

# The Parent-Child Assistance Program



A Model of Effective Community  
Intervention with High-Risk Families

**For more information about the PCAP intervention, contact:**

***Parent-Child Assistance Program (PCAP)***

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## *Attention all readers:*

Information about PCAP and protocols and forms can  
be found at:

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

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## **Section One:**

# The Parent-Child Assistance Program: An Introduction

## 1.1 The Primary Goal

**The primary goal of the Parent Child Assistance Program is to prevent future births of alcohol and drug exposed children. We do this by addressing the needs of the mothers—and getting them stabilized in a whole host of ways.**

## 1.2 The Problem

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 exposure carries the potential for neonatal complications, lifelong neurodevelopmental damage, and the likelihood of a compromised home environment.

Women who fit the eligibility profile for the Parent Child Assistance Program (PCAP) have been vilified in a social and political climate suggesting that alcohol/drug-addicted mothers are responsible for a variety of social ills. They have been labeled unmotivated and difficult to reach, and many professionals have come to view them as a hopeless population. Not surprisingly, chronic substance-abusing women become distrustful of “helping” agencies. Yet alienation from community resources only exacerbates the problem. The result is that those women at highest risk for delivering children with serious medical, developmental and behavioral problems are the least likely to seek and receive prenatal care and other assistance from community resources designed to help them.

*PCAP was developed in response to the problem of maternal substance abuse. These mothers live in our communities with their children and families. They are not throwaway women, and there are things we can do to help them improve the quality of their lives and become healthy and productive people.*

The PCAP model was developed because we understand that these mothers *were themselves* the abused and neglected children of just a decade or two ago. They were born into troubled families, and grew into young women who used alcohol and drugs and delivered babies born into the same circumstances as their mothers had been. Social welfare, medical, and educational systems, if available, were not able to break this ongoing cycle of deprivation. Turning our backs on mothers because they are difficult to work with does not make their problems go away. It does ensure that these women 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.

The PCAP model is informed by research on effective home visiting interventions for low income populations that has demonstrated the success of strategies including comprehensive focus, frequent visits, and well-trained staff. The PCAP intervention uses these general lessons and applies them specifically to women who abuse alcohol and drugs during pregnancy, an underserved population.

### **Selected Resources on maternal substance use**

Black, M.M., Nair, P., Kight, C., Wachtel, R., Roby, P., & Schuler, M. (1994a). Parenting and early development among children of drug-abusing women: Effects of home intervention. *Pediatrics*, 94, 440–448.

Centers for Disease Control and Prevention (CDC) (2002). Alcohol use among women of childbearing age—United States, 1991 – 1999. *JAMA*, 287(16):2069 – 2071.

Conners N.A., Bradley, R.H., Mansell, L.W., Liu, J.Y., Roberts, T.J., Burgdorf, K. & Herrell, .JM.(2004). Children of mothers with serious substance abuse problems: an accumulation of risks. *Am J Drug Alcohol Abuse*, 30(1):85 – 100.

Ebrahim S.H. & Gfroerer, J. (2003). Pregnancy-related substance use in the United States during 1996 – 1998. *Obstet Gynecol*, 101(2):374 – 379.

Ebrahim, S.H., Luman, E.T., Floyd, R.L., Murphy, C.C., Bennett, E.M. & Boyle. C.A. (1998). Alcohol consumption by pregnant women in the United States during 1988 – 1995. *Obstet Gynecol*, 92(2):187 – 192.

Frank, D., Augustyn, M., Grant-Knight, W., Pell, T. & Zucherman, B. (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure: a systematic review. *JAMA*, 285(12):1613 – 1625.

Loman LA, Sherburne D. *Intensive Home Visitation for Mothers of Drug-Exposed Infants: An Evaluation of the St. Louis Linkages Program*. St. Louis, MO, USA: Institute of Applied Research, April 2000.

Lustbader AS, Mayes LC, McGee BA, Jatlow P, Roberts WL. Incidence of passive exposure to crack/cocaine and clinical findings in infants seen in an outpatient service. *Pediatrics* 1998; 102(1):e5.

Mattson SN, Riley EP. A review of the neurobehavioral deficits in children with fetal alcohol syndrome or prenatal exposure to alcohol. *Alcohol Clin Exp Res* 1998; 22(2):279 – 294.

Navaie-Waliser M, Martin SL, Campbell MK, Tessaro I, Kotelchuck M, Cross AW. Factors predicting completion of a home visitation program by high-risk pregnant women: the North Carolina maternal outreach worker program. *Am J Public Health* 2000; 90(1): 121 –124.

Nelson, J., & Marshall, M.F. (1998). *Ethical and legal analyses of three coercive policies aimed at substance abuse by pregnant women*. Charleston, SC: The Robert Wood Johnson Foundation.

Ornoy A, Michailovskaya V, Lukashov I, Bar-Hamburger R, Harel S. The developmental outcome of children born to heroin-dependent mothers, raised at home or adopted. *Child Abuse Negl* 1996; 20(5):385 – 396.

Paltrow L.M., Cohen, D., & Carey, C.A. (2000). *Year 2000 overview: Governmental responses to pregnant women who use alcohol or other drugs*. Philadelphia, PA: National Advocates for Pregnant Women of the Women's Law Project.

Singer LT, Arendt R, Minnes S, Farkas K, Salvator A, Kirchner HL, Kliegman R. Cognitive and motor outcomes of cocaine-exposed infants. *JAMA* 2002; 287(15):1952 – 1960.

## 1.3 Background

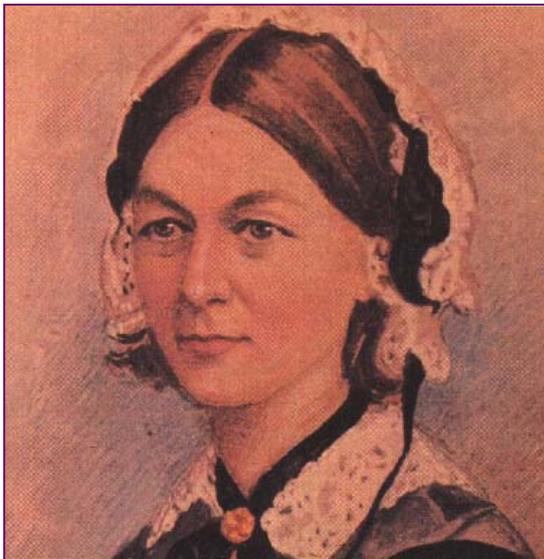
*“PCAP is an intensive 3-year, home visitation case management model for pregnant and parenting drug and alcohol abusing mothers. Working at PCAP is not a desk job.”*

*—PCAP Case Manager*

*In the course of doing early research on fetal alcohol syndrome and prenatal cocaine effects, we spent a lot of time in the homes and saw clearly the profound and sometimes overwhelming problems these mothers experienced. We knew that in order to prevent fetal alcohol syndrome and drug-exposed births, we needed to develop an intervention that was substantive and meaningful for the mothers.*

PCAP began in 1991 at the University of Washington as a federally funded research demonstration designed to test the efficacy of an intensive, 3-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 efficacy, and the Washington State legislature subsequently funded PCAP to develop sites throughout the state. The model has been replicated at numerous other sites in the United States, Canada, and New Zealand.

### PCAP Evaluation Outcomes



***“Results shown are***  
***ence Nightingale Quote***

***- Florence Nightingale (1894)***  
***(On demonstrating the effectiveness***

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 from three different studies.

### **Study 1. Original Demonstration Cohort (1991 – 1995)**

Ernst, C.C., Grant, T.M., Streissguth, A.P., and Sampson, P.D. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. 3-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1): 19–38.

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. Post-Program Follow-Up Cohort (1997 – 1998)**

Grant, T., Ernst, C.C., Pagalilauan G. & Streissguth, A.P. (2003). Post-program follow-up effects of paraprofessional intervention with high-risk women who abused alcohol and drugs during pregnancy. *Journal of Community Psychology*, 31(3): 211–222.

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,  $p < .01$ ).

### **Study 3. Seattle and Tacoma Replication Cohorts (1996 – 2003)**

Grant, T., Ernst, C., Streissguth, A. & Stark, K (2005). Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. *American Journal of Drug and Alcohol Abuse*, 31(3): 471-490.

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%)

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- 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%)

### **The PCAP Evidence Base: 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.

Published evaluation reports on the PCAP intervention with mothers who have or may have FASD and on FASD prevention include three manuscripts in peer-reviewed journals:

Grant, T., Huggins, J., Connor, P., Pedersen, J., Whitney, N. & Streissguth, A. (2004). A pilot community intervention for young women with fetal alcohol spectrum disorders. *Community Mental Health Journal*, 40(6): 499–511.

Grant, T., Huggins, J., Connor, P. & Streissguth, A. (2005). Quality of life and psychosocial profile among young women with fetal alcohol spectrum disorders. *Mental Health Aspects of Developmental Disabilities*, 8(2): 33–39.

Grant, T.M., Bookstein, F.L., Whitney, N.L. & Streissguth, A. (2006). Neonatal cranial ultrasound leads to early diagnosis and intervention in baby of alcohol-abusing mother. *Mental Health Aspects of Developmental Disabilities*, Oct/Nov/Dec 2006, 9(4):125-127.

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And three descriptive chapters:

Grant, T.M., Ernst, C.C., Streissguth, A.P. & Porter, J. (1997). An advocacy program for mothers with FAS/FAE. In: The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities. A.P. Streissguth & J. Kanter. (Eds.). Seattle: University of Washington Press, pp. 102–112.

Grant, T.M., Youngblood Pedersen, J., Whitney, N. & Ernst, E. (2007). The role of therapeutic intervention with substance abusing mothers: Preventing FASD in the next generation. In: Attention Deficit Hyperactivity Disorder and Fetal Alcohol Spectrum Disorders: The Diagnostic, Natural History and Therapeutic Issues Through the Lifespan. K. O'Malley (Ed.). Hauppauge, NY: Nova Science Publishers, Inc.

Streissguth, A.P. & Grant, T.M. (2010). Prenatal and postnatal intervention strategies for alcohol-abusing mothers in pregnancy. In: Drugs in Pregnancy – The Price for the Child: Exposure to Foetal Teratogens and Long Term Neurodevelopmental Outcome. D. Preece & E. Riley (Eds.) London: MacKeith Press.

## 1.4 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
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.

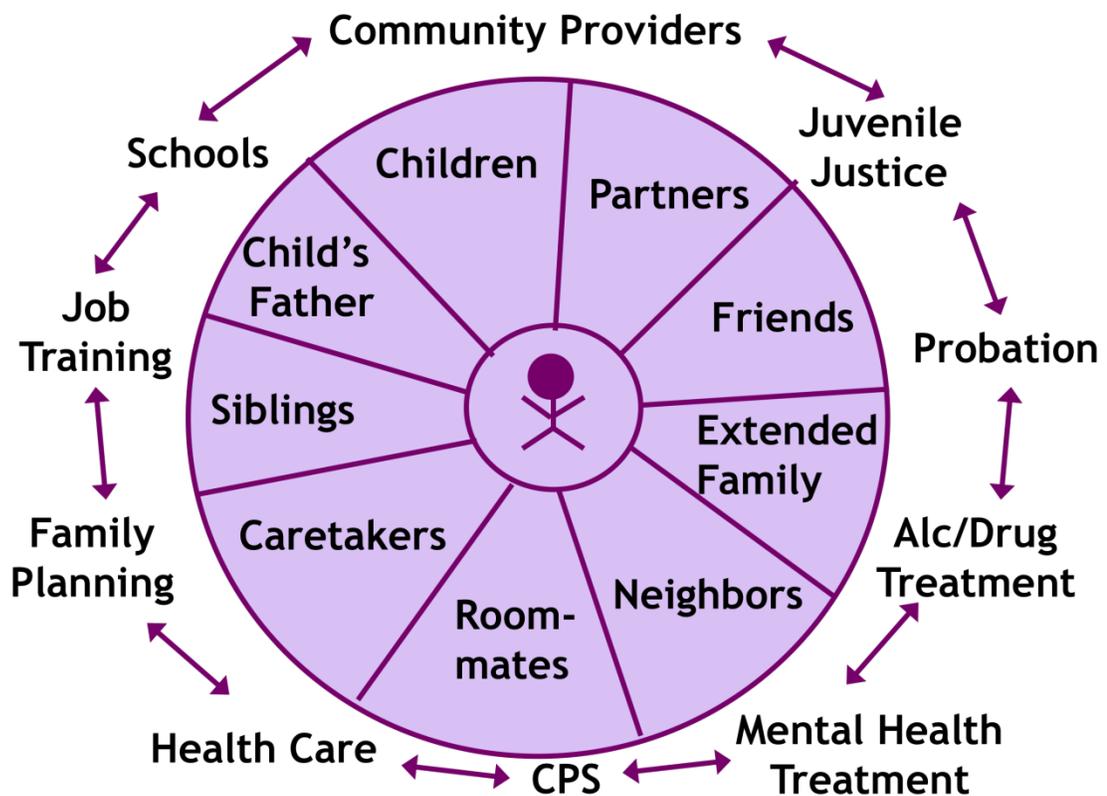
<a href="#"><u>PCAP Pre-Implementation Checklist</u></a> <i>Planning for PCAP Replication</i>	<a href="#"><u>PCAP Fidelity Assessment</u></a> <i>Evaluating PCAP Replication</i>
<p>The PCAP Pre-Implementation Checklist is a quality assurance tool to be used in the pre-implementation phase of PCAP replication 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.</p>	<p>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.</p> <p><a href="#">(click here for 8" x 14" version)</a></p>

## 1.5 Effective Case Management

The PCAP model embodies elements of effective case management. Research shows 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

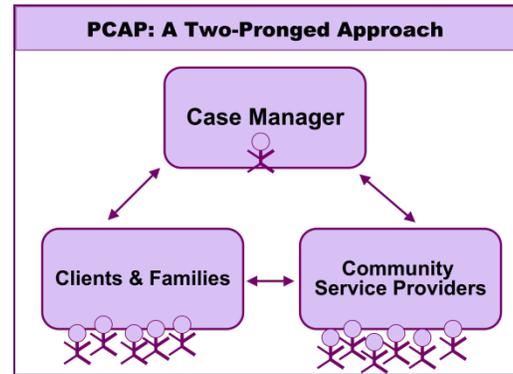
### PCAP Incorporates These Characteristics



## 1.6 Overview of PCAP Model

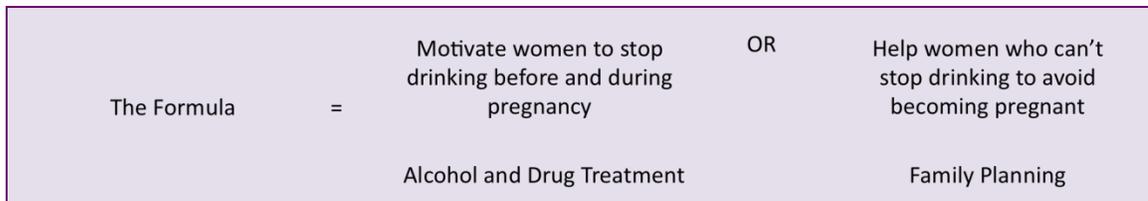
### The Two-Pronged Intervention Approach

The PCAP approach is two-pronged: paraprofessional case managers (sometimes called advocates or case managers) provide extensive role modeling and practical assistance directly in the home with the client, and they connect clients to a comprehensive variety of services in the community, assuring that clients actually receive the services they need. PCAP case managers work with a caseload of 15 to 16 families each, for a 3 year period beginning during pregnancy or within six months after the birth of an index child.



### The Formula for Preventing Alcohol and Drug-Exposed Births

There is a straightforward formula for preventing future alcohol/drug exposed births.



#### Selected Publications

Grant, T. M., Ernst, C. C. & Streissguth, A. P. (1996). *Intervention with high risk mothers who abuse alcohol and drugs: The Seattle advocacy model. American Journal of Public Health, 86: 1816-1817.*

Grant, T. M., Ernst, C. C., Streissguth, A. P., Phipps, P. & Gendler, B. (1996). *When case management isn't enough: A model of paraprofessional advocacy for drug- and alcohol-abusing mothers. Journal of Case Management, 5(1): 3-11.*

Grant T. M., Ernst C. C., McAuliff, S. & Streissguth A. P. (1997). *The Difference Game: Facilitating change in high-risk clients. Families in Society: The Journal of Contemporary Human Services, 78(4), 429-432.*

## 1.7 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.

### Relational Theory

Relational theory holds that a woman's sense of connectedness to others is central to her growth, development, and definition of self. Researchers and practitioners have studied this dynamic and have found positive interpersonal relationships 1) are critical to successful outcomes among women with substance abuse disorders who are in intervention, treatment, and recovery settings; 2) may determine the extent of client compliance and retention in an intervention; and 3) may be more important to improvement than concrete services received.

The PCAP model holds that the relationship between case manager and client is central to the success of the intervention, because it is an important path through which change occurs. PCAP puts the concept of relational theory into practice by offering personalized, knowledgeable and compassionate case management for three years, a period of time long enough for the process of gradual and realistic change to occur.

#### **Selected Publications on Relational Theory**

Amaro, A. & Hardy-Fanta, C. (1995). *Gender relations in addiction and recovery*. *Journal of Psychoactive Drugs*, 27, 325–337.

Barnard, K.E., Magyary, D., Sumner, G., Booth, C.L., Mitchell, S.K. & Spieker, S. (1988). *Prevention of parenting alterations for women with low social support*. *Psychiatry*, 51, 248–253.

Finkelstein, N. (1990). *Treatment issues: Women and substance abuse*. Washington, DC: National Coalition on Alcohol and Drug Dependent Women and Their Children.

Finkelstein, N. (1993). *Treatment programming for alcohol and drug-dependent pregnant women*. *International Journal of the Addictions*, 28(13), 1275–1309.

Miller, J.B. (1991). *The development of women's sense of self*. In J.D. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver, & J.L. Surrey (Eds.), *Women's growth in connection* (pp. 11–26). New York: Guilford.

Pharis, M.E. & Levin, V.S. (1991). "A person to talk to who really cared" High-risk mothers' evaluations of services in an intensive intervention research program. *Child Welfare*, 70(3), 307–320.

Ramey, C.T. & Ramey, S.L. (1993). *Home visiting programs and the health and development of young children*. *The Future of Children*, 3, 129–139.

Surrey, J.L. (1991). *The "self-in-relation": A theory of women's development*. In J.D. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver, & J.L. Surrey (Eds.), *Women's growth in connection* (pp. 51–66). New York: Guilford.

Wasik, B.H. (1993). *Staffing issues for home visiting programs*. *The Future of Children*, 3, 140–157.

Weiss, H.B. (1993). *Home visits: Necessary but not sufficient*. *The Future of Children*, 3, 113–128.

## Stages of Change and Self-Efficacy

The constructs of stages-of-change and self-efficacy dovetail. The stages-of-change approach recognizes clients will be at different stages of readiness for change at different times, and ambivalence about changing addictive behavior is normal. Self-efficacy is the belief in one's ability to perform in ways that will produce desired outcomes, and expectations about self-efficacy are influenced most powerfully by an individual's own past accomplishments. A client's self-efficacy determines whether she will begin a behavior, put the required effort into it, maintain her efforts, and thus progress to another stage of change.

*"This work takes a lot of mental energy. You have to be feeling, you have to be knowing and understanding. You need to have a plan, but you have to let the client figure out the plan for herself. You wait for that tiny indication that the client sees the way and is ready to change. Then you reach out at the right time to help her move along. I have hope and faith in people. I really believe they want to change if they say they do."*

— PCAP Case Manager

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 have a positive influence on clients' efficacy expectations, motivational states, and, ultimately, behavior by:

- Providing clients with concrete, practical opportunities to accomplish goals of abstinence, 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; and
- Role modeling, as someone who has achieved personal goals similar to those the client may be aiming toward.

## Harm Reduction

### ***Selected Publications on Stages of Change***

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.

Miller, W.R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Olds, D., Kitzman, H., Cole, R. & Robinson, J. (1997). Theoretical foundations of a program of home visitation for pregnant women and parents of young children. *Journal of Community Psychology*, 25(1), 9-25.

Prochaska, J.O. & DiClemente, C.C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change*. New York: Plenum Press.

Rollnick, S. & Bell, A. (1991). Brief motivational interviewing for use by the non-specialist. In W.R. Miller & S. Rollnick, *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Sherman, B.R., Sanders, L.M. & Yearde, J. (1998). Role-modeling healthy behavior: Peer counseling for pregnant and postpartum women in recovery. *Women's Health Issues*, 8(4), 230-238.

## Section One: The Parent-Child Assistance Program—An Introduction

The framework of the PCAP intervention is influenced by harm reduction theory. Harm reduction is based on the assumption that alcohol and drug addiction and the associated risks can be placed along a continuum, with the goal being to help a client move along this continuum from excess to moderation, and ultimately to abstinence, in order to reduce the harmful consequences of the habit.

In practice, PCAP case managers focus attention not simply on reducing alcohol and drug use, but on reducing other risk behaviors and addressing the health and social well being of the clients and their children. For example, an important PCAP program goal is to reduce the risk of births of future alcohol- and drug- affected children. Not every client will be able to become completely abstinent from alcohol and drugs during her childbearing years. PCAP works with those women to choose effective family planning methods in order to avoid becoming pregnant, and to reduce harm.

### ***Selected Publication on Harm Reduction***

Marlatt, G.A., & Tapert, S.F. (1993). Harm reduction: Reducing the risks of addictive behaviors. In J.S. Baer, G.A. Marlatt, & R. McMahon (Eds.), *Addictive behaviors across the lifespan* (pp. 243-273). Newbury Park, CA: Sage Publications.

## **Section Two:**

# Getting Started: Operations

## 2.1 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 Section 1.4 - Fidelity to the PCAP Model).

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 and/or outpatient treatment agencies.

## 2.2 Budget Considerations and Categories

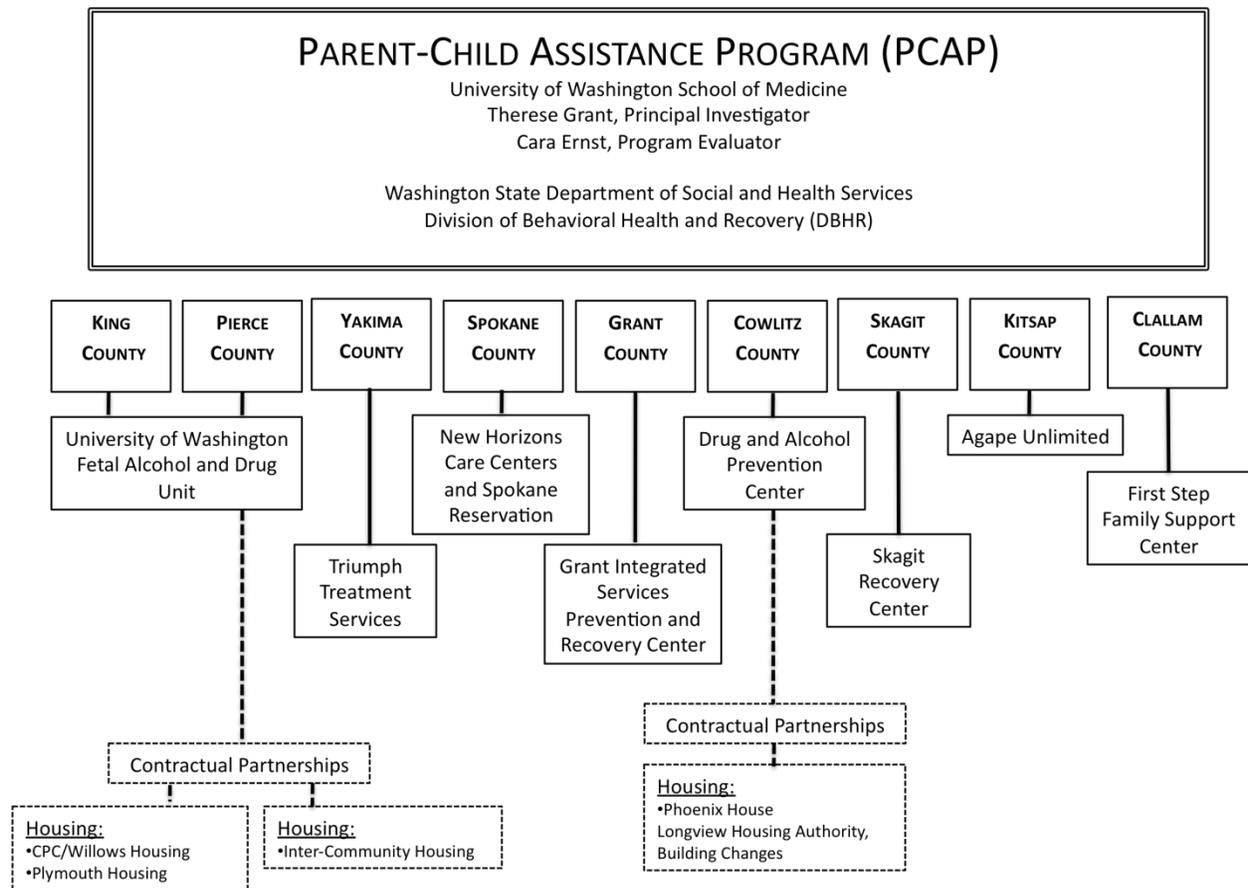
Below are the basic budget categories required for operation of a PCAP site. The exact amounts of these items will change depending on the size of the PCAP site and the geographic region within which the program operates.

Category	Common line items
Set Up	<ul style="list-style-type: none"> <li>• Office furniture and equipment (desks, chairs, phones, fax machine, etc.).</li> <li>• Computers for supervisor, assistant, and at least one computer for every two case managers.</li> <li>• Mobile cellular phones (with GPS tracking capability if possible), chargers and batteries, for supervisor and all case managers to enable communication and increase safety in the field.</li> <li>• 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 state motor pool vehicles, leasing or buying vehicles to use long term, using personal cars with mileage reimbursement.</li> </ul>
Salaries and Benefits	Full PCAP site <ul style="list-style-type: none"> <li>• Clinical supervisor</li> <li>• 6 case managers</li> <li>• Half-time office assistant</li> </ul> Half PCAP site <ul style="list-style-type: none"> <li>• Clinical supervisor</li> <li>• 3 Case managers</li> <li>• Quarter-time office assistant</li> </ul>
Personnel Services	<ul style="list-style-type: none"> <li>• Client needs/incentives (at least \$50/client/year)</li> <li>• Employee Training (approximately \$200/employee/year)</li> </ul>
Other Contractual Services	<ul style="list-style-type: none"> <li>• Postage</li> <li>• Utilities</li> <li>• Insurance</li> <li>• Printing</li> <li>• Evaluation database &amp; software license</li> <li>• Repairs</li> <li>• Copies</li> </ul>
Rent	
Travel	<ul style="list-style-type: none"> <li>• State vehicle motor pool fees, leasing fees, or mileage reimbursement.</li> <li>• Air fare if necessary</li> </ul>
Supplies	<ul style="list-style-type: none"> <li>• Office supplies</li> <li>• Miscellaneous</li> </ul>

- Food

### 2.3 Kinds of Agencies Hosting PCAP Sites

PCAP hosting agencies are typically substance abuse treatment or public health agencies. In Washington State, most PCAP sites are established and operated through county-based agencies. The organizational structure below represents how these agencies come together to create the Washington State PCAP program.



*For more specific information on PCAP hosting agencies in Washington State:*

**Triumph Treatment Services**

<http://www.triumphtx.org/>

*Triumph is a multifaceted agency providing a continuum of care for chemically dependent individuals and their families.*

**Grant Mental Health Care**

<http://www.gmhealthcare.org>

*Grant Mental Health Care offers initial and crisis services, children and family services, psychiatric services, and adult services within Grant County.*

**Drug Abuse Prevention Center (DAPC)** <http://www.dapcenter.org/>

*DAPC is a non-profit organization offering a variety of drug treatment programs for individuals and families.*

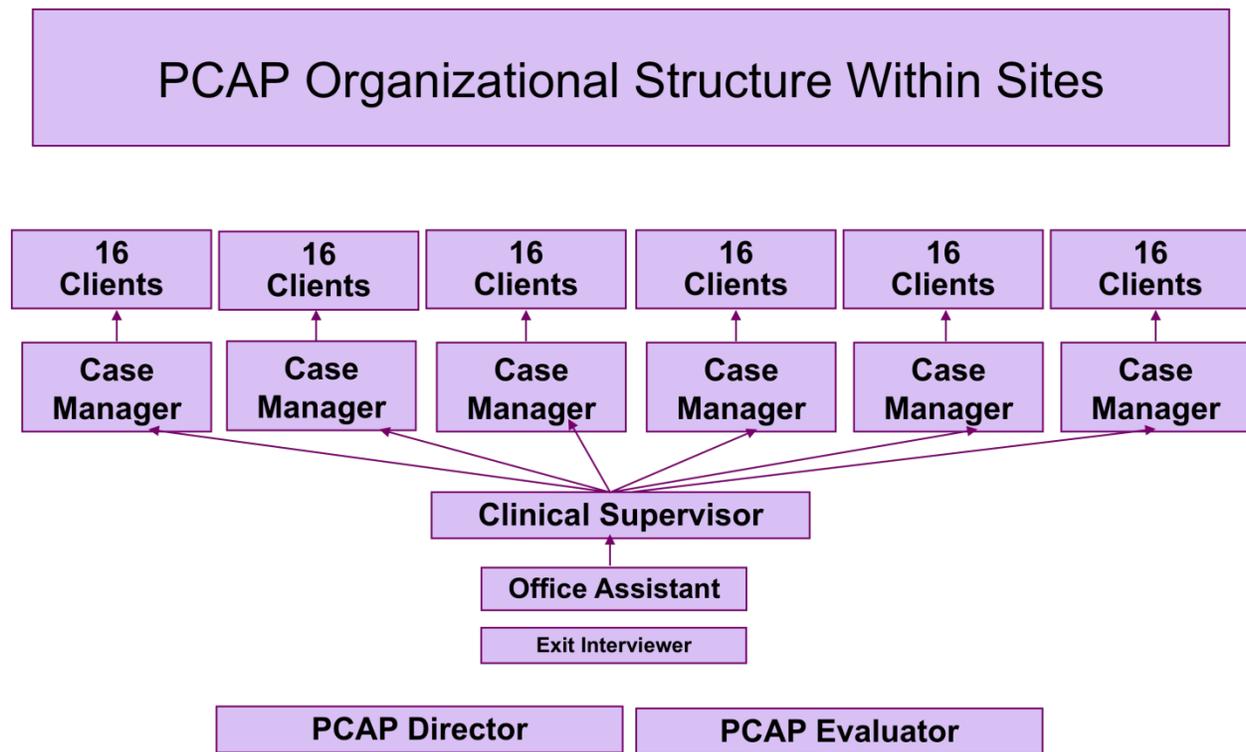
**First Step Family Support Center**

<http://www.firststepfamily.org>

*First Step Family Support Center is a non-profit organization providing support and education services to encourage the healthy development of families in Clallam County.*

## 2.4 PCAP Organizational Structure within Sites

The PCAP administrative structure is designed to work with a paraprofessional staff, while at the same time creating a rewarding work environment. Each PCAP program site ideally employs a clinical supervisor and case managers at a ratio of 1:6. Each case manager works with up to 16 PCAP 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.



## 2.5 PCAP Staffing

Core PCAP staff qualifications and job descriptions:

[Clinical Supervisor Job Description](#)

[Case Manager Job Description](#)

[Office Assistant Job Description](#)

### [Advertising 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 other home visitor 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.

Estimate of PCAP case manager time spent in physical activities:

Sitting	5.5 plus hrs/day
Standing in one place	0-2.5 hrs/day
Walking	0-2.5 hrs/day
Lifting	30 lbs
Lifting frequency	0-2.5 hrs/day
Carrying	30 lbs
Carrying frequency	0-2.5 hrs/day
Pushing/pulling (file drawers, carts, strollers)	0-2.5 hrs/day
Bending	0-2.5 hrs/day
Squatting	0-2.5 hrs/day
Climbing	0-2.5 hrs/day
Reaching	0-2.5 hrs/day
Driving	0-2.5 hrs/day
Simple grasping/fine motor	0-2.5 hrs/day
Keyboarding or typing	0-2.5 hrs/day

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

<p>Driving</p>	<p>Essential:</p> <ul style="list-style-type: none"> <li>• Transport clients and their children</li> <li>• Provide outreach services to connect clients with community agencies</li> </ul> <p>Provide outreach services to locate missing clients</p> <p>Details:</p> <p>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.</p>
<p>Home Visits</p>	<p>Essential:</p> <ul style="list-style-type: none"> <li>• Conduct two home visits/month per client)</li> </ul> <p>Provide housing support/ case management services</p> <ul style="list-style-type: none"> <li>• Obtain and maintain current CPR, Infant CPR Certification</li> </ul> <p>Details:</p> <p>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.</p>
<p>Office Work</p>	<p>Essential:</p> <p>Complete required paperwork</p> <p>Demonstrate cognitive/ organizational abilities to keep track of up to 16 clients, their families and their service providers</p> <p>Document all activities accurately and in a timely manner</p> <p>Details:</p> <p>PCAP paperwork requires approximately 8-10 hours per week at a desk writing, making phone calls, typing, and computer data entry.</p>

## 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 frequently take months to re-engage with someone new, or they may drop out of PCAP entirely.

### Successful Case Managers

Successful case managers have varied styles and approaches to working with clients, but 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 for the client, each small step she takes toward rebuilding her life is a risk deserving of 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

### Unsuccessful Case Managers

Case managers who have not been successful in the position have taught administrators important lessons, including:

- Former alcohol or drug abusers must be in recovery for at least 6 years and, equally important, must be maintaining a stable, recovery-oriented lifestyle with a solid support system. They must have moved well beyond the chaotic circumstances associated with the former lifestyle.
- The case manager/home visitor position is not a desk job with a predictable schedule. It is an outreach position: case managers go to the clients; the clients are not expected to come to the case managers. Case managers who cannot flexibly manage multiple issues and prioritize quickly as crises arise will find this work stressful and disheartening and are unlikely to form successful relationships with clients.
- A judgmental or apprehensive attitude on the part of the home visitor is detrimental to building an open relationship with the client.

## PCAP Policy on Telecommuting

Administrators may not want to allow telecommuting, with the exception of home visiting, until staff are very experienced and familiar with the PCAP model.

At established sites, 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.

Additionally, some case managers do data entry from home. Sites that allow home data entry must have specific database confidentiality protocols addressing the security characteristics of PCAP online data entry from any computer.

Case managers intending to telecommute are required to:

- Discuss telecommuting with supervisor and get approval first;
- Have a clear plan for the work she'll be doing;
- 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.); and
- Document time on the PCAP Time Summary form.

Guidelines:

The PCAP Client File protocol states that: "Client files are not 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."

The PCAP Boundaries protocol states: "Case managers may choose to work with clients on the weekend or evening if the situation warrants, and will first discuss with and get approval from supervisor (e.g. to identify the therapeutic goal)."

Supervisors typically agree that whether or not they approve that a case manager may work from home depends on the characteristics and responsibility of the individual case manager.

## 2.6 Case Manager Characteristics

PCAP is a paraprofessional model in the sense that case managers are uncredentialed in helping professions such as nursing or social work. Staff are hired at a higher standard than most programs that use paraprofessionals: prior to hire, they must have at least four years of community-based experience working in a social services field with high-risk populations or with women who have prenatal substance abuse or associated problems (or the equivalent combination of education and experience).

In the PCAP model, case managers understand the high-risk setting in which clients live. Most case managers have faced at least one significant obstacle to well-being; examples include domestic violence, poverty, single parenting, an alcoholic parent, or personal alcohol or drug abuse. More importantly, case managers have overcome obstacles and achieved significant success – for example, by going back to school or 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 grounded in reality. 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
- At least four years of prior community-based experience in social service settings with high-risk populations, or the equivalent combination of education and experience
- Experience as mothers is helpful
- Tenacity, persistence

*"I've lived through the things they've been through, so I'm not afraid or intimidated. I've lived with domestic violence. For someone to tell a client in a domestic violence situation to just up and go, it's not that easy. There are lots of plans to think about. I understand when someone says, 'I can't just leave right now.' But I can help plan a strategy, because I've lived it."*

—PCAP Case Manager

*"I know what it's like to be a single parent, homeless, and on welfare. I share a common ground with my clients as far as those things go. The difference is that I saw what the obstacles were, and overcame them. I just kept moving ahead and learned that where there's a will, there's a way."*

—PCAP Case Manager

*"I do (this work) in large part because I am the biological mother of a fetal alcohol effect son. I am a recovering alcoholic. 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. There are a lot of rewards. Women do get their lives turned around, and I know that 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

## 2.7 Role of Clinical Supervisor: In the Program and In the Community

Role of Clinical Supervisor in the Program	Role of Clinical Supervisor in the Community
<ul style="list-style-type: none"> <li>• Screens referrals</li> <li>• Assigns new clients to case managers</li> <li>• Administers consent/client service agreement</li> <li>• Conducts ASI intake interview</li> <li>• Supervises individual case managers weekly</li> <li>• Facilitates weekly group staffing meeting</li> <li>• Accompanies/observes case managers on home visits</li> <li>• Identifies training needs and arranges trainings</li> </ul>	<ul style="list-style-type: none"> <li>• Establishes PCAP identity</li> <li>• Solicits referrals</li> <li>• Facilitates communication among providers</li> <li>• Identifies service barriers</li> <li>• Interacts with agencies to resolve barriers</li> <li>• Participates on task forces, work groups</li> <li>• Provides feedback, data to community</li> </ul>

PCAP clinical supervisors have a two-pronged role. They provide direction and supervision within PCAP as well as play a central role in building PCAP’s identity in the wider 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.

## 2.8 Lessons Learned About Maintaining Staff and Accountability

### Staff Retention

Paraprofessional models are considered to be cost-effective because staff are compensated at lower rates than professionals. However, this is only true as long as there is little turnover among the paraprofessional staff, given costs of rehiring, retraining, and shifting caseloads.

PCAP case managers have described three administrative components of the PCAP model as contributing to job satisfaction and retention:

- weekly group staffing;
- individual weekly supervision;
- receiving feedback on client success over time.

### Work Environment

A positive office environment contributes to case manager retention. To this end, it has been advantageous to hire case managers who have work experience and who understand behaviors expected within the context of an office culture. Even so, problems still arise—common problems for PCAP staff teams to face are:

- gossip or inappropriate venting of frustrations in the office that can be overheard when others are on the phone;
- leaving the shared agency cars in unacceptable condition for the next driver;
- inconsistency in completing paperwork in a timely manner;
- inappropriate smoking behavior.

When relevant to the group, problem areas are discussed at staff meetings and case manager input is sought in resolving issues (e.g., case managers as a group devised a checklist and delegated tasks for upkeep and monitoring of agency cars, and case managers suggested assigning paperwork catch-up days for those who were behind).

### Communication and Accountability

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 not going to be in the office, case managers leave information indicating their destination (e.g. name, address, phone number of client) and expected return time. This information is 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

Case managers work full-time with flexible hours, because important client events and crises do not necessarily occur on weekdays between the hours of eight and five o'clock. Case managers

- must get prior approval from the clinical supervisor if it becomes necessary to work evening or weekend hours, and they must identify the clinical purpose for the work;
- are discouraged from working more than 40 hours per week;
- if they do work over 40 hours, they must record the hours on the Weekly Time Summary Form and the extra hours off as soon as possible, preferably within the next week; and
- are never permitted to accrue more than 10 hours in additional flex time.

## 2.9 PCAP Training

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

### Case Manager Pre-Service Training:

- Guidelines for new hires
- Didactics (classroom/workshop)
- Observation
- Field accompaniment (“shadowing”)

### **Training on Relevant Topics from Outside, Professional Sources**

These in-depth trainings may be specifically arranged for PCAP staff, or they may be *already occurring* trainings that PCAP staff locate and attend. Because at hire PCAP staff 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:

- Alcohol and drug abuse (behavior, treatment and recovery, relapse prevention)
- Motivational Interviewing
- 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)

### **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. These 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
- Planned parenthood
- Local police department
- Local substance abuse treatment agency

#### ***Example of PCAP In-Service Training with Local Providers***

*“We invited Planned Parenthood to come to 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, Planned Parenthood 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 rolodexes, but knowing who they are and what they look like, inviting them to our offices, and spending time with them so we understand each others’ work.”*

# **Section Three:**

## **Getting Started: Clinical**

## 3.1 Client Eligibility

Women are eligible to enroll in PCAP who meet three basic criteria.

### **1. Pregnant or up to six months postpartum**

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 heavy alcohol and/or drug abuse during the pregnancy**

Note: Underreporting is common. Additional substance abuse risk signs that may indicate a woman's probable eligibility include:

- positive maternal/infant toxicology screens during pregnancy or at delivery
- previous alcohol or drug exposed pregnancies
- previous children removed from custody due to alcohol/drug abuse
- history of alcohol/drug treatment or treatment failures

**and**

### **3. Ineffectively engaged with community service providers**

Note: 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 a good indicator that these service connections have not made a positive difference in her life).

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: when she leaves treatment what is her support system? Who will help her avoid relapse? Who will coach her in taking the next steps toward recovery and an improved quality of life? The intention is not to duplicate services, but to enroll those women who really need our long term intervention.

*There is **a second way** in which women are eligible for PCAP, 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.*

## 3.2 Special Considerations: The Client Population

### Mental Health

An important consideration at enrollment is a woman’s mental health status. At intake 50 to 60% 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 may 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 mental health provider and treatment facility where she can obtain therapy and medication. The question to ask is whether PCAP is enough to address the needs of the woman.***

The clinical supervisor should consult whenever possible with other PCAP clinical supervisors or professionals to determine 1) how the woman would benefit from our services; 2) which additional wrap-around 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.

*“We enrolled a client in PCAP who had schizophrenia. The referring mental health treatment provider really wanted the woman enrolled in PCAP. She was accepted on the condition that her mental health provider work hand-in-hand in conjunction with the PCAP case manager for the three year duration of the program. It required a lot of commitment from the mental health folks, but it was an important condition for PCAP to insist on”.*

*“A client was enrolled at the PCAP site and it was only after we began working and interacting with her that we realized that she was seriously cognitively impaired and probably should not be parenting at all. The PCAP staff consulted with the women’s substance abuse and mental health treatment facility where the client was attending outpatient treatment and together the team recommended the removal of the child from the mother’s care. However, when the team discussed the case with Child Protective Services (CPS), they said, “But she is going to be in PCAP, and PCAP is going to keep an eye on her and her baby.” PCAP nevertheless advocated for the removal of the child because we realized PCAP would only give the woman and CPS an illusion of safety for the child that could not be guaranteed, even with regular PCAP home visitation and connection to services.”*

## Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorders (FASD) are birth defects of the brain caused by prenatal alcohol exposure. FASD may be further compounded by a poor postnatal environment (e.g., being raised by an alcoholic mother, multiple foster care placements). The brain is the organ most vulnerable to the effects of alcohol; it can be damaged even in the absence of facial or other physical characteristics.

### Behavioral Phenotype 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

### Challenges of Getting a Medical Diagnosis

- Little access to diagnostic clinics/assessment for adults
- Documentation of prenatal exposure may be unavailable
- Facial features and growth deficiency often absent in adulthood; childhood photos and growth records are often unavailable
- Inability of client to follow through with all the steps required, without assistance

### Identifying PCAP Clients We Suspect Have FASD

The clinical supervisor asks the clients at intake:

- “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 biologic mother alive? If not, how old were you when she died?”
- “Were you raised by someone other than your biologic parents?”

The clinical supervisor asks about behaviors indicating cognitive problems:

- Impulsivity
- Behaviors that seem ‘stupid’
- 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

### **Help 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**

Figure out 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.”*

### **The Fundamentals**

- Revise your expectations based on client’s level of functioning
- Set reasonable goals
- Help set up structure and consistency
  - Be consistent in appointment times, locations, and providers
  - Be alert for changes/transitions—monitor more carefully, do advance problem-solving
- Alter language: use short sentences, minimize abstract, and use concrete examples
- Learn client’s “unique” language patterns
- Present information strategically:
  - Use multiple modes
  - Simple step-by-step instructions (written and/or with illustrations)
  - Role-play
- Ask client to demonstrate skills (don’t rely solely on verbal responses).
- Revisit important points during each session.
- Teach generalization: Don’t assume a skill learned in one context will transfer to another.
- Help client identify physical releases when escalating emotions become overwhelming.
- 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% published in the National Comorbidity Study (Streissguth, Barr, Kogan, and Bookstein, 1996; Kessler, Borges, and Walter, 1999).

#### Suicide Intervention/Prevention

- Recognize client is at increased risk for suicide
- Refer client for mental health evaluation/treatment
  - Alert provider about possible cognitive issues
- Standard suicide assessment protocols do apply
  - 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?”
- Check for a disconnect between seriousness of the suicidal behavioral and the level of intent to die
- Obtain family/collateral input
  - Address basic needs and increase stability
  - Treat depression
  - Teach distraction techniques
  - Remove lethal means
  - Increase social support
- Do not use suicide contracts (because these clients tend to be very impulsive)
- Monitor risk closely
- Reinforce and build reasons for living
- Strengthen advocate-client relationship

#### **Motivational Interviewing (MI) Works 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
- Accepts interim goals: step-by-step, “baby” steps toward ultimate goals
- Client’s self-efficacy is influenced most powerfully by her own accomplishments

#### MI Modifications for FASD Clients

- Provider may need to be more active in helping 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 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 client to carry a notebook wherever she goes, for providers to write down instructions, appointment times, etc.
- Help client find an activity that’s calming, comfortable, fun, and easy to access (music, swimming)

#### Using the Difference Game with clients who have FASD

- Give client the cards one at a time.
- Select one or two *reasonable* goals.
- Identify “baby steps” it will take to reach each goal.
  - Assign client one or two baby steps at a time and have her report back.
  - Reinforce every step in the right direction.

#### 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:

- deal with emergencies
- 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.

Working one-on-one with the mom and child is a “good fit” for FASD clients. Why?

- Individualized intervention is tailored to the mom’s learning style
- Many opportunities for hands-on practice and role modeling
- The work is in the home and on “field trips” (decreases problems generalizing)

*“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 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)

#### ***Selected Publications***

*Connor, Sampson, Bookstein, Barr & Streissguth 2000, Developmental Neuropsychology, 18(3), 331-354.*

*Grant, T., Huggins, J., Connor, P., & Streissguth, A. (2005). Quality of life and psychosocial profile among young women with fetal alcohol spectrum disorders. Mental Health Aspects of Developmental Disabilities, 8(2): 33–39.*

*Grant, T., Huggins, J., Connor, P., Pedersen, J., Whitney, N., & Streissguth, A. (2004). A pilot community intervention for young women with fetal alcohol spectrum disorders. Community Mental Health Journal, 40(6): 499–511.*

*Huggins, J.E., Grant, T., O’Malley, K. & Streissguth, A.P. (2008). Suicide attempts among adults with fetal alcohol spectrum disorders: Clinical considerations. Mental Health Aspects of Developmental Disabilities, 11(2):33–41.*

*Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Arch Gen Psychiatry 1999;56(7):617-626.*

*Streissguth A., Barr H., Kogan J. & Bookstein F. Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE). Final Report to the Centers for Disease Control and Prevention (CDC). August, 1996. Seattle, University of Washington. Fetal*

## Additional Challenges Working with the Target Population

PCAP works with an inherently challenging population. It is important to be aware of the main challenges so staff can contextualize client behaviors and work with clients to set the most reasonable expectations and goals for client improvement. Unreachable expectations for clients do not serve them or the community well.

1. All of our clients are substance abusers: substance abuse can cause cognitive problems and psychiatric symptoms
  - Cognitive problems could include: memory loss, learning problems, and impaired decision making
  - Psychiatric symptoms could include: anxiety, angry outbursts, paranoia
  - *Remember: These symptoms can clear when a person stops using, but it takes time. The brain needs a drug free environment to heal. Sometimes behavior can initially look worse when clients initiate treatment. It will take time for the brain to remap itself and begin functioning more normally.*

### Functionality of clients can be compromised for a variety of reasons, including:

2. Psychiatric co-morbidity
  - Nationally, about 30% of women nationally who have a substance use disorder have a co-occurring serious mental health disorder (typically anxiety or major depression).
  - Within the PCAP client population, consistently more than 30% of women experience a psychiatric co-morbidity.
3. 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.
4. History of traumatic brain injury.
  - Approximately 47% of PCAP clients were physically abused as children and 76% have been beaten as adults. Many have been involved in serious accidents.

### 3.3 Client Recruitment

*“PCAP’s best recruitment strategy is having a good reputation in the community...positive word of mouth really matters.” –PCAP Administrator*

#### Three-Step Recruitment Process

##### 1. 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 in the community
- Developing a cadre of agencies and individuals who will make referrals to PCAP
- Maintaining rapport and a good reputation with these agencies

#### ***Strategies for generating referrals:***

- Develop a PCAP brochure that briefly describes the intervention, the eligibility criteria, outcomes to date, and contact information. See [Washington State PCAP Brochure](#) example.
- DO NOT send a mass mailing to community providers.
- Do schedule brief, in-person meetings with supervisors or administrators at the agencies most likely to come into contact with eligible women.
- 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.
- Do invite the agency supervisor and/or agency staff to attend a PCAP staff meeting to learn more and meet the case managers.
- Do emphasize that PCAP is a best practices, evidence-based model, and distribute a list of PCAP articles published in peer-reviewed journals.
- Do follow up on these meetings, and always send a thank you note.
- 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.

## 2. Screening and Accepting Referrals

The supervisor (not the case managers) is the PCAP team member who is responsible for a screening the referrals and determining eligibility. Having a single ‘point person’ in this role ensures that enrollment is standardized. Supervisors often consult with other supervisors if they are unsure about whether or not a potential client meets the enrollment criteria.

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

### ***The PCAP clinical supervisor is responsible for:***

- Screening each new referral by completing every section of the Community Referral Screening Questionnaire (CRSQ)
- Making 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)*
- Making enrollment decision (may need to confer with other PCAP supervisors), and contact client to inform her and obtain her verbal consent
- 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

**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. If that assumption is incorrectly made, the child could be at high risk.

### ***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.

### 3. 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. 2010).  
Within these, keep files labeled:
  - Pending eligibility decision (Note: this is for CRSQs that are in process and don't have enough information yet to determine eligibility)
  - Eligible and enrolled
  - Eligible but refused
  - Eligible but not located
  - Not eligible

*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 excellent documentation showing 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 initially agreed 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 she did not want to enroll. The documentation showed that PCAP had stayed in close contact with CPS throughout this process, and informed them immediately of the mother's refusal to enroll. It was clear that CPS knew that the baby was not under the watch of PCAP.*

## Addressing Common Recruitment Challenges

### Challenge: Community misconceptions about PCAP.

Nearly every new PCAP site has had the experience of 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 that week).*
- *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. (PCAP data indicate that about 60% of clients have custody of/are living with their child at PCAP exit. A significant part of PCAP work is assuring 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 delivering babies born into the same circumstances as they were.

**While this is not an excuse for their current behavior, these clients are not throwaway people.** PCAP data show us that most of these women do want to learn how to be healthy adults and good mothers. They need a lot of help doing that; they need to be taught, they need good role models, they need someone to demonstrate and help them practice, someone to give praise and constructive criticism. **Turning our backs or 'kicking them out' because they are difficult to work with does not make their problems go away.** It does ensure that they will continue to lead dysfunctional lives and continue to bear children who suffer in turn, incurring tremendous community social and economic costs.

- 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 in organizing case consultation meetings with the provider (after Releases of information are signed). Be patient, professional, transparent, and consistent. As the case 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.

*“My clients basically had no parenting when they were kids. I sometimes think of them as toddlers learning to walk on their own two feet. In the beginning I show them how and I hold their hands until they start to feel confident and take steps on their own. Sure, they fall down and it hurts. I help them get up and try again until they start to get steady and strong. I praise them when they make it, and challenge them to go a little farther every time. At the end of PCAP my clients are off and running on their own, without my help.”*

–PCAP case manager

*The social worker couldn’t believe her eyes when I took my client to the welfare office six months after she’d been in PCAP. She couldn’t believe it was the same woman. That office called PCAP with three referrals in the next few weeks after that.”*

–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 was a heavy user during pregnancy but the woman 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 do her best to gain some trust with the woman so that she will more accurately disclose her pregnancy alcohol and drug use.

To gain a client’s 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 we know how to help her turn her life around; many of our case managers had stories just like hers;
- DO NOT try to persuade her by offering housing options or transportation; her interest in PCAP should be because she wants to stop using and make changes in her life;
- Try to reduce her level of shame and guilt by telling her that in early pregnancy most women don’t know they’re pregnant, and so don’t stop using alcohol and drugs. Ask her if this was the case for her;
- 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 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 probably doesn’t fit PCAP. I give the caller phone numbers of housing resources to try.” –PCAP Clinical Supervisor*

**Challenge: Community providers may refer women to PCAP in hopes that we’ll be able to reduce their workload.**

For example, child welfare social workers commonly make an appropriate referral, and later expect that the PCAP case manager will provide all the transportation for court-mandated weekly-supervised visits with the mother and child (which is actually child welfare’s legal obligation).

**Addressing the Challenge:**

The PCAP case manager, with supervisor assistance if necessary, must explain that PCAP will do some of these visits, but the size of our caseloads and obligations to other clients make it impossible to provide this service regularly. We offer to help the child welfare worker develop a child visitation plan that is realistic, and we follow up every week to assure that these visits are actually occurring. If they are not, we go back to the planning stage. The important point is that the mother and child see each other on a regular basis, and that visitation is not disrupted or contentious.

**Challenge: Community providers may refer women to PCAP in hopes that we'll relieve them of the most difficult clients on their caseload.**

**Addressing the Challenge:**

Women are only enrolled in PCAP if they meet all eligibility criteria, and in many cases these are indeed the most difficult clients on a service provider's caseload. However, in accepting the client into PCAP, the clinical supervisor must emphasize to the referring agency that we will expect to work closely with the agency (if they provide services appropriate for the client) and with other service providers throughout the intervention.

*"As a PCAP clinical supervisor, I cannot say 'yes, yes, yes' to every request from other service providers. PCAP cannot be the 'fix all' program in the community. It puts the entire PCAP program in a vulnerable position if you make promises that you cannot keep."*

*—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 her until then. If we have not located her by then, she is considered "not eligible."

**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 at near full capacity and has steady incoming referrals, or if the site has a waiting list already, then missing referrals have 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 6 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 recruiting party is responsible for letting the woman know that they have referred her to PCAP, and asking her if it's alright if someone talk with her about what we can offer.

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

**Addressing the Challenge:**

The closer a woman is to the delivery, 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.

The ideal is to enroll a woman as early as possible during pregnancy to reduce the potential for substance exposure to the baby. However, most women are not ready to accept intervention at this early stage because the pregnancy is not a reality for them; they have not begun to plan for the baby, and may simply want to continue to "party" until the baby is actually born. If a site enrolls a client too early in her pregnancy it can work against the efforts to engage her in PCAP because she may not be ready.

The best time to enroll a woman in PCAP is as close as possible to the time of delivery, because she is most vulnerable at this time and is more likely to recognize that she really needs extra help.

**Challenge: Are women ever enrolled in PCAP for a second round 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 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 feels she would benefit from PCAP during the additional three years, what has changed, why PCAP should create another opening for her when the client 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 have reenrolled have fewer than half of the women who were referred for a second round of PCAP.

### 3.4 Client Intake

The PCAP intake interview process:

- Is a thoughtful, caring, and nonjudgemental 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**; and
- 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**

- Welcome the client and explain PCAP.
- 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.
- Review in detail, and have the client sign and date the [Client Services Agreement](#) and [Consent Form](#) (in Washington State).
- Administer PCAP Addiction Severity Index (ASI) intake interview.

**Frequently Asked Questions about Client Intake**

*Q: Why can't the intake interview be done in the client's home?*

A: The client's home is usually unpredictable and chaotic. In addition, the chance of having the client's confidentiality violated is high within the client's home, as the interview may be overheard by children or other adults. PCAP interviews need to be conducted under similar, 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 the same as going to a doctor's office-- before she can go into the 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, or 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.

### Case Manager Role

- Schedule interview with the clinical supervisor and the client.
- 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.
- Inform client that the consent and interview process will take about 2 hours.
- 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).
- Provide childcare at the PCAP office if the client brings her children.

## 3.5 PCAP Safety Protocols

PCAP staff members are home visitors who may find themselves in situations in which their personal safety is at risk. The [PCAP Safety Guidelines](#) were developed to help staff avoid risky situations, and respond to problems if they arise. 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.

## 3.6 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.

### Specific Forms in the Client File

- **1st section:** [Client ID Sheet](#) (on top), [Tracing Update Information](#), and [Client Services Agreement](#)
- **2nd section:** [Service Coordination](#), [Releases of Information](#)
- **3rd section:** [Mom](#) and [Target Child Medications/Immunization Information](#)
- **4th section:** Assessments and [Goals](#) (Difference Game, [Strengths and Needs](#), [ASI last page](#))
- **5th section:** [Case Notes](#)
- **6th section:** Correspondence

### **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**

- Idea for collecting information for the Tracing Information Update:
  - o 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**

- Here keep a copy of the Client Services Agreement signed by the client at the intake interview.

### **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.

The case manager:

- 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).
- Contacts each service provider on the list and introduces herself, explains the program and her role as a PCAP case manager. The service provider may ask the case manager to fax the ROI before they talk.
- Continually updates Service Coordination form 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, and which providers the client is longer involved with.
- Keeps prior Service Coordination contact pages in this section of the files, and never discards old information as it may be valuable in tracing.

#### Service Coordination Form Strategies

- Beginning with a new client’s enrollment, each case manager systematically contacts service providers who are currently involved with her client and locates additional professionals and providers whose skills and services will be necessary to help the client meet personal and program goals.
- After obtaining necessary Releases of Information from the client, the case manager 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.
- Case managers help clients manage multiple life problems that will otherwise complicate and interfere with service provision by the professionals. 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)

In general:

- 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 question.
- 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.

#### Do I need to get ROIs from the client’s family members?

You should get ROIs from:

- The family member who has legal custody of the target child
- The family member who is the primary caregiver for the target child
- The emergency contact person(s)

You do not need ROIs:

- to report abuse/neglect to child welfare (case managers are mandated reporters)
- from boyfriends, friends (not subject to confidentiality laws)

**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 "Seattle 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:**

**Mom and Target Child Medications**

**Mom Medications:**

Case managers

- Record information about medications the client is taking or that have been prescribed for her. They record this information in accurate detail in order to: keep clients on track with their medications; remind them when prescriptions need to be filled; and have information available for medical providers who may need to know exactly what medications a client is on (for example, before they prescribe a new medication, 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 medication containers to determine name and dosage.
- Record this information on the medications form.
- Include medication for physical problems, mental problems, and birth control medications.
- Update information as necessary, and date every update.
- More than one medications 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.
- Check off immunizations that the target child has received and when, using the immunization schedule on the back of the TC Medications form.

**4th Section:**  
**Assessments and Goals**

**Assessments**

- Assessment Tools: Difference Game, Family Strengths and Needs, Difficult Life Circumstances (DLC), last page of ASI (profile of client needs).
- Completed by case manager within 6 weeks after client enrollment.
- Reviewed as soon as possible in supervision.

**Goals** (see details in section 4.2 of this manual)

Goals are evaluated and reestablished every four months because this amount of time allows clients to (a) accomplish short-term, concrete tasks (e.g., complete paperwork for housing waiting lists or enroll in a neighborhood parenting class, and (b) make progress on long-term goals requiring fundamental, gradual life changes (e.g., staying in recovery or avoiding contact with former abusive partner).

The case manager

- Completes goals sheet with each client at enrollment. Administering the Difference Game first helps elicit issues important to client and that she may want to consider as goals;
- Reviews as soon as possible in supervision after each administration;
- Makes a copy to keep in client file;
- Gives a copy to the client so she is reminded of goals she defined.

**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.*

### **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. Then 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.

### **Case Notes: Some 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., “.... as evidenced by....”
- DO keep case notes up to date. DON’T get behind on your notes.
- DO write notes that are useful to you.
- DO strike through mistakes and write above. Don’t use ‘Wite-Out’.
- DO record volatile situations, but also notify your supervisor immediately of these situations.

### 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 Permission for Transport and any other permissions.
- Following these, file other 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 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. 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.
- 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.
- **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: Client File Tips**

- 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 that client’s file.

**Supervisor Lessons Learned about Client Files**

- Supervisor is ultimately responsible for content and quality of client files.
- Supervisor recommendation: do Client File Reviews (audits) every 3 months.
- Client file audit results can be used in personnel actions.

## **Section Four:**

# Delivering the Intervention

## 4.1 The Intervention—Part 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.

*"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

Primary case manager tasks are to:

- Assist clients in obtaining alcohol and drug treatment and staying in recovery;
- Connect women and their families with existing community services;
- Coordinate services among this multidisciplinary network;
- Assist clients in following through with provider recommendations;
- Assure that the children are in safe home environments and receiving appropriate health care; and
- Teach clients how to access community services themselves.

## 4.2 Content of the Intervention

### 1. Establishing a Relationship

Reflecting PCAP's relational theory, the case manager's first step is to build a bond and develop a trusting relationship with her client. Many of our 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, alcohol, and prostitution), so this process may take months. Throughout PCAP, the case manager continues to develop this positive, supportive interpersonal relationship.

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

- Role model honesty and integrity.
- Stay in contact with clients: **regular home visits (twice/month minimum)**, and in addition calls and letters.
- Act as a role model in all their activities with the client: basic skills, social behavior, parenting skills, household management, etc.
- Provide explicit direction, instruction, and advice in the beginning.
- Tell clients a little about themselves, why they chose to do this work.
- Treat clients with respect and dignity.
- Keep the client confidentiality; use Releases of Information.
- Uphold promises (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 connect clients to appropriate service providers.
- Do not make assumptions about how the client feels.
- Do not get caught up in the emotions of the moment.
- Stay in control in problematic situations (*don't react...do respond*).
- Role model effective ways to express anger.
- Continue to work with the client after an unpleasant incident, and **always** help her examine her behavior, and help her learn to respond in ways that are more appropriate and effective.
- Engage the family/friends involved in the client's life.
- Use humor.
- Trace clients who disappear: make weekly attempts; continually obtain updated contact information.

Understand that relapse is part of the disease; tell the client that she will not be asked to leave the program because of relapse or setbacks.

## 2. 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.***

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. 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 give her a to-do list.

### 3. Establishing Ground Rules with Clients

At the start and throughout the intervention, PCAP case managers work with clients to define the nature of the intervention by setting and re-visiting 'ground rules'. **PCAP Ground Rules are not friendly suggestions for PCAP staff; they are an essential part of the model.** Clinical supervisors review ground rules with clients during the intake interview, and case managers remind clients of them as often as necessary during the intervention.

The Ground Rules are these:

- Case managers will not lie to clients or for clients.
- Case managers will not meet with a client if she is high.
  - If the client is high, case managers will acknowledge that it's not a good time, and reschedule.
- Case managers will work with clients through ups and downs: there will be times clients don't like case managers. It's okay if case managers and clients disagree, but they must continue to communicate.
- Case managers have other clients and there may be times when someone else's emergency becomes the day's priority.
- The case manager's role is not to continually respond to client crises, but to help clients move beyond crisis and toward achieving their goals.
- Case managers will be on time or will call if they are running late. Clients should call case managers if they are running late or have to cancel.
- When possible, case managers will let clients know ahead of time if they have to call Child Protective Services (CPS).
- Case managers and clients will have a three-year working relationship, not a three-year friendship.
- Case managers will let clients know when they're giving them too much information about something case managers don't need to know.
- Case managers will tell clients their communication preferences/boundaries for cell phones and pagers.
  - With clients who call the case manager too often (many times per day), consider setting a specific day and time to call them (e.g. every Tuesday and Thursday at 11 a.m.).
  - Discuss when clients should call '911' vs. when to call the PCAP case manager.
- Case managers don't work '24-7'.
- If a case manager and client run into each other in public, the case manager will agree to ignore the client unless the client acknowledges the case manager; in that case it's alright for the client to introduce the case manager.
- Client will agree to tell the case manager if the case manager says or does something culturally offensive, so it won't happen again, and so it won't interfere with the intervention work together.
- Case managers will let clients know that 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."

*"PCAP works with women for three years in their homes and neighborhoods. A lot of things can happen under those circumstances. There is an opportunity for both close relationships and big misunderstandings to develop. We use ground rules from the very beginning to try to prevent misunderstandings that can mushroom into bigger problems and undermine the intervention."*

—PCAP Director

#### 4. Within the First Six Weeks

Two important priorities in the first six weeks of the PCAP intervention are (1) to address a client's major physical and mental health issues, and (2) to use the 'Difference Game' tool to help clients define goals and begin to develop an individualized intervention plan. Other priorities in the first six weeks depend on the client's unique situation. They may include, for example, helping a client arrange for public assistance, or housing.

##### 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 is due to a treatable physical or mental health problem.*

Case managers should take the following steps with each client during the first six weeks of enrollment in PCAP:

- 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.
- Obtain physical, dental, and mental health assessments *at the start of PCAP*.
- 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).
- *Accompany clients to important appointments* to help them communicate their symptoms and problems, and to help them understand what the provider says.
- Help clients learn to keep a notebook and write down what the physician tells them.
- Help clients get prescriptions filled.
- Work with clients to develop a way to remember to take medications as prescribed and comply with recommendations for diet, activity, etc.

##### 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 of 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.

## Goal Setting and Treatment Planning

The ‘Difference Game’ is a card-sort assessment method that was specifically designed to enable case managers to learn more about the client in a comfortable, unthreatening way, and work together with the client to identify client needs. The key benefit of the ‘Difference Game’ is that it provides an accurate assessment of an individual client’s reality, making it more useful in negotiating a service plan, monitoring objective progress, and examining the personal growth throughout the intervention period. After conducting the “The Difference Game” the case manager:

- Helps client define personal goals Identifies the incremental steps required to reach those first goals and who will be responsible for each item;
- Helps client work toward those goals; and
- Evaluates progress often and reestablishes goals every four months.

The ‘Difference Game’ and PCAP Goal Setting protocol provides more details on the assessment process.

### **First step: Learning the Client’s Story Using the Difference Game**

#### **The Difference Game: Four Steps**

1. Sort 31 cards into ‘yes’ and ‘no’ piles
2. Remove ‘no’ cards, and ask client to choose top 5 ‘yes’ cards
3. Rank cards 1-5 in order of importance
4. Discuss each of the top 5 ‘yes’ cards: “Your first card is ‘more sleep’... tell me about this...”

The  
Difference  
Game



**Talk about what you learned in the Difference Game, but remember, the top 5 cards do not necessarily become the Goals.** Clients may only be able to work on 1 or 2 main goals at a time. Be creative in helping the client define her own goals in a way that can be integrated with PCAP program goals (e.g. the need for treatment); reinforce client goals that focus on sobriety, recovery, health, independence.

**Note:** If you have time at a later home visit, discuss the ‘no’ cards. These will tell you a lot about how the client thinks, what she values, and how she accommodated to problems in the past.

#### **Next Steps: Goal-Setting**

- Help client define personal goals that she’ll work on in the first four months
- Clients may only be able to work on 1 or 2 main goals at a time.
- Identify and write down “baby” steps ***you and the client each will take*** to reach each of the goals.
- Make sure baby steps *are attainable* in the designated period because self-efficacy is all about helping clients *achieve and recognize* their own accomplishments.
- Goal setting should be dynamic and flexible! Modify or add new steps as necessary during the 4-month goal period.
- Client crisis? Help client learn to resolve the crisis *herself* by turning crisis resolution into a new goal with logical, appropriate baby steps she must take to address the problem.
- Re-establish goals every 4 months.

- Take a copy of the Goals with you on every home visit, and *refer to it*.
- First goals are often too lofty; they get more realistic over time.
- Clients can keep some of the same goals for the three years. Examples of excellent goals client have worked on during every goal period throughout the three years include “Stay clean and sober” (baby steps: go to my AA meetings 3 times each week; stay away from my old drug dealing friends; get involved with new friends at my church), or the goal “Show my baby I love her” (baby steps: spend a little time playing just with her every day; tell her I love her every day when she wakes up; don’t hit her).

### **5. Working with the Clients: 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 dismantle 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 her 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 who lives with the client 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.

### 4.3 The Intervention: Part II Between the Case Manager and Service Providers

One of the most important components of PCAP is the development of working relationships between case managers and client service providers. 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.

*“Half of my job is getting other people to do theirs.”*  
—PCAP Case Manager

Beginning with a new client’s enrollment, and after obtaining necessary Releases of Information from the client, case managers systematically contact service providers who are currently involved with the client and locate additional professionals whose skills and services will be necessary to help the client meet personal and program goals. As necessary, in order to facilitate the development of a coordinated service plan, the case manager links providers by organizing case consultations or conference calls.

PCAP staff best practices for engaging with other service providers include:

- Identify providers with whom client is already working (start by referring to the ASI intake interview).
- Based on your recent assessments, identify providers with whom you think client should be connected.
- Link clients with available and appropriate community services (PCAP does not provide direct treatment, health, or other services).
- Use the PCAP Services Coordination form to record service provider information.
- Coordinate regular communication among providers to design a plan that will set clients up for success, not failure. Prevent duplication of services, manipulation, and client falling through the cracks.
- Organize and participate in case consultation meetings, including the client.
- A hallmark of PCAP is to respond to phone calls, faxes, emails from other providers within 24 hours.
- 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.

#### **“Attitude of Gratitude”**

This means taking a few moments to thank hard working, responsive service providers and others for their efforts through hand written notes, an email, or a phone call.

PCAP has become known for showing our appreciation to these colleagues. We find that when a case manager takes 5 minutes of her time to write a note, address, and mail it, the working relationship with that provider or agency is noticeably enhanced: the next time the case manager (or any other PCAP worker) calls that provider, she is generally treated with more attention and respect, and issues get resolved more expeditiously.

#### **“Attitude of Gratitude” Activity**

One PCAP site spent a staff meeting creating thank you cards to send to CPS social workers, public health nurses, and others with whom they worked during the year. The response was overwhelming—providers loved receiving the cheery cards, and felt sincerely appreciated for their work with PCAP clients.

PCAP case managers teach their clients to do the same. People learn that they feel happier when they treat others with kindness and respect.

## 4.4 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.

PCAP never calls 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 be in that position. Instead, our role is to confront clients with the reality of their lives, and challenge them to take responsibility for their parenting.

*"Our clients are not stupid. 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*

**Most ideal scenario: Client calls CPS herself with case manager's help. In this case, the case manager:**

- Staffs the issue with her clinical supervisor.
- Using motivational interviewing strategies, discusses her concerns with the client, and helps her to examine the behavior and the situation.
- Explains that because she (the case manager) is a mandated reporter she must see that CPS is notified.
- Explains that if the client herself calls her CPS worker to talk about these 'early warning signs' and difficulties, and to ask for guidance to help get back on track, then she will be conveying a positive image to CPS: she is self aware, eager to improve, and is taking responsibility as a parent who wants to improve.
- Practices and role models this phone call with the client before they call the CPS worker.
- Is with the client when she makes the call to CPS.
- Documents activities carefully in case notes and briefs supervisor.

**Second most ideal scenario: Case manager calls CPS, but informs client first.**

- Start by taking the first four steps above. If client is unwilling to make the call, the case manager does so.
- 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
- Document activities carefully in case notes, brief supervisor, and inform client of the outcome.

**Third scenario: Case manager calls CPS.**

- Case manager staffs the issue with her clinical supervisor.
- 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.
- 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 manager's work on behalf of the child to secure a safe home environment and regular health care.

In general, PCAP and child welfare services work closely together. However, child welfare recommendations are sometimes based on biased attitudes and beliefs, and lack of information and experience. It is not uncommon for a woman to comply with her contract stipulations in order to regain custody of her child, only to learn that her social worker will recommend child removal at a court hearing.

*As advocates, PCAP case managers help clients comply with their individual contracts and act as liaisons between the agency and the client. They 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.*

It is not uncommon for PCAP case managers to voice objections to the courts regarding child welfare decisions. Based on our regular contact and good documentation, judges often turn to the PCAP case manager for accurate information and realistic assessment. In some cases, CPS workers have been held in contempt of court because PCAP has documented in case notes and written correspondence that they:

- did not follow required procedures;
- failed to appear at scheduled meetings;
- came to meetings unprepared;
- failed to provide required child visitation; or
- recommended custody be given to a family member with outstanding warrants or with a known history of child sexual abuse.

In many cases CPS has decided to not investigate a case PCAP reports, or to close a case early without adequate follow-up oversight. In cases like these, PCAP case managers and/or supervisors continue to do home visits and maintain a watchful eye while the woman remains in the program. Clearly, our work is made more difficult if we do not have the strong arm of the civil agency charged with child protection. In extreme cases PCAP asks the police to go to a home to do a 'well child check' and intervene on behalf of the children.

## 4.5 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 of some kind. 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 and the University of Washington, 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 legal counsel.

## 4.6 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 case manager's advocacy, however, requires that when service barriers become apparent and clients do not have the skills to solve 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.

Resolving service barriers requires the PCAP staff member to:

### **1. Identify barriers.**

Recurring problems with specific agencies/workers are identified and discussed in supervision and at weekly staffings.

### **2. Meet with agency partners and develop an appropriate response to the identified barrier. Listen carefully to everyone's version of the story.**

Ask agency worker/manager to attend a PCAP staff meeting or ask if PCAP staff can attend their staff meeting to:

- ascertain the functions and goals of both agencies;

### **When is a barrier not a barrier?**

- When it's a personality clash
- When it's a misunderstanding by the case manager about the protocol, role, or limits of the agency
- When it's an isolated incident
- When it's due to client error

- discuss specific problems that have arisen;
- devise strategies to resolve the situation and
- develop action steps.

**3. Follow up on these meetings.**

Send a Thank You note. Do whatever you agreed to do. Agree to meet again in the future.

**4. Request a meeting with a senior agency representative**

If a problem persists, request a meeting with a manager. Simply requesting action at a higher level may motivate people to do their job.

## 4.7 Supervisor Best Practices

**1. Pay Close Attention to Information on Weekly Time Summary Forms**

In order to manage staff more effectively and achieve better PCAP outcomes, supervisors:

- Keep each case manager's [Weekly Time Summary](#) forms sequentially in a file.
- Review the current week's form during weekly supervision and compare with a few previous forms.
- Pay close attention to how the case manager is balancing her time among the clients.
- Monitor to see that at least 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).

PCAP data indicate that in general, outcomes are better among clients who spend more time with their case managers. Realistically, case managers will not be able to see, or even talk to, every client every week. It's easy for case managers to slip into habits of seeing certain clients more than others because they are easier to get along with, or are doing well. **Don't let this happen.**

Over the weeks the supervisor must help case managers monitor the balance of time and assure that they are spending time on each case, and with each client. Otherwise, you'll find that some clients arrive at the end of the 3-year intervention having received not much intervention, and having poor outcomes to show for it.

**2. [Individual Case Manager Supervision](#)**

Close, regular, interactive supervision is key because the work can be physically/emotionally draining. During each supervision meeting, it is important for clinical supervisors to:

- Review each clients' status 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.

In addition to weekly supervision sessions, successful clinical supervisors also periodically:

- Accompany case managers on home visits to observe and consult.
- Read and sign off on case notes approximately every 3 months, using the PCAP [Client File Review](#) form to assure consistency.

### 3. Advocate-Client Relationship Inventory

The [Advocate-Client Relationship Inventory](#) is a 27-item questionnaire that was adapted 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).
- Is always completed after the final PCAP exit interview.
- In addition, it may be given to clients at anytime during the 3-year intervention (in person or as a mailed survey). In this case it is used by clinical supervisors to assess program quality and client satisfaction or as a tool to help assess personnel problems (e.g. validity of a case manager's reported time spent with clients).

### 4. Weekly Staff Meetings

Effective clinical supervisors ensure weekly group staff meetings are brainstorming, problem-solving sessions and leave case managers in a positive frame of mind for the challenges they face.

During individual supervisions, the clinical supervisor listens for common problems or barriers that should be addressed in group staffing. Clinical supervisors may ask case managers to discuss specific clients in group staffing in order to engage the group in problem solving. Within 2 or 3 weeks, a case manager should give an update to the group, so others can know how their suggestions worked.

General characteristics of weekly staff meetings:

- 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.
- Participants do not make or answer phone calls or text messages and paperwork is not done.

*"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

- Periodically, guests from the local service provider community are invited (local police, Planned Parenthood, child welfare).
- Every so often, clinical 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.
- Local legislators are invited at least once a year to give them first hand exposure to the program, showcase outcomes, and answer questions.

### 5. PCAP Site Newsletter

Clinical supervisors frequently generate a PCAP site newsletter. General ideas on content for PCAP site newsletters include:

- Clean and sober birthdays (e.g., Kathy – 6 months)
- Target child birthdays (e.g., Monty – 1 year old!)
- Client poetry, testimonials
- Fun and free things to do (e.g., library story times)
- Recipes (easy, nutritious)
- Informational articles (e.g., health, child development)

Newsletter guidelines:

- Keep at 8th grade reading level
- No last names, no client photos
- Publish 2 to 4 times per year

### 6. Letter to Client at Exit/Graduation

At PCAP exit, a letter from the clinical supervisor is written to each client 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 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,*

### 7. Conflict Mediation

Case managers occasionally become biased champions for the client's cause, and have made questionable judgments or statements to service providers. In these cases, the clinical

supervisor provides objective assessment and mediates a resolution between the provider and the case manager. The clinical supervisor performs the same role when conflicts arise between clients and case managers.

## 4.8 Case Manager Best Practices

### 1. Maintain Clear Boundaries

Staff boundaries are a critical component of PCAP work, particularly because the relationships with clients endure for 3 years and involve home visitation. [PCAP Boundaries and Standards](#) have been developed through a consensus approach with PCAP staff. Every year, it is important to review and discuss the boundaries. It must be clear to everyone that maintaining these boundaries is required and not simply recommended.

The list of boundaries is not exhaustive; there are others that a case manager may choose to have as an individual, personal boundary, (for example, some case managers do not change diapers).

### 2. Clear Up 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.

### 3. 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.

#### **4. 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.

#### **5. 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:

- 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 (or ideally the mother makes the call to CPS with the case manager accompanying her). 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.

#### **6. Encourage the Mother/Infant Relationship**

The case manager is in an ideal position to give a mother information about her child’s developmental stages, and teach her to have appropriate expectations. 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
- Enroll clients in parenting classes and accompany them if necessary to the first several classes until the mother feels comfortable.

Clients are sometimes impatient and harsh with their children, but case managers rarely observe signs of

#### **Developmental Profiles: Pre-birth Through Twelve K. Eileen Allen & Lynn Marotz**

##### *Synopsis*

This Third Edition text is a comprehensive, concise guide to the development milestones of young children. It describes their physical, cognitive, and affective development from pre-birth through age eight in a non-technical style, informing students of what they can expect and how they can provide appropriate learning experiences at each stage of development.

##### *Ordering Information:*

Delmar Learning  
1-800-998-7498 – about \$50  
<http://www.earlychilded.delmar.com>  
Or, get used on Amazon.com for a lot less.

deliberate injury. For example, a baby who is learning to pick up and eat Cheerios from a tray in front of her is likely to scatter the cereal and the mother may shout or slap the baby's hand because she "made a mess." A good case manager uses this as an opportunity to teach the mother that the baby is just beginning to develop fine motor skills, and that trying to pick up Cheerios is good practice. The case manager can demonstrate loving playfulness as she does an activity with the baby, shows the baby how to do something and praises her.

- A simple but very effective activity is to teach the mother to sit quietly with the baby, and observe him/her playing and responding to various stimuli. Case managers teach a mother to pay attention, to observe, and to understand that her baby has a personality and communicates with every facial expression and gesture.
- A more explicit home visitation activity is to have the mother and baby play and interact for 15 minutes, while the case manager takes notes about what the baby does. This can illustrate to the mother the diversity and complexity of her baby's behavior.
- The case manager may then give the mother a Baby Can Do notebook (this can be a simple note pad that the case manager and mother decorate together, like a 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 day until the next home visit, when she can show the case manager what's happened during playtime.

### **7. Personalizing Clients to Service Providers**

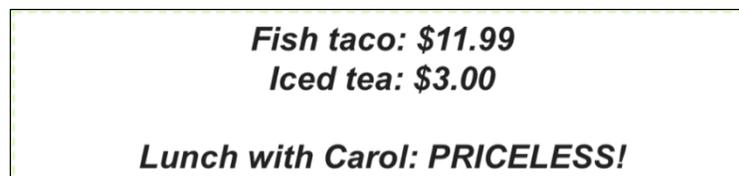
Personalizing the clients transforms them from being a case number in the service provider system to an actual person who is known to the providers.

Case managers help clients personalize themselves by:

- showing them how to send cards and write thank you notes to helpful service providers (including pictures of the kids if possible);
- providing clients with stationery or note paper (PCAP sites can usually get these supplies at no cost from stores who are willing to donate, especially at the end of a holiday); and
- teaching clients to write a clear and polite note.

### **8. Use Humor**

To engage resistant clients, give a PCAP spin to popular marketing and outreach strategies, e.g. on a handmade coupon:



### **9. Minimize Distractions**

Case managers will be more successful if they minimize the distractions on home visits and during other time spent with clients. Minimizing distractions, such as turning off the TV, will help keep 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.

### **10. PCAP Group Activities Can Teach Life Skills**

PCAP group activities can provide clients with opportunities to develop healthy friendships and have fun (without being high), to learn to play with their children, and to learn life skills. Examples of PCAP group activities are holiday parties and summer picnics.

The most successful group activities include a lot of 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 we provide gift-wrap materials and gifts and let the clients wrap presents for the children. Clients enjoy playing games like bingo, and having raffles at the event.

### **11. Meaningful Incentives and Reinforcements** (movie tickets, beauty shop, 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: 200 movie passes, hair cuts, grocery vouchers, gently used baby equipment, school items for older children, theater tickets, and more.

### **12. Use Concrete Activities with Clients**

There are many hands-on activities case managers have found useful over the course of their work with clients.

#### 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 brainstorms with the client about 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 and friends. They write these names inside the circle.

*“My client called her me on a Monday morning to say that she ran into Joe on the weekend and he wanted to go partying, but she remembered that Joe is one of the people who needs to ‘stay behind that fence,’ so she told him no.”*  
--PCAP Case Manager

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 pictorial:

- 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; and
- Helps clients identify healthy people in her life who can be trusted and who might potentially become friends.

Weekly Goals Sheets:

Different from the goal sheets completed every 4 months, weekly goal sheets are informal ways to document progress on daily goals and give clients a sense of incremental success. Case managers have developed their own formats, but generally weekly “to do’s” are listed out and a small box is provided for a gold star or check mark. Making the weekly goal sheet look official helps clients feel proud of what they are doing.

**Weekly Goals**

To Do List: Week of: \_\_\_\_\_

1. \_\_\_\_\_ Completed:

2. \_\_\_\_\_ Completed:

3. \_\_\_\_\_ Completed:

Timeline or Vision Board:

Creating timelines of important life events or important PCAP milestones is another way to help give clients a sense of incremental success. Clients with compromised cognitive abilities particularly enjoy creating timelines as arts and crafts projects. For example, use magazine pictures to create a collage depicting how a client's life has changed through the PCAP intervention or use similar techniques to help clients create a visual depiction of how they want their life to change or what their goals are.

Life Book Activity:

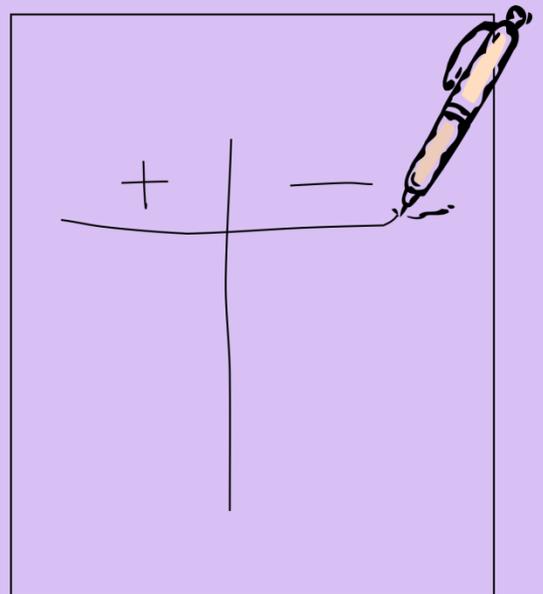
A Life Book is an album clients and case managers create together that focuses on memories of the case manager/client relationship, the client's positive attributes, and the client's dreams for the future. The Life Book can contain photos, collages (using magazine or newspaper words and pictures), narratives, poems, etc.

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 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.

**Pros and Cons**

*Stay with boyfriend?*



## 4.9 Connecting Clients with Treatment

Motivating women to stop drinking and drugging before and during pregnancy means connecting clients with treatment. It is important to remember that treatment completion rates are fairly modest. In Washington State, only 43% of pregnant and parenting women who entered long-term inpatient treatment programs in 2007 completed them.

Additionally, treatment does not always work. Alcohol and drug treatment is not new to most PCAP clients. Recent data indicate at enrollment into PCAP, 84% (N=507) of the clients had previously attended inpatient or outpatient treatment, an average of 2.8 times.

There are important considerations for PCAP staff to take when helping a client get into treatment:

### ***Before Treatment***

- Mandated treatment may be necessary.

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 recognize that drug and alcohol abuse are having a severe impact on their lives may be hesitant to take the major step of beginning treatment.

- Drug Court and Family Treatment Court are beneficial.
- Seek treatment where children can stay with the mother in order to reduce the likelihood of the mother leaving treatment.
- Seek women-only treatment settings.

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.

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

### **Common Reasons Clients are Reluctant to Pursue Treatment:**

- It interferes with caring for their children
- It might lead to loss of custody of their children
- There is fear they may lose their housing if they are enrolled in an inpatient treatment program
- They may be rejected by treatment programs
- There are problems with transportation or an excessive commute to reach services
- There is lack of anonymity in small communities - may fear their situation will become public knowledge despite confidentiality of providers

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***

- Arrange for consistent child visitation (for children who are not with the mother).
- Connect clients with service providers who can help her meet other needs (e.g. mental and physical health) and future needs (housing applications, etc.).
- Help to arrange for post-treatment, transitional housing.
- Stay in close touch; send notes of encouragement and cheer.

### ***After Treatment***

- Relapse is part of the disease; be explicit and honest in discussing consequences with client.
- Help client identify relapse triggers (e.g. people, places, special events).
- Make specific safety plans for how to resist triggers and how to manage relapse if it occurs. This might include carrying with her a list of alternative things to do, and a list of names and phone numbers (including the case manager's).
- Introduce client to relevant support groups.
- ***Clients are not asked to leave PCAP because of relapse or setbacks.***

## 4.10 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.

*“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*

## PCAP 3-Year Outcomes: Family Planning

<b>Family planning at intake</b>	<b>9%</b>
<b>Family planning at exit</b>	<b>60%</b>
More reliable method	46%
<b>Subsequent birth</b>	<b>25%</b>
Subsequent exposed birth	14%
<b>Reduced risk for subsequent alcohol / drug exposed birth</b> (clean & sober $\geq$ 6 mos., OR regular reliable birth control, OR both)	<b>76%</b>

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 now.
- 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 in using birth control.
- 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?*

#### Tip:

Use the term 'family planning' instead of 'birth control'.

#### 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:
  - do goal setting with the case manager regarding addressing the issue with each client;
  - 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 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. Even seemingly simple family planning methods, like the birth control pill, can be confusing to clients. Many clients have reported trouble taking pills correctly; some frequently miss pills and ‘just double up a few days later’. In one situation, a client was putting the pills in her vagina. This client had cognitive disabilities and the approach made perfect sense to her, because ‘through the vagina is how you get pregnant, and where the baby comes out’.*

## 4.11 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.

#### 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.

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; and
- 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.

**Suggestions include:**

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.

## **Section Five:**

# Managing Client Status Changes

## 5.1 Clients Who Leave the Program

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)

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:

- 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.
- Presents this information to other clinical supervisors and the program director at a PCAP quarterly administration meeting, or sends it via email.
- If the group concurs that there is nothing else we can do to engage the client, a decision is made to 'unenroll' her.

### **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.

- Notifies the program evaluator via email so these cases can be identified in the database.

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

### **1. False Enroll:**

A client is false 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:

- Discusses the issue with the case manager;
- Has a conversation with the client 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.
- Gives the client several weeks to consider this decision and calm down if the decision seems to have been impulsive act or an angry response to an issue with a case manager.
- May ask the client to put her withdrawal request in writing, so that all parties are very clear about the client's wishes. **This is not required.** In many cases when clients are asked to take this very concrete and final step, they reconsider.
- Notifies child welfare or the courts if they mandated the client to participate in PCAP.
- Documents all steps above.

## 5.2 “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”: We use the term "backburner client" to describe a "non active" 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.

## 5.3 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:

- We’re ready to help (and we know **how** to help) whenever the client is ready;
- The client is worth it;
- 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:**

- Tracing tips work
- Go where the client goes (methadone dosing, child visits, WIC appt.)
- References are critical. Keep careful record of names and phone numbers of client friends and family, obtained by the clinical supervisor at intake and by the case manager thereafter.
- Mine the clinic file for every bit of information (every provider, phone number, place, friend/relative, etc.)
- Send 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
- Try contacting at night, weekends, holidays

## 5.4 Transferring Clients

PCAP clients occasionally transfer between PCAP sites and rarely between case managers within a site.

**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.

During the ‘Wait and See Period’ the RECEIVING Site:

- Starts a temporary interim client file.
- Enters the transferring client into the onsite client database (not the online database).
- Assigns an interim case manager who will become the permanent case manager once transfer is complete.

- Discusses new transfer with new case manager. Facilitate by giving new case manager original case manager's contact information. Encourage the two to keep in touch to discuss client.
- Does transitional advocacy (keep case notes, inform original case manager of events that should be documented on the biannual, etc.).

Once the "Wait and See" Period is Over, and Transfer is Considered Complete,

**The ORIGINAL Site Supervisor:**

- Fills out the appropriate sections of the online [Client Assignment and Transfer](#) form.
- Sends client file to the receiving site. As a courtesy, include a paper copy of the biannual, covering the parts of the biannual period the client was with the original case manager to facilitate information transmission. If this information was entered into the online database, make sure the receiving case manager knows that the biannual is not complete and that she will need to update it (so that she won't look at the report and assume it has already been done).

**The RECEIVING Supervisor:**

- Contacts the supervisor of the originating site if paperwork isn't received and data does not appear in online database.
- Informs original site supervisor if the client chooses not to stay in new area (at any point).

**Transfers Between Case Managers Within a PCAP Site:**

**Permanent Transfer:**

- Site Supervisor fills out the Client Assignment and Transfer form. The form provides instructions as to what questions need to be filled out for this kind of transfer.

**Temporary Transfer:**

(e.g., for case manager medical leaves or vacation):

- Original case manager remains the official case manager and will resume duties at a future time.
- Do not fill out the online transfer form. The temporary case manager records information on these clients on her own Time Summary form.

(e.g., as when a case manager needs to take over part of a caseload when another case manager leaves her position or goes on extended leave):

- Do fill out the online transfer form so that there is a continuous record of assigned official case managers over time. The temporary case manager records information on these clients on her own Time Summary form, and completes all evaluation paperwork.

## **Section Six:**

# Evaluation and Sustainability

## 6.1 Sustainability

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

- Federal grants (1991-1995; 2004-2006; 2007-2010)
- Private philanthropy (1996-1997)
- State legislative appropriation (1997-present)
- Private foundations (2001; 2005)

### **Sustaining PCAP in the Community**

**Energy and creativity** are required to promote and sustain an innovative program. When you confront a challenge, stretch your thinking. Don't be afraid to try new things. You'll make mistakes, but if you learn from them and grow, it was worth it.

**Believe in** what you are doing, have evidence to support it, and promote it. If you don't, no one else will.

### **Maintain High Expectations and Standards**

**Start early.** Sustaining your program is a process that begins on day one of the program and never stops.

Four elements critical to sustaining a PCAP site are:

1. **Hiring intelligent, committed, and hard-working people**
2. **Developing a well-run organization**
3. **Building a reputation for excellence in the community**
4. **Using data to demonstrate positive, consistent outcomes**

## **The Four P's**

Standard business marketing practices describe the 'Four Ps' framework: Product, Promotion, Place, and Price. This framework can be helpful in developing strategies for sustaining a public health or social services model.

### **1. Product**

PCAP products include:

- **The paraprofessional case management model itself.** Even before outcome data are generated, the core components and unique aspects of the model can be described to the community and professional organizations.
- **Hands-on instruments and tools.** (i.e. The Difference Game)

- **Data.** In addition to qualitative data (client success stories), it's critical: 1) to collect quantitative data using standardized, high quality methods; 2) to analyze and interpret data appropriately; and 3) to convey the results honestly and in a way that your audience can understand. Strong outcome data are key to demonstrating that PCAP makes a difference and should be sustained.

## **2. Promotion**

Create visibility:

- **Establish an identity.** Use every interaction with community providers to build a good reputation. Small steps make a big difference. For example, make it a policy to return calls the same day and to write short, personal notes of thanks or recognition.
- **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.
- **Ask clients to tell their stories.** Personal testimonies from clients who have been successful in PCAP are essential to gaining the attention and support of community agencies, funders, and lawmakers.
- **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 lawmakers.** 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.
- **Create interesting informational materials.** Brochures or newsletters can include the basics of PCAP, key client outcomes, cost-savings data and success stories.
- **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. Find the connection, and then identify a media source and follow-up to get them interested in PCAP.
- **Newsletters and publications.** Sending regular newsletters to community providers is a good way to stay visible and demonstrate successful outcomes and insights about what's needed in the community. Outcomes published in peer-reviewed journals are influential and lend strong credibility to the effectiveness of the intervention.

### **3. Place**

Think about possible venues for promoting PCAP and remember that sometimes the most receptive audience is one that you least expect. Communication strategies will need to vary depending on your audience.

### **4. Price**

In developing strategies for sustaining the program, it's critical to examine information about program cost and cost effectiveness. Provide funders and supporters with information and examples. See below.

## **6.2 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 actual 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 future births of alcohol- and drug-affected children as a result either of the mother's abstinence from alcohol and drugs or use of effective birth control;
- decreased welfare costs as women stay in recovery and become able to work;
- decreased foster care costs as more women become able to care for their children;
- decreased child abuse and neglect as a result of improved parenting or safe and stable child placement;
- decreased costs of crime as alcohol and drug abuse decreases;
- decreased use of emergency room services as alcohol and drug abuse decreases.

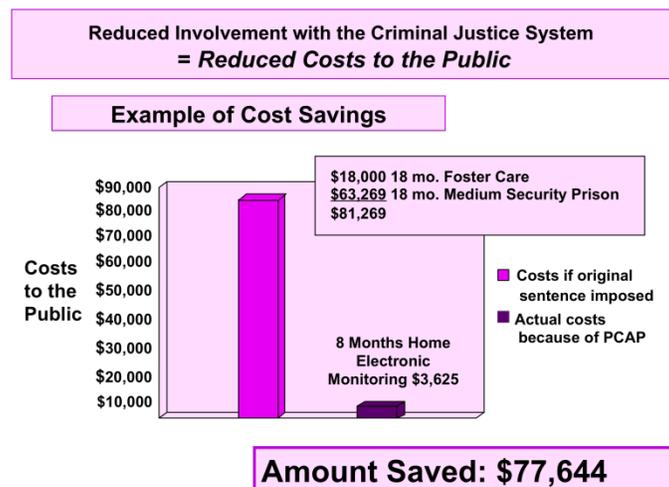
*Cost-savings examples are more powerful and meaningful when they use local or regional cost information applied to actual outcome data from local PCAP sites.*

## Illustrating Cost Effectiveness

### Example: Descriptive

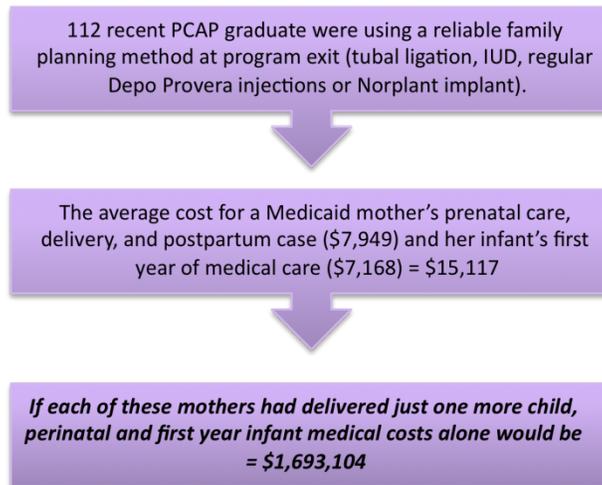
In Washington State, one case manager advocated on behalf of a client who was arrested on an old warrant for forgery. The client was doing very well in PCAP: she had been clean and sober for over a year, was attending school, and had custody of her son. The PCAP case manager organized professionals who had worked with the client to write letters or attend a hearing on behalf of the client, and the judge accepted a 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 home electronic monitoring. The cost savings of \$77,644 was well more than 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 PCAP cost savings example.

### Example: Visual



Source: WA State Dept. of Corrections. <http://www.doc.wa.gov/aboutdoc/budget/docs/statistics/DOCStatisticalBrochure-Jun08.pdf>

## Reduced Costs to the Public through Reduced Medicaid Births



Source: For Medicaid women who gave birth in 2007. First Steps Database (FSDB) Reports.  
[https://wp34.webpine.washington.edu/pub/getach.tcl/Medicaid\\_Paid\\_Maternal\\_and\\_Infant\\_Services\\_for\\_Washington\\_Births\\_to\\_Medicaid\\_Mothers\\_1993-2007.pdf?h=vtBf0sblZzBtwje222PKQVF1EPWI3fjOccC1T2SFW0sl14rcR2K20Z1W5bm1e](https://wp34.webpine.washington.edu/pub/getach.tcl/Medicaid_Paid_Maternal_and_Infant_Services_for_Washington_Births_to_Medicaid_Mothers_1993-2007.pdf?h=vtBf0sblZzBtwje222PKQVF1EPWI3fjOccC1T2SFW0sl14rcR2K20Z1W5bm1e)

### 6.3 Evaluating PCAP

Integrated program evaluation is a key component of PCAP that distinguishes it from many other intervention programs. Evaluation is used for PCAP program development 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:

Ernst, C.C., Grant, T.M., Streissguth, A.P., & Sampson, P.D. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. 3-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1): 19–38.

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:

Grant, T. M., Ernst, C. C., Streissguth, A. P., Phipps, P., & Gendler, B. (1996). When case management isn't enough: A model of paraprofessional advocacy for drug- and alcohol-abusing mothers. *Journal of Case Management*, 5(1), 3–11. (12 months)

Grant, T.M., Ernst, C.C., & Streissguth, A.P. (1996). An intervention with high risk mothers who abuse alcohol and drugs: The Seattle advocacy model. *American Journal of Public Health*, 86(12), 1816–1817. (24 months)

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

Grant, T., Ernst, C.C., Pagalilauan G., & Streissguth, A.P. (2003). Post-program follow-up effects of paraprofessional intervention with high-risk women who abused alcohol and drugs during pregnancy. *Journal of Community Psychology*, 31(3): 211–222.

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:

Grant, T., Ernst, C., Streissguth, A., & Stark, K (2005). Preventing alcohol and drug exposed births in Washington State: Intervention findings from three Parent-Child Assistance Program sites. *American Journal of Drug and Alcohol Abuse*, 31(3): 471-490.

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

Grant, T.M., Huggins, J., Graham, J.C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal Substance Abuse and Disrupted Parenting: Distinguishing Mothers Who Keep Their Children From Those Who Do Not. *Children and Youth Services Review*, 33: 2176–2185.

### **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, page 4).

### **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 2009 PCAP Washington Action Plan as an example of a

document Washington PCAP presents to state legislators to illustrate outcomes of the states 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 a lot of information about the client in a short period of time.
- Allow clients a structured time to think about certain 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.

## **PCAP Uses Two Types of Evaluation**

### **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

### **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

#### \* DatStat, Inc., Seattle, WA

DatStat is a data collection and survey management company that has programmed an online data entry console for Washington State PCAP. This web-based console allows for evaluation data to be tracked and entered, and can generate simple data reports. It presents an easy way for case managers and supervisors to monitor evaluation paperwork deadlines and time management, even from remote locations. The console can be customized for local use by PCAP replications. It does not replace the need for an evaluator, but it can greatly aid the data collection and entry process and offers some simple data tools for internal program evaluation.

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**

- 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 3 interviews being conducted by an experienced interviewer, and code along. Next, the new PCAP interviewer is required to conduct 3 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.
- 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.
- To minimize bias, ASI exit data should be gathered using a trained interviewer who is not affiliated with the clinical aspects of the program.
- 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.
- 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.

### **Improving Biannual Assessment Accuracy**

- 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 casenotes.
- Biannuals 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.

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

## **External vs. Internal Program Evaluator**

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. (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.)

## 6.4 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.