



## CONSENT FORM

### PARENT-CHILD ASSISTANCE PROGRAM (PCAP) University of Washington Department of Psychiatry and Behavioral Sciences

**Head Researcher:**

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**Researcher's Statement:**

The University of Washington researchers would like to have your picture to use at education and training about the PCAP program. These events might be for researchers, staff at programs wanting to use PCAP, or health care or social service workers.

#### **What would I be asked to do?**

If you agree, I would take a picture of you and your child while you are in the program. I would take your picture either at the PCAP office or at a place you choose. The picture could be taken either sitting or standing. It would show your face, so people would be able to see who you are.

If I take a picture of your child with you, the UW researchers will blur the top half of your child's face to protect privacy. They won't tell your name or your child's name when they show the picture. They will ask everyone who is at a training to keep it private too. They won't use your picture in any papers, reports, or handouts.

#### **What are the possible risks or harms if I take part?**

The risks to you of having your picture taken could include breaks in your privacy. Someone at a training might see your photo and know who you are.

#### **What are the possible benefits?**

There may not be a direct benefit to you, but it may help increase awareness about how mothers can become healthy and drug free.

#### **What are my choices if I don't take part?**

You don't have to have your picture taken. If you do have it taken, I will show it to you, so you can tell me if it is OK to use it. If you have your picture taken and change your mind later, you can write to or call the head researcher at the toll free number listed at the top of this form and the UW study team will destroy the picture.



**What else do I need to know?**

Your picture won't have your name on it. This consent form will be locked up at the study office. This consent won't be stored with your photo. The UW study team will keep your photo for 6 years after the study ends.

|   |      |
|---|------|
| INVESTIGATOR SIGNATURE  | DATE |
| <p><b><u>If you agree to participate:</u></b><br/>                 I have read this consent form. The clinical supervisor has told me that they want to take a picture of me and my child. The UW researchers would use it at education and training events about PCAP. The picture will show my face, so people will be able to tell who I am. Someone at training might know me. If my child is in the picture with me, the top half of my child's face will be blurred so no one will know who they are. The clinical supervisor told me how our privacy will be protected. I freely agree to have my picture taken with my child. The clinical supervisor will show it to me first, so I can decide if it is OK to use it. If I change my mind, the UW researchers will destroy the picture. I have had a chance to ask questions. If I have any questions about this or want to change my mind after my picture is taken, I can call the head researcher listed at the top of this form.</p> |      |
| PARTICIPANT SIGNATURE   | DATE |

Copies to:     Participant  
                   Researcher's file