help Clients Enhance Safety and Improve the Quality of the Home Environment
An important role of the case manager is to teach the mother to pay attention to the quality of the home environment in order to make it safe and comfortable for the family. Steps to take include helping the mother to:
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- Turn away former acquaintances who drop by to party with her, or who need a place to sleep.
- If a case manager suspects that someone in the household (for example, a boyfriend) is abusing a child, they talk to the mother and notify Children’s Protective Services. The immediate aim is to stop harm to the child. The next step is to teach the mother to pay closer attention and recognize problems, to resist pressure from “friends” who pose a risk to her family, and to protect her children (or lose custody of them).
- Reduce the level of stimulation from loud music and other noise.
- Clean the house, remove trash, and keep potentially harmful items out of the child’s reach.
- Work with landlords to make repairs in electrical wiring or broken windows and install smoke alarms.

Promote Development of the Mother/Infant Relationship
The case manager is in an ideal position to give a mother information about her child’s developmental stages, discuss appropriate expectations, and show her appropriate, fun, and inexpensive learning activities she can do with her child in the home. The book noted in the text box to the right is an easy to use, concise reference guide that should be in every PCAP office for case managers to use in planning interesting, meaningful home visits. For example, in preparing for a home visit, a case manager would read the section relevant to the child’s age, copy the pages describing simple age-appropriate learning activities, and assemble/bring with her any materials needed (e.g. small containers or boxes, a ball). At the home the mother and case manager would talk about what’s happening at this stage of the child’s development, and play with the child as the case manager shows the mother how the learning activities are done. Case managers teach clients about behaviors that are normal and appropriate for children of different ages; role model positive ways of responding to a child’s behavior; and connect clients with specialists if warranted.

Home Visitation Activity Examples
Clients are sometimes impatient and harsh with their children, but case managers rarely observe signs of deliberate injury. For example, a baby who is learning to pick up and eat
Cheerios is likely to scatter the cereal and the mother may shout because she “made a mess.” A case manager uses this as an opportunity to demonstrate loving playfulness. She teaches the mother that the baby is developing fine motor skills and picking up Cheerios is good practice; she does a Cheerios pick up activity with the baby, and praises her.

- Sit quietly with the mother and observe the baby playing and responding to various stimuli. Show her the fun and delight possible in paying attention, observing, and seeing that her baby has a unique personality and communicates with every facial expression and gesture.
- Ask the mother and baby play for 10 minutes, while the case manager takes notes or phone video of what the baby does. This “Baby Can Do” activity illustrates to the mother the diversity and complexity of her baby’s behavior.
- Give the mother a “Baby Can Do” notebook (a simple note pad, or scrap book). Ask her to set aside play time with the baby each day, and jot down what she sees and notices: the baby’s funny faces, vocalizations, discoveries, responses.
- Ask the mother to do this every other day until your next home visit, when she can show the case manager what’s happened and how her baby is changing.

Personalizing Clients to Service Providers
Helping clients to “personalize” themselves transforms them from being a case number in the service provider system to an actual person who is known to the providers. Case managers can do this by helping clients send cards and write thank you notes to helpful service providers (including pictures of the kids if possible). Case managers can provide clients with stationery or note paper (PCAP sites can usually get these supplies donated from stores, especially at the end of a holiday); and teach clients to write a clear and polite note.

Use Creative Outreach Strategies, Humor
To engage resistant clients, use creative outreach strategies.
Examples:
- Make a handmade coupon offering the client Free Lunch with her case manager – priceless!
- A case manager dropped off a half-dozen diapers on a resistant client’s door step with a note saying she would like to meet with her. After no response, she did it again. Another time she left four. Finally she left only one diaper with a note. The client called and said someone must be taking the diapers off her porch. They finally connected and met.
**Minimize Distractions**

Case managers are more successful when they minimize distractions on home visits and during other time spent with clients. Minimizing distractions, e.g., turning off the sound on the TV, keeps the focus on the goals of the visit. On the other hand, some case managers find that listening to the radio in the car can help make the atmosphere more congenial and less awkward.

**PCAP Group Activities**

PCAP group activities can provide clients with opportunities to develop healthy friendships, have clean and sober fun, discover pleasure and joy, learn to play with their children, and learn life skills. A few examples of group activities organized by PCAP sites are family 5k walk/runs, arts and crafts workshops, holiday parties and summer picnics.

The most successful group activities include *active client participation*. For example, at holiday parties the PCAP staff bring plain sugar cookies and the clients work with their children to decorate the cookies; in a separate room PCAP provides gift-wrap materials and donated gifts and let the clients wrap presents for the children. Clients enjoy playing games like bingo, and having raffles and photo booths at events.

**Meaningful Incentives and Reinforcements** *(movie tickets, beauty salon, job clothing)*

Positive reinforcement is powerful, and clients are highly motivated when they have a reward to anticipate. Case managers pay attention to what is meaningful for their clients and offer those items as inducement or reward after an important goal is reached. To meet these needs, PCAP sites seek donations from merchants in the community, and in Washington State have received goods and services worth thousands of dollars including: zoo and movie passes, haircuts, grocery vouchers, gently used baby equipment, school items for older children, and more.
The Intervention Part II: The Case Manager and Service Providers

“Half of my job is getting other people to do theirs.”
- PCAP case manager

The underlying premise of case management is that everyone benefits when clients reach their optimum level of wellness, self-management, and functional capability.

Case management is defined as:

- A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs.
- A process characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.


1. **Beginning with a new client’s enrollment**, and after obtaining necessary Releases of Information from the client, case managers: Locate providers with whom you think client should be connected, based on Goals and “baby steps” client has identified. Consider service providers who are currently involved or working with the client (this information will be in the ASI intake interview).

2. Link clients with available and appropriate community services (PCAP does not provide direct treatment, health, or other services).

3. Use the PCAP Services Coordination form to record service provider information.

4. Coordinate efforts of the client’s service providers by organizing regular communication and case consultation among them, and including the client. The goal is to design a plan that will set clients up for success, not failure, and to prevent duplication of services, manipulation, and client falling through the cracks.

5. A hallmark of PCAP is to respond to phone calls, faxes, emails from other providers within 24 hours.

6. Assure that mother and baby actually receive and follow-up with services intended. Do not simply hand clients a list of phone numbers until the client is well into the intervention and has demonstrated that she can do this on her own.

7. If necessary, formal memoranda of understanding (MOU) may be drawn up between PCAP and key agencies at the onset of the program. MOUs describe services an agency can be expected to provide to our clients and what the agency can expect from PCAP.

**How to conduct a case consultation**
After releases of information are signed, and with a specific purpose for scheduling a meeting, a PCAP case manager arranges a meeting or conference call to bring members of a client’s provider network together (with the client present if possible). If the client plans to attend, the case manager helps her prepare by:

- Helping the client organize and write down her thoughts and articulate her concerns and goals.
- Role modeling appropriate phone and social behavior, and practicing with the client.
- Helping the client follow through with the plan.

**Example of a PCAP scenario:** A client was stable in recovery and complying with her family treatment court order that she attend outpatient treatment five mornings a week, and a probation requirement that she do urine screening twice a week elsewhere. Then, after being on a waiting list for over a year, the housing authority assigned her to a safe, low-income apartment, but it was in a neighborhood that would require her to make two bus transfers to get to her treatment destination. Because she was doing well, child welfare returned her two children to her custody. While these were all positive events, the client was overwhelmed and uncertain that she would be able to manage. The PCAP case manager organized a meeting with the client and the service providers involved. When the group communicated about the realities of the situation, the providers decided on a plan that would support the mother in her recovery, rather than set her up for another failure. They found a treatment facility (including urine screening capacity) near her new home.

**Resolving Service Barriers**

PCAP does not expect clients to get special treatment from other agencies by virtue of the fact that they are enrolled in our program. The very nature of PCAP advocacy, however, requires that when service barriers become apparent and clients do not have the skills to resolve problems for themselves, we intervene and speak up on their behalf. Our ultimate intent is to identify and effectively address service barriers from the point of view of any woman going through that system, not just women fortunate enough to have a PCAP case manager.

**Identifying barriers**

Service barriers are recurring problems with specific agencies or workers that are identified by the supervisor during the course of supervision or at weekly staffing meetings.

When is a “barrier” not a true barrier?
1. **When it’s a personality clash.**
   Depending on the day and the personalities involved, an individual case manager’s style could be interpreted as “pushy,” and be met with a defensive response from agency personnel. Other agency personnel might welcome the same advocate’s behavior as interested and energetic. Supervisors should be careful to note the type and frequency of barriers expressed by individual advocates.

2. **When it’s a misunderstanding by the case manager about the protocol, role, or limits of the agency.**
   In these cases, the case manager apologizes for her misunderstanding/mistake, finds out the correct procedures, and educates the other PCAP staff.

3. **When it’s an isolated incident.**
   Mistakes happen, and while lost files or missed appointments can be frustrating, it is not a systemic service barrier if the incident is isolated or not preventable.

4. **When it’s due to client error or misunderstanding.**
   A client may insist that an agency didn’t follow through when it was actually the client who missed an appointment, or a client may misrepresent to her PCAP case manager the recommendations they received from another provider. As early as possible in PCAP, case managers obtain Releases of Information from clients so they may talk with other providers about appointments and plans, and so they may investigate if a client complains about a system barrier. A client is more likely to succeed when everyone in her resource network is aware of, and in agreement with, her service plan.

**Addressing barriers: Moving from conflict to consensus.**

Identifying a service barrier is the first step. More challenging is communicating the problem to the provider, and working collaboratively to resolve it. PCAP’s goal is not to be confrontational, but rather to solve problems and work on building mutual understanding among providers so we can continue to serve families well. Our guiding principle in addressing barriers is that good communication with providers is crucial.

**What to do: Practical steps**
1. Know agency representatives by name and face in order to make interactions more personal and less bureaucratic. When people have met face to face they are more likely to develop a sense of personal responsibility to each other, and accountability for the quality of one’s work.

2. Deal with individual conflicts immediately as they arise. Try to resolve small problems before they become large ones. Make a polite phone call, leave messages. If your call isn’t returned that day, phone again the next day until you get a response. In extreme cases, when a PCAP case manager has needed feedback and was not getting a response from the provider, she has gone to the agency office and waited until the provider could see her. (Service providers have said after the fact, “We don’t like it, but it works!”).

3. Speak with an agency supervisor/manager if a provider is consistently inaccessible or if a problem persists. The supervisor doesn’t necessarily have to be drawn into the problem, but may be able to connect you. Simply requesting action at a higher level may motivate people to do their job.

4. Listen carefully to everyone’s version of the story (e.g., the agency representative, the client) without being confrontational or accusatory. Only after all the facts are known, and the “puzzle pieces” put together, can you begin to understand and resolve the problem in a reasonable and fair way.

5. **Before** an issue becomes a chronic barrier, invite an agency director or supervisor (and other staff if appropriate) to attend a PCAP staff meeting or a brown bag lunch as guests. The purpose is to:
   - Ascertain the functions and goals of both agencies.
   - Discuss specific problems that have arisen.
   - Devise strategies to resolve the situation.
   - Develop action steps.

   Invited guests should never be made to feel uncomfortable or defensive. Given the proper frame of reference, these meetings are brainstorming sessions that improve understanding and ultimately improve the quality of services for the clients. In the course of discussing specific problems, do not mention individual client or provider names. Client confidentiality should not be violated, nor should gossip about agency personnel be tolerated.

6. Ask if PCAP staff members may attend a staff meeting at the other agency. The agenda can include a brief description of PCAP’s role, an acknowledgment that you are all working toward the same end, and finally, a discussion of the problems you have encountered with the agency and questions about problems they may have encountered with PCAP.
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7. Airing difficulties makes it possible to address them, instead of trying to work around them or deny their existence.

8. Follow up on these meetings. Do whatever you agreed to do. Write a thank you note to the agency staff and PCAP staff for their input, and reiterating points that were agreed upon.

9. Schedule a follow-up conversation to discuss progress or status of the issue.

Interfacing with the Child Welfare System

PCAP staff are mandated to report child abuse and neglect as outlined in the PCAP Abuse and Neglect Protocol. As regular home visitors, they are in a unique position to identify problems that may place children at grave risk in families who would otherwise have disappeared from notice by health and social service providers. They instigate removal of children from the home when necessary.

The issue of child custody is a recurrent theme in clients’ lives because a majority of the women have had children removed from their care by the state. Regaining custody is a common goal stated by clients in their first year in the program, although case managers do not necessarily concur that reunification is in the best interests of the child/ren.

When possible, case managers will let clients know ahead of time if they have to call Child Protective Services (CPS) or child welfare.

PCAP case managers work closely with clients and CPS workers to assure that clients are compliant with CPS contract conditions and expectations. There are times, however, when PCAP workers believe it is necessary to make a report to CPS.

“**My job is to motivate my clients to THINK about their own lives, make better decisions, and take responsibility for what they do every day. I ask my clients, ‘Who’s driving this bus?’**”

—PCAP Case Manager

PCAP case managers try to avoid making reports to CPS ‘behind the client’s back.’ Typically, when a client is reported to CPS by a provider or family member, she feels victimized and blames the person reporting for being ‘the bad guy.’ PCAP does not want to alienate clients. Instead, our role is to present clients with the reality of their behavior, help them recognize areas that need to change, challenge them to take responsibility for their parenting, and offer support as they make changes.

When a child welfare report needs to be made

Ideal scenario: Client calls CPS herself with the case manager’s support and as a witness. In this case, the PCAP case manager:

1. Staffs the issue with her clinical supervisor.
2. Using motivational interviewing, discusses her concerns with the client and why she believes a report is warranted, and helps the client examine the circumstances.

3. Explains that because she (the case manager) is a mandated reporter she must see that CPS is notified.

4. Explains that if the client herself calls the CPS worker to talk about these early warning signs and difficulties, and ask for support/guidance, she will be demonstrating to CPS self-awareness, and the intent to take responsibility as a parent who wants to improve.

5. Before the call, practices the phone call with the client.

6. Is with the client when she makes the call to CPS.

7. Documents activities carefully in case notes and briefs PCAP supervisor.

**Second most ideal scenario:** Case manager calls CPS, after informing client first.

1. Start by taking the first four steps above. If client is unwilling to make the call, the case manager does so.

2. Ideally, case manager is with the client when case manager makes the call to CPS. If this can’t happen, case manager makes the call alone.

3. Document activities carefully in case notes, brief PCAP supervisor, and inform client of the outcome.

**When scenario #1 or #2 are not possible:** Case manager calls CPS.

1. Case manager staffs the issue with her PCAP clinical supervisor.

2. If the client is unable to be located or is unwilling to talk about the issues, the case manager calls CPS to make the report.

3. Document activities carefully in case notes, brief supervisor, and inform client of the action and the outcome.

The turning point for successful resolution of child custody issues occurs when the mother realistically comes to terms with her ability to parent, and is willing to consider the best interests of the child. For some mothers this means deciding to relinquish custody to a foster family who has bonded with the child and would like to adopt. For others it means staying in recovery and doing whatever is necessary to resume or maintain custody of her child/ren. Regardless of who has custody, case managers work on behalf of the child to secure a safe home environment and regular healthcare.

**How PCAP and child welfare services work together**
In general, PCAP and child welfare services work closely together. However, in some locales child welfare recommendations may be based on biased attitudes and beliefs, or lack of information and experience.

As advocates, PCAP case managers help clients comply with their individual contracts and act as liaisons between the child welfare agency and the client. Case managers keep careful documentation and maintain releases of information so they can communicate with all parties, verify compliance or non-compliance, and advocate accordingly upholding agreements made in the contract.

PCAP case managers count on child welfare workers to:

- Follow required procedures.
- Attend scheduled meetings.
- Complete tasks they agreed to do.
- Come to meetings prepared.
- Provide or arrange for required child visitation.
- Assure that child custody is not awarded to a family member with outstanding warrants or with a known history of child sexual abuse.

In some cases, CPS will decide not to investigate after a report is made, or will decide to close a case earlier than the PCAP case manager thinks is wise. In these cases, our work is made more difficult because we do not have the strong arm of the civil agency charged with child protection. PCAP case managers continue their work, do home visits, and maintain a watchful eye while the mother remains in the program. In extreme cases PCAP has asked the local police to go to a mother’s home to do a ‘well child check’ on behalf of the children.

**Interfacing with the Legal System**

PCAP staff are sometimes requested and/or subpoenaed to provide testimony in administrative or civil proceedings, or they may receive a subpoena to produce documents. The [PCAP Legal Protocol](#) provides guidance in responding to these requests.

Some of the details in the Legal Protocol are specific to Washington State PCAP, but the information and recommendations can be generalized to PCAP sites elsewhere. PCAP sites affiliated with local agencies or institutions should, in addition, seek guidance from their agency legal counsel.

*Note: In Washington State, PCAP research records (not clinical records) are protected by a federal Certificate of Confidentiality issued by the U.S. Department of Health and Human Services. This Certificate protects the research records from subpoena, meaning that in Washington State PCAP staff cannot legally be forced to release identifiable information about the research records.*
Exit Interview: In brief

**When:**
- The target window time for scheduling the exit interview is one month before or after the client’s exit or “graduation” date.
- Early exits can be conducted up to 6 months before exit date if necessary.

**Where:**
The office (ideal)
- Interviews take place in the exit interviewer’s office or in a private room at a PCAP office. Ideally the case manager accompanies the client to introduce her to the interviewer.

Home or neutral location
- If the client cannot come to a PCAP office, the interview can take place in the client’s home, or at a neutral location as long as privacy can be insured and childcare is arranged.

Phone
- As a last resort, the interview can be done by phone, as long as the client can arrange for privacy without interruption. Interviewer arranges for consent forms to be signed and mailed to interviewer first.
Section Six

Special Considerations and Challenges in Working with the Target Population
Recognizing Potential Challenges

PCAP works with an inherently challenging population. Recognizing potential challenges can enable staff to better understand behaviors they encounter and work with clients to set realistic and reasonable expectations and goals.

All of our clients have serious substance abuse problems: Substance abuse can cause cognitive problems and psychiatric symptoms. Cognitive problems can include: memory loss, learning problems, and impaired decision making. Psychiatric symptoms can include: anxiety, impulsivity, paranoia. These symptoms can clear when a person stops using, but it takes time because the brain needs a drug free environment to heal. It is not uncommon for behavior to temporarily worsen after clients initiate treatment and stop using, as the brain “remaps” itself.

Functionality of clients can be compromised for other reasons, including:

1. **Psychiatric co-morbidity.**
   
   Nationally, about 30% of women who have a substance use disorder have a co-occurring serious mental health disorder (typically anxiety or major depression). Within the PCAP client population, approximately 50% of women self-report a psychiatric co-morbidity at enrollment.

2. **Clients themselves may be exposed prenatally to drugs or alcohol,** and may subsequently experience a Fetal Alcohol Spectrum Disorder or other effects of prenatal exposures. Over 90% of the PCAP client population report having a mother or father who used drugs; over 50% report having mothers who were substance users.

3. **History of traumatic brain injury.**
   
   Nearly 50% of PCAP clients were physically abused as children and 75% have been beaten as adults. Many have been involved in serious accidents. Traumatic brain injury (TBI), if unrecognized and untreated, can affect a person’s cognitive abilities, memory, behavior, emotional control, and mental health. Among 1,150 PCAP clients, 33% have sustained a serious head injury during their lifetime. This is perhaps not surprising, given that PCAP clients report high rates of physical abuse both as children (approximately 40%) and as adults (approximately 70%).

Working with Clients Who Have Fetal Alcohol Spectrum Disorder (FASD)

Fetal alcohol spectrum disorders (FASDs) are conditions caused by prenatal alcohol exposure in amounts sufficient to cause permanent impairments in brain functioning. The
extent of damage largely depends on timing, dose, frequency, and pattern of exposure. Prenatal alcohol exposure during critical periods of gestation can produce varying patterns of neurocognitive deficits, behavioral impairments, and adaptive problems.

**Behaviors Typical of FASD**

**Poor Executive Functioning**
- Difficulty organizing stored information to plan future activities
- Difficulty regulating and sequencing behavior
- Difficulty inhibiting responses and delaying gratification
- Lack of cognitive flexibility
- Poor judgment

**Difficulty with Incoming Stimuli**
- Gets overstimulated in social situation (a crowded room, or among strangers)
- Overreacts to situations with surprisingly strong emotions
- Displays rapid mood swings set off by seemingly small events
- Has poor attention span
- Has trouble completing tasks

**Identifying PCAP Clients We Suspect Have FASD**

At PCAP intake, the clinical supervisor asks clients:
- “Did your mother ever have a problem with alcohol?”
- “Did she drink alcohol when you were young?”
- “Did she drink alcohol while she was pregnant with you?”
- “Is your biological mother alive? If not, how old were you when she died?”
- “Were you raised by someone other than your biological parents?”

In addition, the clinical supervisor may ask about behaviors common among people with FASD:
- Impulsivity
- Doing the same thing over and over, even if it has caused problems
- Trouble learning in school
- Problems handling money
- Out of control behavior/assaults precipitated by a stressor
- Crimes as a secondary participant
- Repeated minor offenses
- Failure to follow through with services / recommendations

If you suspect a client may have FASD, help the client obtain a neuropsychological evaluation.
- Should be conducted by a neuropsychologist who is knowledgeable about FASD.
- Provides a “roadmap” that identifies cognitive and functional strengths and deficits.
• Helps clarify how client learns best.
• May be critical for obtaining disability benefits.


Strategies for Working with Women Who May Have FASD

Determine the client’s level of functioning: Does she …
• Overreact?
• Have trouble keeping money?
• Have trouble using numbers in daily life (estimating time, distance, costs)?
• Have trouble remembering?
• Lose her temper unexpectedly?
• Have ‘friends’ who take advantage of her?
• Fail to follow through with appointments?

Remember that not all clients who have FASD are alike. It may be a case of “can’t” vs. “won’t.”

What You Can Do

1. Revise your expectations based on client’s level of functioning.
2. Set reasonable goals.
3. Help set up structure and consistency.
   a. Be consistent in appointment times, locations, and providers.
   b. Be alert for changes/transitions—monitor more carefully, do advance problem-solving.
5. Learn client’s “unique” language patterns.
6. Present information strategically:
   a. Use multiple modes.
   b. Simple step-by-step instructions (written and/or with illustrations).
   c. Role-play.
7. Ask client to demonstrate skills (don’t rely solely on verbal responses).
8. Revisit important points during each session.
9. Teach generalization: Don’t assume a skill learned in one context will transfer to another.
10. Help client identify physical releases when escalating emotions become overwhelming.
11. Assess client vulnerability to victimization.
Suicide Risk among Individuals Who Have FASD

The rate of suicide attempt among adults with FASD is 23%. This is five times higher than the general U.S. population rate of 4.6%.

**FASD Suicide Intervention/Prevention**

1. Recognize client is at increased risk for suicide.
2. Refer client for mental health evaluation/treatment.
3. Alert provider about possible cognitive issues.
   b. Modify to accommodate neuropsychological deficits and communication impairments. For example, instead of “How does the future look to you?” ask “What are you going to do tomorrow? Next week?”
4. Check for a disconnect between seriousness of the suicidal behavioral and the level of intent to die.
5. Obtain family/collateral input.
6. Address basic needs and increase stability.
   a. Treat depression.
   b. Teach distraction techniques.
   c. Remove lethal means.
   d. Increase social support.
7. Do not use suicide contracts (because these clients tend to be very impulsive).
8. Monitor risk closely.
9. Reinforce and build reasons for living.
10. Strengthen advocate-client relationship.


**Motivational Interviewing (MI) with People Who Have FASD.**

**How?**

- Listening to the client builds the relationship.
- Case manager “teaches from the event” when problems occur, reflecting back to client the consequences of the client’s own actions.
- Keeps the focus on “How can I help?” or “This is what I can do to help” (vs. “I told you so”).
- Focuses on client’s strengths.
- Client’s self-efficacy is influenced most powerfully by her own accomplishments.

**MI Modifications for FASD Clients**

The provider may need to be more active in helping the client examine her behavior.

- Discuss events immediately.
- Identify steps that led to the event vs. let client discover them.
• Ask more close-ended vs. open-ended questions.
• Offer solutions and have client choose best option.
• Explore choices visually if possible.
• Teach the client to ask for what she needs from the people in her life.
• Help the client think about assets that are available. “Who is helpful to you when you have a problem?”
• Teach the client to carry a notebook wherever she goes, for providers to write down instructions, appointment times, etc.
• Help the client find an activity that’s calming, comfortable, fun, and easy to access (music, swimming).

Using the Difference Game with clients who have FASD
1. Give the client the cards one at a time.
2. Select one or two reasonable goals.
3. Identify “baby steps” it will take to reach each goal.
   a. Assign the client one or two baby steps at a time and have her report back.
   b. Reinforce every step in the right direction.

The Protective Payee

A protective payee is an individual, other than the client and other than a PCAP staff member, who manages the family's money and benefits for the purpose of safeguarding the health and welfare of the family.

Clients with FASD often have a poor idea of how money works and how to manage it. PCAP case managers can assess a client’s understanding of money by watching how she counts money, understands her bills, and describes transactions with others. Having a protective payee is preventive: it help the client avoid running out of money, giving money away, getting services cut off, etc.

Women with FASD as Parents

For clients who have FASD and are parenting, a critical task for PCAP case managers is to identify educated, committed family members or mentors nearby who can and will observe, guide, and intervene when necessary.

Case managers should assess the mother’s ability to:
• Respond to and manage emergencies successfully
• Pick safe people to be in their children’s lives
• Maintain housing
• Pay their bills
• Provide appropriate learning opportunities
• Pay attention to their children as individuals
• Understand children’s developmental stages
Parenting classes
Parenting classes for mothers with FASD tend to not be effective. Instead, working one-on-one with the mom and child is a “good fit” for FASD clients. Why?
- Individualized intervention is tailored to the mother’s learning style.
- Many opportunities for hands-on practice and role modeling.

The work is in the real settings of the home and community on “field trips”, which increases true understanding and decreases problems generalizing lessons to different settings.

“I really liked working with my PCAP case manager. She was very supportive and taught me to be more observant of my kids. If they do something now, I know they are trying to tell me something so I try to respond. I am trying to reverse the chain. I got beat up as a kid. I didn’t get anyone who sang to me or played with me. I am trying to do these things with my kids, A. taught me how to do this.”
— Mother who has FASD and two children under age 2

Improving Treatment Completion among Women with FASD
Consider:
- Group (distracting) vs. individual (focused) therapy.
- Assigning a ‘treatment buddy’ to help her understand and comply with house rules.
- Creative ways to prevent/deal with outbursts and poor impulse control (try an ice water face bath, ice cubes on wrists, jump roping or other safe physical outlets).
- Alter their environment to accommodate to their disability (a quiet room).

See Section One for relevant publications on FASD and FASD interventions.
Section Seven – Managing Client Status Changes

Section Seven

Managing Client Status Changes
Client Exit Procedures

Beginning at 24 Months

Throughout PCAP and especially during the client’s final year in PCAP, a primary role of the case manager is to help link the client and her children to mentors, resources, and programs that will endure after she graduates from PCAP. Procedures for guaranteeing the child’s safety and stability need to have been set in motion well before the end of the 36-months in PCAP.

During the last year in PCAP, discuss with each client:
- Accomplishments she has achieved during the course of the program. This reflection can be a powerful source of self-esteem.
- How to build upon goals already achieved. Designing strategies to attain future goals is a good method for focusing attention on the future rather than on leaving PCAP.

At Client Exit

The case manager-client relationship ends after 36 months in the program. This can be positive when conceptualized as a transition to a new phase or a beginning rather than an ending.

The work that the case manager and client have done over the past 3 years forms the springboard for this new phase.

Case managers are responsible for facilitating closure with clients and the client family and/or service provider team. Case managers facilitate this closure through letters and special graduation events including dinner or a party for the target child.

The client exit process involves data collection: the exit interview, and a case manager-client relationship inventory - administered by an interviewer who is not the PCAP supervisor or case manager.

Supervisor Responsibilities
- Keep track of clients who are graduating.
- In supervision, monitor the tracing and scheduling of all clients due to graduate.
- If the client is out of contact as graduation approaches, make every attempt to help the case manager locate and schedule the client for an exit interview.
- If the client has been lost, but is found prior to the graduation window, the exit interview may be conducted early. The supervisor should discuss early exit decisions with the case manager.
- Provide exit interviewer with database-generated client ID information.
- Write brief ‘thank you for participating’ note to client.
Case Manager Responsibilities

- Schedule exit interview to be conducted at PCAP office
- Transport client to/from interview
- Provide childcare during interview
- Create a Certificate of Graduation for each client

Exit Interviewer Responsibilities

- Administer consent forms
- Administer exit Addiction Severity Index (ASI) interview
- Administer Case Manager-Client Relationship Inventory
- Provide client with $20 grocery gift certificate or cash as compensation for the interview

Possible Graduation Activities

Case managers use their creativity to arrange individualized activities with clients to mark what is for many clients a milestone occasion.

Case Manager Letter to Client

An individualized, personal letter to the client from the case manager at the end of the program is a powerful tool. The case manager describes what the client has meant to her, what she has taught the case manager, how she helped the case manager grow personally and professionally, and the belief the case manager has in the client’s worth and potential. Obviously, the nature of the relationship with each client will be different, and these letters will be written at the discretion of each case manager depending on the context and quality of the relationship.

Arrange a Special Event

- Surprise the client with lunch or dinner at a special restaurant. Tell the client you’ll pick her up, ask her to dress up and find childcare. Call the restaurant ahead to see if they’ll deliver a special dessert to the table (for example, a small cake with the client’s name on it), take a photo, etc.
- Celebrate the target child’s third birthday with a wrapped gift.
- Help the client organize a small birthday party for the target child’s third birthday.
After Client Exit

The case manager-client professional relationship ends after 36 months in the program, and case managers will be taking on new clients on an ongoing basis. After a client exits PCAP, the case manager-client relationship is guided by the following policies:

- Clients are welcome to call the office and/or the case manager for information, referrals, and letters of recommendation.
- Case managers may not do home visits, provide transportation, or make appointments for former clients. Supervisor must approve exceptions.
- In the case of friendships that have developed, time together should not be during work hours, and is not recorded on the Weekly Time Summary form.

Clients Who Leave the Program Early

PCAP sites can expect that about 30% of the clients who are enrolled will not complete the 3-year program. In Washington State PCAP, among 763 mothers enrolled during a recent period, a total of 132 (17%) did not complete the program for the following reasons:

- Disengaged or disappeared and could not be located in spite of intensive tracing efforts (n=45)
- Moved out of the area (n=37)
- Withdrew voluntarily because they did not think they needed PCAP (n=35)
- Died (n=10)
- Were sentenced to a long prison sentence (n=5)

What if the client or the target child dies during PCAP?

In case of death of either client or target child, the case manager notifies the clinical supervisor and completes a case note in the file re: circumstances of death. The clinical supervisor reviews the case file and debriefs with case manager and provides support.

The case manager offers support and assistance to the family.

The PCAP director and program evaluator are notified by email; using client ID#, not names. We do not request death certificates from the State. A PCAP notification of death should be completed on the online the database.

If it was a client death, we may continue to provide PCAP services to the target child and caregivers until the end of the 3-year agreement. The client file stays active as long as we provide case management to the target child and caretakers. If the target child is not receiving PCAP services, the case file should be closed and stored.

If it was a target child death, the client is welcome to stay in PCAP until the end of the 3-year agreement. Many clients whose target child dies choose to leave PCAP after a few months.
An additional 108 (14%) participated in PCAP but did not complete the 3-year exit interview for the following reasons:

- Repeated no-shows for the exit interview
- Did not want to end PCAP
- Could not be located
- Were too busy

Women are not dropped from PCAP or asked to leave because of relapse or setbacks; however, our best practices caseload size is limited to 16. If a client has moved out of area or has not engaged in spite of intensive outreach, the clinical supervisor may ‘un-enroll’ her so we can create an opening and give another woman an opportunity to enroll in PCAP.

Un-enrollment is a decision made by the clinical supervisor (not case managers) on a case-by-case basis. It requires careful consideration and input from colleagues. Clients who are un-enrolled may not reenter the program. The clinical supervisor:

1. Prepares a short description of case details. Pertinent information includes:
   - enrollment date, did the client complete the intake process (ASI parts A and B),
   - number of face to face contacts, location and custody of the target child,
   - information about the woman’s whereabouts, steps the case manager has taken to try to locate and engage the client.
2. Presents this information to other clinical supervisors and the program director at a PCAP quarterly administration meeting, or sends it via email.
3. If the group concurs that there is nothing else we can do to engage the client, a decision is made to ‘un-enroll’ her.
4. Notifies the program evaluator via email so these cases can be identified in the database.

There are two categories of un-enrollment: un-enroll and withdrawal. A client may be declared an un-enroll or withdrawal after any length of time in the program if she meets any of the conditions below.

1. **Un-Enroll:**
   A client is un-enrolled from PCAP if she meets one of the following conditions:
   - Intake ASI never completed because client could not be located or for other client-related reasons.
   - Intake ASI completed, but client never engaged with case manager.
   - Client was engaged with case manager for a period of time but now has not been engaged for a period of time (4 to 6 months typically), and she does not give signals that she is likely to engage in the future.
   - Client moved out of the area and is not likely to move back in near future.
   - Staff discover a client misrepresented herself and she is actually ineligible for PCAP.
2. **Withdrawal:**
The PCAP consent form states that participation is voluntary and clients may withdraw. If a client states that she wants to leave PCAP, the clinical supervisor:

1. Discusses the issue with the case manager.
2. Has a conversation with the client if possible to determine her reasons, how serious she is about this, and whether there is something PCAP has done to dissuade her, or can do to re-engage her.
3. Gives the client several weeks to consider her decision if it seems to have been impulsive or an angry response to an issue with a case manager.
4. Notifies child welfare or the courts, if they had mandated the client to participate in PCAP.
5. Documents all steps above.

### Active Clients versus Non Active Clients

"Active client": engaged with the program, sees her case manager (two times/month on average is the ideal), returns phone calls.

"Non-active client" (or "backburner client"):

- Client has been out of regular contact for a period of time; case manager may not be certain of her whereabouts, but is in contact with tracing sources and has a reasonable expectation client may re-engage with the program.
- Client is not engaged but she still has the target child and is still abusing substances.

Case managers continue to trace/search for backburner clients. Backburner is often a precursor to un-enrollment from the program, depending on whether the woman reappears within a reasonable length of time. If a backburner client does not reengage within 6 months she is usually unenrolled, depending on the situation.

A backburner client is no longer counted as part of the case manager’s caseload. However a backburner client ID will still appear on the case manager’s Time Summary form and time spent searching for her/attempting to engage her is recorded. Tracing time is noted under "Other" on the Time Summary form client line.
Tracing Clients Who Are Missing

Successful tracing starts on the day the client enrolls in PCAP. If you wait until she is missing to start developing your tracing strategies, you’ve waited too long.

Case managers who have missing clients may spend months in intensive, creative tracing efforts. Outreach is not intensive if a case manager has simply made repeated phone calls to the same numbers or gone to the woman’s home to find her not there. Clients who are wary at the start of PCAP may be testing the case manager and the program. Case managers respond by being persistent and letting the client know that:

1. We’re ready to help (and we know how to help) whenever the client is ready.
2. The client is worth it.
3. We’ll continue to be persistent and creative in reaching out to her, wherever she is.

Scenarios:
“We have no current way to stay connected to the client. She is connected to nothing at this time. Client did leave an approximate mile marker of where she is staying. I have advised case manager not to go alone but to team up with another advocate and attempt a home visit.”

“Client called in and left message for the case manager. She then called me wondering why the case manager had not called back. I asked her if the case manager had her number and she told me that there was no phone to return calls to.”

Tracing Tips

In brief:

- Tracing tips work.
- Go where the client goes (methadone dosing, child visits with CPS, WIC appointments, court appearances).
- References are critical. Keep careful record of names and phone numbers of client friends and family, obtained by the clinical supervisor at intake and throughout PCAP by the case manager.
- Mine the clinic file for every bit of information (every provider, phone number, place, friend/relative, etc.).
- Send the client letters / notes.
- Put mileage on your car.
- Check with neighbors at last known address.
- Check the jail roster.
- Use websites (e.g. Facebook) and data bases.

For extensive, detailed Tracing tools and strategies see:
Transferring Clients

If a PCAP client moves to a different area of the state, she may transfer to the PCAP site located in that area.

Transfers between PCAP Sites:

- The supervisor of the client's ORIGINAL site contacts the supervisor at the site where the client is moving (the RECEIVING site) to find out if there are any openings and if a transfer is possible at this time. This step must be done supervisor to supervisor; NOT by the case manager, and NOT by the client.
- Allow a three-month "wait and see" period before officially recording the transfer and moving data from one site to another. This is because in many cases after the clients move they change their minds and return to the original site.
- During this period, the original case manager is responsible for evaluation paperwork; the original case manager should talk with the receiving site case manager to get information about what has happened at the receiving site. Exception: time spent with client is recorded on the Time Summary Form of whichever case manager actually worked with her that week.

For additional details on transfer protocols and documentation, see:
Section Eight

PCAP Evaluation

Appendix A
Start-up Considerations

Appendix B
Program Considerations
Integrated program evaluation is a key component of PCAP that distinguishes it from many other intervention programs. Evaluation is used for PCAP program oversight as well as for generating program outcomes. Because outcomes are generated on a regular, ongoing basis, we have outcomes to share when others in the community need them. Evaluation activities also allow us to standardize the intervention and make it consistent from site to site, while allowing for the individualized work with clients that is so important.

Why Is Evaluation an Integral Part of PCAP?

Evaluation demonstrates whether or not a program works.
PCAP uses evaluation to assess the effectiveness of the model. These outcome evaluations are shared with staff and may be published in order to share information with a larger audience. For example, the original PCAP demonstration project in 1991-1995 used evaluation data to compare outcomes between program participants and a comparison group, and demonstrate that the program was effective:


Even before the 3-year original demonstration was complete and full outcome data were available, PCAP used evaluation data to report trends at 12 and 24 months:


In 2003 a medical student used PCAP data to study clients’ status 2.5 years after they graduated from PCAP:


In 2005, evaluation data were used to compare outcomes from two Washington State PCAP replication sites with the original PCAP demonstration site to show that the PCAP model continues to be effective:

In 2011, PCAP data were used to explore how maternal risk and protective characteristics and service elements are associated with mother/child reunification:


In 2014, PCAP data were used to examine factors that predict subsequent births and subsequent alcohol or drug-exposed births among mothers enrolled in PCAP:


**Evaluation allows for standardization of PCAP services.** Evaluation data are used to monitor adherence to the PCAP model across locations and over time, allowing for a degree of program standardization/project fidelity. Use of a secure web-based online data entry console can allow for standardization of PCAP data instruments and collection protocols (see Evaluation Support Activities).

**Evaluation allows for more effective use of public resources by closely monitoring funded programs.** Outcome reports are generated on a regular basis for use by PCAP administrators, clinical supervisors, and funding agencies.

**Evaluation produces data that can be used to generate or sustain funding.** Brief reports highlighting client characteristics and specific outcomes can be generated for use with lawmakers and funders. See 2017 PCAP Summary of Evidence as an example of a document Washington PCAP presents to state legislators to illustrate outcomes of the state’s investment in PCAP.

**Evaluation helps explain how the model works and allows us to determine "best practices."** For example, comparing Time Summary data with outcomes helps determine the optimal time to spend working with clients.

**Administration of evaluation instruments can strengthen a case manager’s work with clients.** Assessment instruments have been designed to support case managers’ work in the field and can aid in the process of working with clients. For example:

- **The Difference Game** – Assessing needs, getting clients involved, establishing contact
- **Progress Towards Goals Form** – Taking baby steps
- **Biological Children Form** – Assessing status and potential needs
These PCAP instruments were designed using feedback from case managers to ensure that the instrument enhances the work with clients in addition to gathering data. Administering assessment instruments can:

- Provide case managers with information about the client that will aid in making decisions about appropriate service connections.
- Allow clients a structured time to think about aspects of their lives that they don’t often think about, or may never have thought about before.
- Give case managers an opportunity to work with clients at the time these issues come up, via follow-up conversation and planning.

**Evaluation can be used to help reduce case manager burnout.** Working with this population can be hard, especially when things aren’t going well with an individual client. Evaluation provides a format for looking at the work of advocacy from a broader perspective and can help bring case managers and staff back to the "bigger picture." This is done by sharing evaluation results with case managers and staff at regular participatory data discussion meetings.

**Evaluation can be used to monitor ongoing work with clients.** Using data reports every 6 months, PCAP provides feedback on ongoing site-specific outcomes. (Note: the online DatStat data entry console can produce real-time reports using Time Summary data; other reports can be generated on a regular basis by an evaluator). This can enhance performance by specifying site strengths and weaknesses and helping to identify training needs.

**The Two Types of Evaluation**

1. **Outcome Program Evaluation**
   
   PCAP outcome evaluation is based on a quasi-experimental multiple measure pre-/post-test design. Specifically, client self-report information from the Intake ASI (PCAP modification of the 5th Addiction Severity Index) is compared to information on the Exit ASI (PCAP modification of the 5th Addiction Severity Index) on key areas expected to be impacted by PCAP intervention. In addition, intervention "dose" (time spent with case manager) can be compared to client exit outcomes using Time Summary data. Interim data may be assessed using the case manager-report Biannual Documentation form.

   PCAP Outcome Evaluation focuses primarily on six areas where changes are expected as a result of PCAP intervention. These include:
   - Alcohol/drug treatment
   - Abstinence from alcohol/drugs
   - Family planning & subsequent birth
   - Health & well-being of target child
   - Family connection with services
   - Stability indicators: education, source of income, employment
Section Eight – PCAP Evaluation

2. Ongoing Program Evaluation

Maintaining a focus on evaluation can aid critical thinking and problem solving about what works, and what doesn’t. Sometimes very valuable lessons can be learned from an apparent “failure” with a client.

Ongoing program evaluation activities are important to the healthy operation of a PCAP site, the quality of the outcome data generated, and sustainability. Such activities include:

- Ongoing training on evaluation
- Regular data-feedback participatory meetings with staff
- Specialized data reports for use by clinical supervisors
- Specialized data reports to share with the community

Evaluation is not simply filling out data forms.

Why it matters.

Clinicians may do very good work, but if it is not accurately and fully documented, they cannot demonstrate the quality of the work they do. It is undeniable that the primary focus of a clinician cannot be on evaluation activities. It is up to the program do what it can to support evaluation activities in a systematic organized way, to make it easier for the clinician to provide accurate, complete data at the time of service. Evaluators are very limited with what they can do with incomplete data after the fact.

Data must serve the program. It is from data that evaluation results are compiled and program decisions are made. If the data are not accurate and complete the reliability and usefulness of any resulting report is affected.

Using Data to Evaluate Performance

**CAUTION**

Do not use client outcome data as a measure of an employee's job proficiency. Outcome evaluation activities should be clearly defined as separate from personnel evaluation. A case manager’s performance evaluation should be clearly tied to her job performance, not to her client’s performance. Time Summary data is, however, a useful tool in assessing case manager adherence to PCAP expectations, e.g. how she spends her time, whether she is seeing all of her clients, how much face to face time she has with clients, etc. An examination of the data may bring some problems to light and possibly indicate needs for further training.

When reviewing data with staff, do not compare case managers’ caseloads to each other, or one site to another in a critical, judgmental way. Instead, look for reasons for differences, and ways to learn from other case managers or sites.
Organizational Program Evaluation Support Activities

Use of a centralized online data gathering system
It is helpful to both the clinician and the evaluator to have evaluation support in place in a concrete, structured way. A key advantage with using a secure web-based online data gathering console is that evaluation collection can be easily monitored and both clinical and evaluation/data problems can be spotted and corrected quickly. It is important to have an onsite person in charge of evaluation oversight as it is very easy to lose focus on documentation in the midst of actually performing clinical work.

Important elements of an online evaluation system to generate necessary support for staff and evaluator:

- User-friendly: easy access to forms, system for organizing evaluation activities, easy data entry.
- Access to central database from remote locations.
- Generates real-time information (reports) on the status of data entry, what forms are in, whether they are complete, what is overdue.
- Improves accuracy of data collected through technical enhancements that don’t allow out-of-range data to be entered, or questions to be skipped.
- Generates real-time reports on how time is spent with clients (using information from the Case Manager Time Summary Form entered weekly).
- Easy download of data for use by evaluators.

In addition to the onsite person, usually an office assistant, who monitors the evaluation database on a monthly basis, PCAP uses their internal evaluator for evaluation training, retraining, and reinvesting staff in evaluation as necessary. PCAP acknowledges that the primary focus of clinicians is on clinical work, and provides additional support to periodically recalibrate a focus on evaluation so that the quality of PCAP data and outcome reports remains consistently high.

New Hire Evaluation Training
This mandatory training for new staff includes training by the evaluator on what PCAP evaluation is and why it’s important, each person’s role in data collection including strategies they can use to enhance accuracy, and detailed training on coding of forms. A key focus is to get the new hire invested in the evaluation of the program. If an online console is used to enter data, training should be provided at this time on how to use it. Training on evaluation makes more sense to the trainee if it is after the general PCAP training so that the new case manager can see how evaluation activities fit in with, and support, what they will be doing.
Ongoing Onsite Evaluation Training

As a part of supervision, supervisors should oversee evaluation activities and provide regular feedback to case managers. For example, supervisors can examine whether a case manager is balancing her time on a caseload by looking at the completed Time Summary form for the previous week (a longer term report can be generated by the DatStat console). Monitoring of timely entry of all data can be examined at the same time (this can be enhanced using the Scheduled Forms report available from the DatStat console).

Yearly Evaluation Refresher Training

Annual refresher training is conducted by either the evaluator or the person assigned to monitor internal program evaluation. This can be done either with multiple sites at a central location, or as part of a yearly site visit by the evaluator. This training reviews PCAP evaluation activities and data collection forms, and focuses on why evaluation is done and the things everyone can do to ensure that client activity is documented as accurately as possible.

Evaluation Site Visits: Participatory Data-Discussion Meetings

The PCAP evaluator produces a report to the funder every 6 months, which includes 3 sections: the demographics, outcomes of clients currently active in the program (Biannual Documentation data), and client exit outcomes. Site staff members meet with the evaluator to review and discuss this data, which allows them to examine the "bigger picture." These meetings include discussion of:

- Whether the data seem to reflect the case managers’ clinical experience.
- Time summary pie charts illustrating data over time, and among sites.
- Specific data reports that have been generated for other purposes.

It is important is that case managers feel free to participate at these meetings. It should not be a lecture on the data. This is an excellent time to answer questions about coding and special situations that arise.

Producing Quality Evaluation Results

"Garbage In, Garbage Out"
Numbers are meaningless unless they are accurate.

Accuracy is Essential to Quality PCAP Evaluation

The goal of evaluation activities is to document as closely as possible the reality of the women in the program in order to learn how to better help clients. We want to know not only what works, but what doesn’t work so that we can make adjustments and
improvements in the program. Ensure that staff are never afraid to report “bad news.” Essential to this goal is absolute honesty in reporting and, most importantly, a focus on good documentation habits. Because we make every effort to describe reality as closely as possible, we can generate data that are useful and trusted:

- **For the Community** - What works, what doesn’t?
- **For the Agency** - Are we doing the best we can?
- **For Replications Sites** - Are the core components consistent with the original model? Does PCAP work as well in different locations? What’s the same, what's different?

### Enhancing Accuracy

The quality of PCAP evaluation requires that staff understand the value of evaluation and be invested in high quality evaluation. For this reason, evaluation training should not be a one-time thing, but instead an integrated part of the program.

### Improving ASI accuracy

1. ASI interviewers need to be trained by a highly experienced ASI trainer. The PCAP Intake ASI modification includes the standardized 5th edition ASI, but it is different in places and requires training in addition to standard ASI training. After this initial didactic ASI training, the new PCAP interviewer is required to observe 2 interviews being conducted by an experienced interviewer, and code along. Next, the new PCAP interviewer is required to conduct 2 interviews with an experienced interviewer observing and coding along. After each of these interviews, the two compare coding while referring to the ASI coding manual to resolve discrepancies. The goal is to reach 95% coding agreement in order to enhance reliability of PCAP data.

2. Intake ASIs are not administered by PCAP case managers. They are administered by supervisors because of the extensive training involved and because they serve as an invaluable supervisory clinical assessment tool (in addition to collecting research data). Calendars, prompts, attention to administration conditions, and assurances of confidentiality are used to enhance the accuracy of the client’s self-report.

3. To minimize bias, ASI exit data should be gathered using a trained interviewer who is not affiliated with the clinical aspects of the program.

4. Assure the client of confidentiality by setting up interview conditions to encourage honest disclosure (e.g., interviewing client without family members present, minimizing distractions, etc.), and using calendars to help the woman more accurately recall specific details.

5. ASI interviews are done at intake, sometimes with long spans of time in between client enrollments. Where PCAP has more than one site, it is helpful to have yearly ASI refresher trainings including a mock interview and coding comparisons among interviewers to improve reliability and minimize inherent drift.
Section Eight – PCAP Evaluation

Improving Biannual Assessment Accuracy
1. A copy of the biannual form should be kept in the file on which to keep notes of client progress as the 6 month period progresses. Memory alone over a full case-load of clients for what has happened for each individual over the past 6 months will not serve accuracy best. It also saves time over having to review the past 6 months of case notes.

2. Biannually should be reviewed by the supervisor to ensure that they are accurate. Some case managers may need more review (reminders) than others.

Improving Time Summary Accuracy
A printed copy of the time summary report should be brought into case manager supervision every week for review.

Enhancing Timely Completion of Data
The PCAP office assistant or supervisor should monitor that data forms are completed on time and are done correctly. Supervision should include review of data entry to be sure that all forms are entered on time. When necessary, supervisors may assign a "paperwork" day to help case managers organize their time and complete their paperwork. Data forms that are entered late are never as accurate as data forms entered soon after the fact.

1. All PCAP staff should have basic evaluation training at hire covering an overview of evaluation: why PCAP uses it, and their important role in maintaining the quality.

2. Ongoing training is needed, including yearly evaluation refresher training to enhance staff investment in producing quality data.

3. Evaluation forms should be reviewed on a random basis by PCAP supervisors to see that they are being filled out completely and accurately.

Evaluation Basics that Enhance Accuracy and Integrity of Data

Evaluation Activities Should be User-Friendly and Useful to Clinical Work
PCAP ongoing program evaluation activities are geared toward making evaluation user friendly and useful. PCAP staff members need to clearly understand why and how evaluation is useful to them and their clients.

- As much as possible, evaluation activities should support intervention activities.
- Intervention activities expected to impact outcome are assessed in an ongoing manner (i.e., don’t measure more than you need, keep the data gathering burden as light as possible).
- Provide materials to aid in resolving issues. Detailed manuals should be available, accessible, used, and updated. Training should be ongoing. Expect and anticipate ‘drift’.
Important Elements to Cover in Evaluation Training

1. Explain (demystify) basic concepts of evaluation. Use analogies as necessary. *For example: "Evaluation is like taking a picture. Evaluation methodology is like the camera used to take the picture. Input from case managers is like focusing the lens. The quality of the evaluation is measured by the quality of the picture."*

2. Invest case managers in the evaluation.
   - Case managers are documenting something real: their clients' lives.
   - Their attention to detail and accurate reporting is critical and essential.
   - Honesty in reporting is essential. Don't judge what is "good" or "bad" when reporting, just report what is. Relapse is a process, sometimes something very valuable can be learned from an apparent relapse “failure.”
   - Evaluation results are used; they will be applied to this program, and perhaps to programs yet to come.
   - Evaluation activities will result in something valuable that will be used by the program to enhance the work they are doing with their clients.
   - Evaluation results have wide-reaching impact.
   - Accurate documentation of your work and the clients' progress will help not only your clients, but other women and families you will never meet.
   - Results may be published, to share with other communities what this program has learned.
   - Show staff evaluation products such as outcome reports, time summary pie charts illustrating how time is spent, etc., to demonstrate how the data they generate are used.

3. Emphasize their role in protecting the quality of the evaluation
   - Review the consent form and what PCAP promises clients about their data.
   - Explain that we use numbers (not names) to identify clients on data forms as a protection for clients.
   - Explain what should and shouldn't be put on a data form (i.e., no client names, brief comments but not case note level detail).
   - Caution against completing data forms, or leave them lying about, in a location where they might be seen by others.
   - Enter data in a timely manner. Data that are entered late are never as accurate as data entered soon after the fact.
   - Write paper forms as legibly as possible. Someone may have to enter that data later.
   - Be careful to be accurate in your keystrokes when entering data online. What is entered is what will be reported as data. Online, there is no middleman data entry
person to catch mistakes or to point it out if something doesn't look right. Review each page before you submit.

- Avoid missing or unknown data. Use strategies to ensure that you know the answers to as many questions as possible (example, keep a blank Biannual documentation form in your file to keep notes on, and to aid you in seeing what you will need to know to fully complete the form online).
- Be sensitive to contextual issues of administration and to special circumstances.
- Make sure the client has enough time to complete the instrument; that she is not distracted and that a person is not present in front of whom she may not give honest responses.
- Example of special circumstance: the client may not be able to read and may not tell you. Offer to read questions to the client when unsure.
- Explain the concept of bias so that case managers can learn to become aware of their own biases in order to reduce the effects of bias on reporting.

4. Train (and retrain) case managers in the specifics.
   - Assessment instruments: how to code, how to resolve coding questions.
   - How to use assessment instruments to enhance their work with clients.
   - How to use intake forms such as the Difference Game, Difficult Life Circumstances, and Biological Children at Enrollment forms, as well as the Goals and Biannual forms.
   - Use the Administration of Evaluation Forms Flow Chart as an aide to understanding when forms are done, when they are due and how everything fits together.

PCAP may be evaluated by either an internal ("in-house") or external (contracted) evaluator.

**External Evaluation**
PCAP evaluation activities include ongoing program evaluation and evaluation training, as well as outcome evaluation. Unless you find an external contractor able to provide all of the elements, an additional person within the organization needs to be assigned to the internal program evaluation tasks.

**Internal Evaluation**
If you are using an internal evaluator to do the outcome evaluation, it is important that the evaluator not be closely involved in the clinical aspects of the program or its clients. For quality outcome evaluation, objectivity by the evaluator must be maintained as much as possible. External knowledge about individual clients may unintentionally influence the data editing judgments that must be made from time to time.

The PCAP database presents its own challenges to the evaluator. Unlike in a standard research project, in PCAP the case managers, who typically have not been trained in research methodology, do data collection. With the PCAP database, data cleaning and editing takes on special importance in assuring accurate reporting of data.
Section Eight – PCAP Evaluation

(Note: this can be aided by the use of an online web-based system like the DatStat console: DatStat data forms are designed using skip patterns that hide ‘not applicable’ questions and limitations that won't allow a user to accidentally miss a question. However, note also, if the DatStat console is used to generate reports, these reports will be using unedited, raw data and will include whatever data entry errors were made by operators. For reports to community and funders, a human evaluator needs to review the data and create the reports so that the data are as clean as possible.)

Institutional Review Board (IRB), Research Consent Process, and Protecting Human Subjects

Washington State PCAP data is used for research purposes, therefore we have obtained:

1. A Certificate of Confidentiality from the federal government that protects our research records (not our clinical or program records) from subpoena: http://www.hhs.gov/ohrp/policy/certconf.html

2. Approval from the Washington State Institutional Review Board (IRB) to collect, analyze, and report on research data obtained from study participants (human subjects) after obtaining their informed, signed consent. Clients sign a Participant Consent Form.

Those interested in replicating PCAP and collecting data for research or evaluation purposes should check with their local Human Subjects institution or agency about requirements.
Appendix A

Start-up Considerations
Pre-Implementation: Community Considerations

Conducting a thoughtful pre-program (pre-implementation) assessment is essential in ensuring that the setting is appropriate for successful implementation and delivery of the PCAP intervention. This brief assessment will help to:

- Identify potential project hurdles
- Identify environmental factors needed for this type of project
- Identify critical partners
- Highlight issues relevant for service delivery to high-risk populations

The assessment may be implemented through a variety of mechanisms, including desk research and informal interviews with key informants. These questions are also part of the PCAP Fidelity Checklist (see Appendix B).

Three specific questions are used to help determine a ‘goodness of fit’ between an organization or community’s characteristics and the PCAP model. They are:

1. **What is the extent of the maternal substance abuse problem in your organization/community?**
   Communities with data available to demonstrate a significant maternal substance abuse problem are appropriate locations for PCAP implementation.

2. **How well do key stakeholder community agencies collaborate with each other?**
   Effective PCAP implementation and operation requires a culture of collaboration among service provider agencies within a community. Dysfunctional communication or defensive/territorial tendencies among agencies will not support the positive outcomes typically associated with the PCAP model.

3. **Is the community agency interested in housing PCAP an appropriate fit for the model?**
   PCAP is best operated within a hosting agency known for being a successful provider of services to high-risk families or substance abusing populations. It is also beneficial if the hosting agency recognizes and accepts the theoretical foundations of the PCAP model (relational, stages of change, and harm reduction theories). Most of the PCAP sites in Washington State are affiliated with substance abuse inpatient
 Agencies Hosting PCAP Sites

In Washington State, PCAP funding contracts are administered by the Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR). Agencies interested in operating a PCAP site in their county submit an application to DBHR and are selected based on their qualifications. Agencies that operate PCAP sites are typically substance abuse treatment or community social service or health agencies.

For PCAP sites in Washington State, visit: http://depts.washington.edu/pcapuw/contact-us/contact-list

PCAP Organizational Structure within a Site

The PCAP administrative structure is designed to support the case management staff and create a rewarding work environment. Full PCAP program sites employs a clinical supervisor and case managers at a ratio of 1:6. Each case manager works with up to 16 clients. When multiple PCAP sites are operating within a state or province, ideally the sites are coordinated and in close communication, supported at the program level by a director and evaluator.

Quarterly Administrative Meetings

In Washington State, every three months clinical supervisors from all PCAP sites statewide meet together with the program director and evaluator for a half-day pot-luck and meeting. The purpose is to share site updates, discuss challenges, make decisions together about policies, discuss training needs and resources, and consider opportunities. Minutes are kept and distributed later. Supervisors do this work because they find it meaningful and rewarding, and the tone of the meetings is supportive and helpful.

Budget Considerations and Categories

Below are the basic budget categories required for operation of a PCAP site. The exact amounts of these items differ depending on the size of the PCAP site and the geographic region.
## Appendix A – Start-up Considerations

<table>
<thead>
<tr>
<th>Category</th>
<th>Common line items</th>
</tr>
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</table>
| **Set Up**          | • Office furniture and equipment (desks, chairs, phones, fax machine, etc.).  
                       • Computers for supervisor, assistant, and at least one computer for every two case managers.  
                       • Mobile cellular phones (with GPS tracking capability), chargers and batteries, for supervisor and all case managers to enable communication and increase safety in the field.  
                       • Automobiles for case managers to transport clients and to use on home visits (include outfitting costs, i.e. baby seats installed that are up to standard). Options include using agency vehicles, leasing or buying vehicles to use long term, using personal cars with mileage reimbursement. |
| **Salaries and Benefits** | **Full PCAP site:**  
                       • Full-time clinical supervisor  
                       • Six full-time case managers  
                       • Half-time office assistant  
                       • Hourly exit interviewer (beginning three years after first enrollment)  
                       **Half PCAP site:**  
                       • Half-time clinical supervisor  
                       • Three full-time case managers  
                       • Quarter-time office assistant  
                       • Hourly exit interviewer (beginning three years after first enrollment) |
| **Personnel Services** | • Client needs/incentives (at least $50/client/year)  
                       • Employee Training (approximately $200/employee/year) |
| **Other Contractual Services** | • Postage  
                       • Utilities  
                       • Insurance  
                       • Printing  
                       • Evaluation database & software license  
                       • Repairs  
                       • Copies |
| **Rent**            | Office space for staff, including:  
                       • At least one private office where supervisor can conduct intake interviews and exit interviewer can conduct interviews in private  
                       • Space with conference table for staff meetings and small trainings  
                       • Waiting room area with space for clients and children to feel comfortable |
| **Travel**          | • Agency vehicle fees, insurance, leasing fees, or mileage reimbursement.  
                       • Air fare if necessary |
| **Supplies**        | • Office supplies  
                       • Miscellaneous  
                       • Food |
Appendix B

Program Fidelity, Sustainability, and Cost Savings Considerations
Fidelity to the PCAP Model

A successful PCAP replication site:

1. Maintains fidelity (or faithfulness) to the theoretical foundations of PCAP and implements the core characteristics of the basic PCAP model, and at the same time.
2. Reflects the unique characteristics of the community it serves.

The PCAP model is supported by theory and evidence of effectiveness based on research. Furthermore, the program has been operational for over twenty years and the intervention methods are supported by field practice and expert clinical opinion.

When the program is implemented in a new community it is important to recognize the cultural, structural, geographic, and social differences that may potentially impact the model. While adaptations are an important part of replication, there are thirty-seven core characteristics that are recognized as being essential in order to see successful outcomes in PCAP clients.

The PCAP Pre-Implementation Checklist and PCAP Fidelity Assessment are two tools created to promote fidelity to the intervention model.

**PCAP Pre-Implementation Checklist** – Planning for PCAP Replication

The PCAP Pre-Implementation Checklist is a quality assurance tool to be used in the pre-implementation phase of PCAP replication site development. The checklist reviews the core characteristics necessary in designing a PCAP replication site. The checklist should be used by agencies that are contemplating implementation of PCAP and are interested in assessing the feasibility of such implementation.

**PCAP Fidelity Assessment** – Evaluating PCAP Replication

The PCAP Fidelity Assessment is a quality assurance tool that helps to assess the degree of adherence of the PCAP model in a new agency or community context. The tool reviews the core characteristics of the PCAP model and provides information on how well the local agency or community is implementing PCAP. ([Click here for 8” x 14” version](#))

**Sustainability**

PCAP has been in operation in Washington State since 1991 with funding from diverse sources including:

- Private philanthropy (1996-1997)
- State legislative appropriation (1997-present)
- Private foundations (2001; 2005)
Four elements that are critical to sustaining a PCAP site include:
- Hiring intelligent, committed, and hard-working people
- Operating a well-run organization
- Building a reputation for excellence in the community
- Using data to demonstrate positive, consistent outcomes

**Strategies Used to Create Visibility and Promote PCAP**

**Establish a positive identity.** Use every interaction with community providers to build a good reputation. Small steps make a big difference. For example, have a standard protocol for everyone who may answer the office phone (professional, friendly, responsive – “How can I help you?”). Make it a policy to return calls the same day and to write short, personal notes of thanks or recognition when the situation warrants.

**Ask successful clients to participate in their own case consultation meetings with other providers.** Clients who become healthy members of the community are one of the most positive endorsements for PCAP.

**Participate in the community.** Maintain an active presence on task forces, workgroups and committees relevant to the population PCAP serves. Don’t wait to be invited—volunteer to serve.

**Talk with community leadership.** The sooner your PCAP site is recognized and known to local leadership, the more beneficial it will be for long-term sustainability. Invite your elected officials to visit a PCAP staff meeting, and take the time to communicate with and inform lawmakers until you find a ‘champion’ who believes in your work and will speak up to colleagues on the program’s behalf.

**Seek media/internet coverage.** Pay attention to current events unfolding in your community, think about how they might relate to your PCAP work, and contact a media outlet to explain. A child welfare incident can be a springboard for a story about how PCAP prevents child abuse and neglect. Community concern about drug activity and youth give way to coverage about solutions, e.g. PCAP’s successful outcomes among high-risk mothers raised in dysfunctional homes.

**Ask former clients to write or tell their stories.** Personal written or spoken testimonies from clients who have graduated successfully from PCAP are powerful tools for gaining the attention and support of community agencies, funders, and lawmakers.
Newsletters and publications. Sending newsletters to community providers is a good way to stay visible. Create interesting informational materials that include the basics of PCAP, key client outcomes, cost-savings data, success stories about service providers working together for the benefit of clients and families, and insights about what’s needed in the community.

Demonstrating Cost Effectiveness

Determining precise cost-savings of home visitation programs to the public over the long-term is difficult and requires complex statistical modeling. As a holistic intervention, many areas may be affected in ways that will eventually result in decreased costs. Long-term effects may become evident only years after intervention.

Nevertheless, using outcome data from your local PCAP sites along with local or regional cost information, you can develop examples that demonstrate your program's cost savings. Among areas of expected impact are:

- Reduced costs associated with future births of alcohol/drug-affected children because of the mother’s abstinence from alcohol/drugs or her use of family planning.
- Decreased welfare costs as women stay in recovery and become employed.
- Decreased foster care costs as more women retain or regain custody of their children.
- Decreased child abuse and neglect as a result of improved parenting or safe and stable child placement.

Cost-savings examples are most powerful and meaningful when they use local or regional cost information applied to actual outcome data from local PCAP sites.

Fewer substance exposed births.

Only 12% of mothers enrolled in PCAP had a subsequent alcohol/drug-exposed infant within three years compared to 21% of similar mothers over the same time period who received typical substance abuse treatment alone without intensive case management. This comparison sample was from a large, randomized controlled trial in another state (Ryan et al., 2008).
The estimated lifetime cost for every infant born with Fetal Alcohol Syndrome (FAS) is $2 million. PCAP shows over $20 million in lifetime cost savings due to effective intervention for PCAP mothers who were former binge drinkers (Casey Family Programs, 2013).

Economists found that Alberta, Canada PCAP prevented approximately 31 cases of Fetal Alcohol Spectrum Disorders among 366 clients in a 3-year period. The net monetary benefit is approximately $22 million, indicating that PCAP is cost-effective and the net monetary benefit is significant. This amount is likely underestimated as the study did not include benefits from reduced unemployment (Thanh, et al., 2015).

Reduced dependence on child welfare

PCAP children who were in out-of-home care and reunified at PCAP exit had a shorter average length-of-stay (3.8 mos.) than WA state average (20.4 mos.). Each successful reunification = savings of over $21,000 per child (Casey Family Programs, 2013).

Reduced dependence on public assistance

From 2007 to 2012, Temporary Assistance for Needy Families (TANF) was the main source of income for 61% of women entering PCAP compared to only 31% at exit (Casey Family Programs, 2013).

Sources


In Washington State, one case manager advocated on behalf of a client who was arrested on an old warrant for forgery. The client was doing well in PCAP: she had been clean and sober for over a year, was attending school, and had custody of her son. The PCAP case manager organized professionals who had worked with the client to write letters or attend a hearing on behalf of the client, and the judge accepted an attorney’s recommendation that the client be sentenced to 8 months of home electronic monitoring (where she and her son could continue to live together), instead of 18 months in a medium security prison (with her son placed in foster care).

This solution resulted not only in a very positive outcome for mother and child, but also in substantial cost savings to the public. Had the original sentence been imposed, the prison and foster care costs incurred would have amounted to $81,269, versus the $3,625 cost of 8-month home electronic monitoring. The cost savings of $77,644 well-exceeded the case manager’s annual salary and benefits, and this was just one instance of intervention with one client (the case manager has 16 clients on her case load). The simple bar chart below is one way to illustrate this.

**Reduced Involvement with the Criminal Justice System**

= **Reduced Costs to the Public**

- **8 Months Home Electronic Monitoring $3,625**
- **$60,000**
- **$50,000**
- **$40,000**
- **$30,000**
- **$20,000**
- **$10,000**
- **$90,000**
- **$80,000**
- **$70,000**

**Amount Saved: $77,644**

- **$18,000 18 mo. Foster Care**
- **$63,269 18 mo. Medium Security Prison**
- **$81,269**

**Costs if original sentence imposed**

**Actual costs because of PCAP**
Detailed information about PCAP, including evaluation protocols and forms can be found at:

http://depts.washington.edu/pcapuw/

For more information, please contact:
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