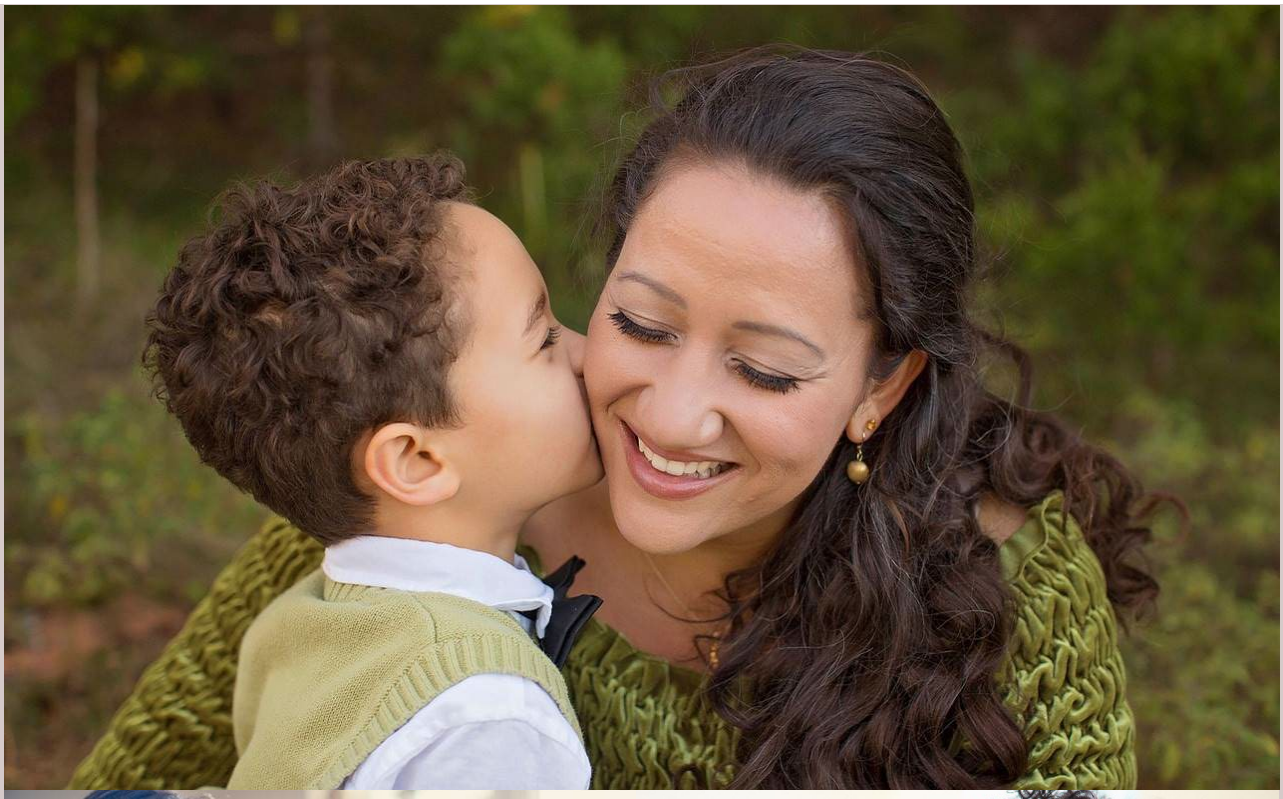
Parent-Child Assistance Program (PCAP)

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



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Section One

The Parent-Child Assistance Program: An Introduction

Addressing the Problem of Maternal Alcohol and Drug Use

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

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

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

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

An Intergenerational Cycle

Pregnant and parenting individuals who use alcohol and drugs are typically vilified and blamed as bad mothers. They have been labeled "unmotivated", "difficult to reach", and

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"hopeless." Yet many in this at-risk population *were themselves the abused and neglected children in our communities just a decade or two ago,* growing up in settings where no one noticed or intervened. PCAP data illustrate this intergenerational cycle:

Childhood History of PCAP Mothers	**N = 1160**
One/both parents used alcohol/drugs	89%
Physically/sexually abused as a child	63%
In foster care system as child	23%
Ran away as a child	58%
Did not finish high school	37%

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

There are no "throw away" people. Mothers with substance use disorders have often been labeled "difficult to reach" and "hopeless". Turning our backs on them because they are difficult to work with does not make their problems go away. PCAP undertook the challenge to find a way to connect with this population.

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

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

PCAP Background and Primary Goals

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

While doing early research on fetal alcohol syndrome and prenatal cocaine effects, we spent a lot of time in family's homes and saw the profound and sometimes overwhelming problems these mothers were experiencing. It was clear that the prevention intervention we developed had to be meaningful for the mothers.

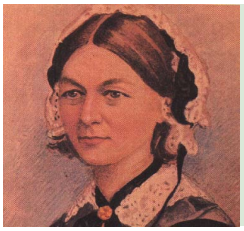
Primary Goals

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

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

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

The PCAP Evidence-Base: Intervention Outcomes



"Results shown are the only test."

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

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

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Study 1. Original Demonstration Cohort (1991 – 1995)

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 (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).

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.

Study 2. Post-Program Follow-Up Cohort (1997 – 1998)

Study 2 was a post-program follow-up of Study 1 intervention group study 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.

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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, $p < .01$)

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

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

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

Compared to the OD, at exit from the intervention a higher proportion of SR and TR subjects:

- Completed inpatient or outpatient treatment (OD= 52%; SR= 76%; TR= 73%)
- Were abstinent from alcohol and drugs at exit for ≥ 6 months (OD= 28%; SR=43%; TR=39%)
- Were abstinent from alcohol and drugs at exit for ≥ 1 year (OD=17%; SR=34%; TR=33%)
- Were abstinent from alcohol and drugs for any ≥ 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%)

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.

Study 4. Maternal substance use and disrupted parenting

Persons with substance use disorders typically have psychosocial characteristics that put them at risk for disrupted parenting. Prior research indicates that comprehensive, accessible services tailored to the mothers' needs can contribute to family stability. This study further explores the complicated interplay of how maternal risk and protective characteristics and service elements are associated with reunification. The study contributes to existing literature by following mothers for three years; examining service needs as identified by the mother; using a summary proportion score to reflect the totality of services received to matched service needs identified; and using logistic regression to examine interactions of services received with critical maternal characteristics. The sample was comprised of 458 mothers enrolled in Washington State PCAP.

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

Grant, T., Huggins, J., Graham, C., Ernst, C., Whitney, N., and 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(11): 2176-2185.

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Study 5. Factors associated with subsequent alcohol and drug exposed births

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

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

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

Grant, T.M., Graham, J.C., Ernst, C.C., Peavy, K.M., & Brown, N.N. (2014). Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births. Children and Youth Services Review, 46: 11-18.

Study 6. Use of Marijuana and Other Substances Among Pregnant and Parenting Women with Substance Use Disorders: Changes in Washington State After Marijuana Legalization

In 2012, possession of marijuana for non- medical use was legalized in Washington State. This study examined how legalization affected alcohol and drug use in a sample of pregnant and parenting women with substance use disorders and enrolled in the Parent–Child Assistance Program (PCAP). Study participants from nine counties in Washington State (N = 1,359) were questioned about their substance use after completing the 3-year PCAP intervention. The sample was divided into two cohorts based on whether participants had completed PCAP before or after legalization. Study results indicated that overall, most study participants (62%) reported complete abstinence from alcohol and nonprescription drugs at PCAP exit. Among those who were still using substances, women who completed the intervention after marijuana legalization (Cohort 2) were significantly more likely to report marijuana use at program exit compared with women who completed the intervention before marijuana legalization (Cohort 1). Among study participants who did not achieve abstinence during the intervention, across both cohorts (pre- and post-legalization), we

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found a positive association of exit marijuana use with alcohol, illegal methadone, other opioids, amphetamines, and cocaine use; exit marijuana use was associated primarily with alcohol use. We conclude that marijuana use at PCAP exit increased significantly after marijuana legalization in the state. Women who were not abstinent from marijuana at program exit were likely to report use of other substances as well. Our study design demonstrates an association but does not allow us to conclude that marijuana use leads to other substance use among this sample of women with a history of polysubstance use.

Grant, T.M., Graham, J.C., Carlini, B.H., Ernst, C.C., & Brown, N.N. (2018). Use of marijuana and other substances among pregnant and parenting women with substance use disorders: Changes in Washington State after marijuana legalization. Journal of Studies on Alcohol and Drugs, 79(1): 88-95.

Fetal Alcohol Spectrum Disorders (FASD) Intervention and Prevention

Approximately 50% of PCAP clients in Washington State report that their mothers used alcohol heavily, and approximately 20% report that they themselves were exposed to high levels of alcohol prenatally. Although few of these clients have a formal medical diagnosis of fetal alcohol spectrum disorders (FASD), many are suspected of having FASD based on their exposure history, their psychosocial profile, and their behavior.
See below for publications on intervention with mothers who have or may have FASD, screening for FASD in treatment facilities, suicidality, and other topics.

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

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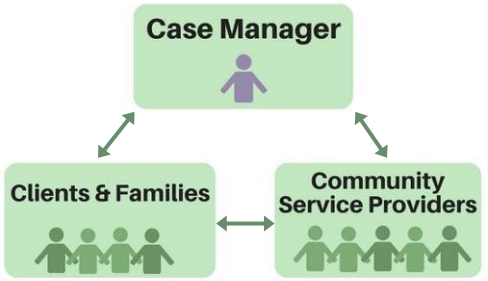
A Two-pronged Approach

The PCAP approach is two-pronged. Case managers:

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



1. Between the Case Manager and the Client

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 clients 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. Clients are closely involved in every plan and decision as the intervention proceeds. The process allows the time and space for clients to develop agency, self-esteem, self-efficacy, and the skills necessary to manage their lives. Working with their PCAP case manager, clients develop recovery capital to enhance their quality of life and reduce the risk of relapse over the long term.

2. Between the Case Manager and Community Service Providers

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

The PCAP case manager has this role. The case manager:

- Is a liaison for communication among the client's provider networks.
- Facilitates the group in developing a service plan that addresses *both the service providers' concerns and the client's goals.*
- Assures that service plans do not create unrealistic expectations of the client.

In addition, professional and agency effectiveness increase when a case manager tackles the barriers (e.g., lack of housing, and/or childcare) that could otherwise hinder or defeat a service provider's aims for a client. For example, a primary care physician can more fully

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focus on a family's health care needs when the PCAP case managers helps with scheduling, provides transportation, and assists the mother with the paperwork involved. The skills that service professionals and case managers contribute are distinctly different, but they are complementary.

Overarching Principles

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

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

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

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

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that this relationship is a healthy one that allows room to grow. As the client increasingly trusts the case manager and experiences the reliability of the relationship, the client becomes more capable of offering consistent attention and care to the child.

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

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

Theoretical Components

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

1. A Relational Approach

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

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

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

- Is critical to successful outcomes among those with substance use disorders who are in intervention, treatment, and recovery settings (Amaro & Hardy-Fanta, 1995; Finkelstein, 1993).
- Determines the extent of client compliance and retention in an intervention (Barnard et al., 1988) and may be more important to treatment outcomes than concrete services received (Pharis & Levin, 1991).

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

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

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

PCAP clients often present defensively at the start of the intervention; most are ashamed of their substance use in pregnancy and know they have poor parenting skills. Case managers' shared history allows them to literally "get in the door" on home visits—because they are more easily perceived as understanding and empathetic with clients' situations, allowing them to build rapport more easily with those who might be unapproachable. Case managers' sustained, empathetic "peer" guidance, offered in the context of teaching and role modeling, promotes clients' social and emotional development as they gradually learn to trust others, trust themselves, and build practical skills.

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

—PCAP Case Manager

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2. Transtheoretical Model

The Transtheoretical Model (Prochaska & DiClemente, 1986) helps us to recognize that clients enrolled in PCAP will vary in their readiness to change over time. The major stages of change are precontemplation, contemplation, preparation, action, and maintenance. Precontemplation refers to a stage in which clients are not thinking about changing their behavior. As they move into the contemplation stage, clients begin to consider the possibility of behavior change. In the preparation stage, a decision has been made to make a change, but the change has not yet begun. Clients are in the action stage when they are actively working on changing their behavior. In the maintenance stage, the change is not so much work anymore and becomes the new normal. It's important to realize that clients don't necessarily move through the stages of change in a linear, forward direction. For example, they may have a slip in the maintenance stage and move back into action, or they may vacillate between precontemplation and contemplation for a long period of time. The best chance of successful outcomes comes when approaches to working with a client match the client's stage of change. For example, giving a client in the precontemplation stage a lot of information about treatment programs is not a good match to where the client is in their readiness to change. On the other hand, when a client moves into the preparation stage, information about treatment programs may be just what the client needs.

Ambivalence about changing addictive and other behaviors (e.g., parenting) is normal and should be expected. Motivational interviewing (MI) is a corresponding conversation style (Miller & Rollnick, 1991) that helps clients examine and resolve ambivalence about change and increase their internal motivation to change. PCAP case managers and supervisors should receive training on MI principles and the use of MI strategies from professionals in their communities **as soon after hire as possible** and periodic MI refresher training as it is available. Supervisors are expected to provide MI practice and reinforcement during supervision sessions and group staffing. A helpful resource used by all PCAP sites is:

Treatment Improvement Protocol (TIP) 35: "Enhancing Motivation for Change in Substance Use Disorder Treatment," https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

Motivational Interviewing (MI)

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

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

Theory into Practice.

> *"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*

The principles embodied in MI naturally complement PCAP's relational theory basis because they call for case managers to be empathetic and nonjudgmental, to listen closely and respectfully to their clients, and to accept and trust in clients' perceptions and judgments about their own lives. In practice, the most important way in which a PCAP case manager has a positive effect on a client's self-efficacy is by listening carefully about what is important to the client and how the client thinks about various problems and valuing this self-expression. Case managers then promote self-directed action by helping clients define and accomplish explicit goals toward behavioral change.

PCAP case managers understand that for clients who have never experienced competence and accomplishment, each small step a client takes deserves attention and encouragement. Acceptance and understanding of the client's situation, and trust in the client's perception and judgment, are critical. Case managers can have a positive influence on clients' self-efficacy expectations, motivational states, and, ultimately, behavior by:

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

PCAP clients' self-efficacy will determine whether they will begin a new behavior, put in the required effort, maintain their efforts and thus progress to another stage of change.

3. Harm Reduction

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

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goals of:

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

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

Given that substance dependence is a chronic relapsing disorder, rather than using an all-or-nothing approach to interventions that require abstinence of participants, intervention programs based on harm-reduction principles may reduce some of the negative consequences associated with substance use while at the same time keeping greater numbers of clients involved in treatment (Burns et al., 2016; Centre for Epidemiology and Evidence, 2014).

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

Theory into Practice.

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

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

- **Family planning**. Family planning means determining the number of children one wants to have, and the spacing of the children, using birth control. 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 abstinent from alcohol and drugs during pregnancy. PCAP works with clients to choose effective family planning methods to avoid having unwanted or unintended pregnancies.

- **Safety planning**. A safety plan is a written agreement between a mother and the PCAP case manager, or between the mother and a child welfare worker, describing how potential threats to the family and to child safety will be managed. Safety plans should be **1) solution focused; 2) family-centered; and 3) collaborative.** They should clearly describe the specific actions and responsibilities of all plan participants. A parental safety plan can include the following elements:
  - Identify a friend, family member, or other supportive person who can check on the parent(s) regularly. It should be a trusted person, who knows the signs of stress in the parent(s), and agrees to act to protect the children, including talking to professionals.
  - Keep a list of community resources and phone numbers, including resources such as rental assistance, support helplines (e.g., parenting support, 12-step), and food assistance. Laminate this list and keep it accessible.

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

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

  See http://www.recovery.org/topics/relapse-prevention/

  Without giving the parent(s) "permission" to relapse, or promising immunity from all consequences, it is realistic to plan for it.
  - Work with the client to develop a list of reasons to stay clean and sober, including both the *risks* to their children and the *joys* of parenting.
  - Help the parent create a visual representation of these concepts and action steps that can be displayed in the home (e.g., a collage or vision board) or

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can be carried with them (e.g., on a laminated key chain with the "number one reason" and a picture of the child).

- Develop a list of people who are not allowed in the home when the children are present. This list should be developed with the help of someone such as the chemical dependency counselor. Laminate this list and keep it accessible.
- Help the mother to identify and plan for how to attend recovery support meetings, such as a 12-step group, on a regular basis.

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

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

Section Three

Program Start-up

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PCAP Staffing and Job Descriptions

Core PCAP staff qualifications and job descriptions:

- *Clinical Supervisor Job Description*
- *Case Manager Job Description*
- *Office Assistant Job Description*

The Role of the Clinical Supervisor

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

In the Program and in the Community

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

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

Within the Program

The supervisor has diverse roles. As an administrator, the supervisor discusses each client's status and reviews paperwork, case notes, and how the case manager allocates time. As a teacher, the supervisor discusses plans for what the case manager wants to address with each client within the next few weeks and makes next-step recommendations to the case manager based on an understanding of the case (and documents these recommendations). The supervisor explores with the case manager how case activities are related to client goals. The supervisor helps the case manager differentiate between crises that need the case manager's intervention now (e.g., connection to mental health services) versus those the client may be ready to self-manage. As a mentor and guide, the supervisor helps the case manager examine and process how activities on the cases may be having a negative effect; the supervisor discusses areas of growth the case manager would like to explore and opportunities for additional training.

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

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

Balancing time among a caseload of 13 to 20 at-risk mothers can be difficult. Supervisors must continually pay close attention to how the case manager is balancing time among clients, and whether the case manager is persistent in trying to find ways to connect and build relationship with every client. This is particularly challenging if a client is rude to the case manager, or continually no-shows for appointments. On the other hand, clients who are doing well are easier to be with, and it's a natural tendency for case managers to

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schedule more time with these clients. **Don't let this happen**. The supervisor's role is to help the case manager avoid extremes, monitor the balance of time, and assure that the case manager is spending time with each client. Otherwise, some clients will end the 3-year intervention having received a relatively small intervention "dose," and having poor outcomes to show for it.

Fostering client independence. Supervisors must be attuned to the potential problem of a case managers over-efficiency interfering with the goal of helping clients develop self-efficacy and achieve healthy independence. For example, a case manager may become frustrated with a struggling client and do the client's work for her, instead of guiding the client in a process that will result in the client developing skills and competency. Every mother who has agreed to be in PCAP hopes on some level for a better life, and for some it will take a great deal of time and persistence before progress can be observed. Alternatively, a case manager may be tempted to step back from a "star" client, failing to remember the importance of continued support in helping client sustain progress.

Individual, one-on-one weekly supervision with each case manager

During each supervision meeting, clinical supervisors:

- Review each clients' status with the case manager, with reference to the Weekly Time Summary sheet to check for accuracy.
- Discuss what the individual case manager wants to accomplish with each case by next week.
- Make next-step recommendations to the case manager based on supervisor understanding of the case (and document these recommendations).
- Help the case manager differentiate between crises that need the case manager's intervention now (e.g., connection to mental health services) versus those the client may be ready to self-manage.
- Explore with the case manager how case activities are related to client goals.
- Discuss how focus can be redirected to the client goals.
- Discuss individual case manager training needs.

Review of Weekly Time Summary Forms

PCAP data demonstrate that in general, client outcomes are better among clients who spend more time with their case managers. To monitor case manager time, maintain fidelity to the PCAP model, and ultimately achieve better PCAP outcomes, supervisors are required to:

- Review Weekly Time Summary forms every week, ideally during supervision with the case manager.
- Run data reports and monitor to assure that on **average 55% of time each week (22 hours in a 40-hour week) is spent working directly on the client caseload (face to face time and time on behalf of client).**
- Note that realistically, case managers will not be able to see, or even talk to, every client every week. The amount of time spent with clients depends on many factors and will naturally vary.

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

Client File Reviews/Chart Audits

Supervisors are required to read and sign off on case manager case notes approximately every four months, using the PCAP Client File Review form to document that client files are up to date, complete, and accurate.

Case Manager-Client Relationship Inventory

The Case Manager-Client Relationship Inventory is a 27–item questionnaire that was adapted for PCAP (with permission) from an instrument developed for the Memphis New Mothers Project (Barnard, 1998). The Inventory assesses a client's perception of the quality of the relationship with their 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 clients reach their potential); 3) "ongoing developmental" (assisting clients with the developmental issues of a mother learning and growing in their various roles); and 4) "harmony" (promoting harmony among the mother, family, and case manager).

The Inventory:

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

Weekly Staff Meetings

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

The clinical supervisor can use this valuable time to best advantage by:

1. Listening for and noticing common themes in individual supervision sessions with the case managers.
2. Then asking case managers to discuss specific clients or situations as case study illustrations at the weekly group meeting to stimulate brainstorming and discussion.
    a. Other case managers offer ideas and support and reflect on experiences with their own clients.
3. Subsequent staffing meetings provide continuity when case managers give updates on client status and on how others' suggestions have worked.

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

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

Weekly staff meeting expectations:

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

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

— PCAP case manager

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

— PCAP case manager

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PCAP Site Newsletter

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

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

Newsletter suggestions: Keep at 8th grade reading level; **no last names, no client photos.**

Letter to Client at Exit/Graduation

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

Example:

Dear -----,

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

Sincerely,

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The Role of the Case Manager

PCAP case managers are required to have:

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

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

"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

Other key characteristics of PCAP case managers include:

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

Advertising for <u>The Case Manager Position</u>

In advertising for the case manager position, administrators ensure that notification of job openings reaches diverse populations. The most successful case manager recruitment has occurred through word-of-mouth by service providers who understand the scope of the role and through recommendations of current case managers who know what the position requires. Some of our successful case managers have come from programs they found

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frustrating because they permitted only short-term contact with clients who clearly needed more consistent, long-term support to achieve positive outcomes.

Case Manager: Physical Elements/Requirements of the Position

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

Driving	Essential: • Transport clients and their children • Provide outreach services to connect clients with community agencies Provide outreach services to locate missing clients Details: Must have a valid driver's license and be able to drive a vehicle/ travel daily (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.
Home Visits	Essential: • Conduct two home visits/month per client) Provide housing support/ case management services • Obtain and maintain current CPR, Infant CPR Certification

	Details: Home visits require case manager to access homes that are not ADA compliant, so case managers may need to climb stairs to access clients' homes. Case managers must wear clothing and shoes that 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.
Office Work	Essential: • Complete required paperwork • Demonstrate cognitive/ organizational abilities to keep track of up to 20 clients, their families, and their service providers • Document all activities accurately and in a timely manner Details: PCAP paperwork requires approximately 8-10 hours per week at a desk writing, making phone calls, typing, and computer data entry.

Communication, Accountability, and Safety

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

"Flex" Time

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

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

- Case managers have flexible hours because important client events and crises do not necessarily occur on weekdays between the hours of eight and five o'clock.
- Case managers must get prior approval from the clinical supervisor and/or the appropriate agency staff person if a situation requires the case manager to work outside of regular work hours, and case managers must identify the clinical purpose for the work.
- Full time staff (40 hours per week) are expected and encouraged to complete their work week within 40 hours and are discouraged from working more than 40 hours per week.

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

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

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

1. Discuss telecommuting with supervisor and get agency approval first.
2. Have a clear plan for the work to be done.
3. Deliver the "product" when returning to the office (e.g., case notes completed; biannual forms data-entered, case note documentation of tracing calls or provider contacts, etc.).
4. Document time on the PCAP Time Summary form.

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

PCAP client files or its contents are never to be taken out of the office. When the case manager is not working with a file it should be kept in the PCAP office locked filing cabinet designated for that purpose. Supervisors should be able to locate client files quickly and access information easily.

Lessons Learned About Hiring

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

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Successful Case Managers

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

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

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

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

PCAP Training

To maintain fidelity to the model, PCAP must be implemented by highly trained, clinically supervised case managers. Comprehensive, ongoing training is an essential component of the PCAP model. Several types of training occur in PCAP: pre-service training, ongoing training on relevant topics from outside sources, ongoing in-service training with local providers, annual 2-day refresher training on the PCAP model, annual refresher training in PCAP evaluation protocols, and annual .reliability training for the Addiction Severity Index.

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1. Supervisor and Case Manager Pre-Service Training:

See Training Requirements for Supervisors and Training Requirements for Case Managers. All pre-service training should be administered by experienced PCAP staff who have been effectively implementing the intervention for a minimum of three years. These training requirements should be completed before the case manager assumes a caseload independently.

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

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

Critical training topics include:

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

3. Ongoing In-Service Training with Local Providers

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

- Child welfare workers
- Social Security benefits social workers
- Family Planning

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- Local police department
- Local substance use treatment agency

Example of PCAP In-Service Training with Local Providers

"We invited staff from a local family planning agency to attend a staff meeting to talk with us about problems we were having with clients who were not making their appointments for Depo-Provera shots on time (women on Depo Provera receive injections every three months). If a woman missed her appointment, she typically had to start all over again with a pregnancy test, she would sometimes miss that appointment or want to reschedule, and in the interim might become pregnant unintentionally. In meeting with us, agency personnel gained an understanding of the at-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 other's work."

4. Annual Refresher Training on the PCAP Model

Annual refresher training is conducted by experienced and trained PCAP clinical supervisors. Trainings are held at a central location with supervisors, case managers, and office assistants from multiple sites attending or via videoconference.

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

5. Annual Supervisor Refresher Training on PCAP Evaluation Protocols

Annual refresher training for PCAP clinical supervisors in PCAP evaluation protocols is conducted by the PCAP state evaluator. Training is held via videoconference or in-person at an accessible location.

6. Annual Reliability Training on the Addiction Severity Index

Annual proficiency training for the Addiction Severity Index (ASI) for baseline and follow-up ASI interviewers is conducted by the PCAP evaluation team. Training is held via videoconference or in-person at an accessible location.

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Safety Guidelines

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

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

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

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

Topics addressed in the Safety Protocol include:

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

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Client Eligibility

The PCAP supervisor determines whether an individual who has been referred is eligible for the program. Prospective clients are eligible to enroll in PCAP if they meet three criteria.

1. ***Pregnant or up to twelve months postpartum.****
   Note: If an individual enrolls in PCAP then terminates the pregnancy, has a miscarriage, or the target child dies, the client and remains in PCAP unless the client decides to withdraw.

   and

2. ***Self- report of at-risk alcohol and/or drug use during the pregnancy.*****
   The prospective client must self-report heavy or problematic alcohol or drug use during the index pregnancy. Underreporting is common at the initial referral stage and should be expected.
   If the following information is available, it may be helpful in determining whether a client meets this criterion:
   - Any positive maternal/infant toxicology screens during pregnancy or at delivery?
   - Any previous alcohol or drug exposed pregnancies?
   - Any previous children removed from custody due to alcohol/drug use?
   - Any history of alcohol/drug treatment?

   and

3. ***Ineffectively engaged with community service providers.***
   Individuals referred to PCAP may already have several providers or case managers, such as a Child Protective Services (CPS) worker, a public health nurse, or a probation officer. The fact that they have providers does not mean that they are effectively engaged with those providers, and the fact that they are using substances while pregnant is an indicator of a need for additional or a different kind of help.

   Prospective clients referred to PCAP may currently be in substance use inpatient or outpatient treatment. This does not make them ineligible—the questions to consider are these: when leaving treatment what is their long-term support system? Who will support them in relapse prevention? Who will coach them in taking the next steps toward recovery and an improved quality of life? Enrolling those who are also in treatment in PCAP is not a duplication of services.

** PCAP may enroll up to twenty-four months postpartum if space is available.*
*** Includes use of opioid medication as prescribed for opioid use disorder.*

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Prospective clients are also eligible for PCAP if they meet the following criteria, *although fewer than 5% of our clients are enrolled this way:*

1. *Those who have delivered a child with a diagnosis of FASD*

   and

2. *Are still drinking*

   and

3. *Are likely to become pregnant again*

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 to prevent future heavily exposed and damaged children.

Special Considerations: Mental Health Conditions

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

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

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

If a prospective client is referred who has a profound mental health problem such as a psychotic disorder or schizophrenia, ***the clinical supervisor must consider whether PCAP case management is an appropriate service for this individual****, or if the person needs instead a referral to a psychiatrist and treatment facility to obtain long term therapy and medication management. The question to ask is whether PCAP is enough to address the needs of the person*.

The clinical supervisor should consult whenever possible with other PCAP clinical supervisors and/or professionals to determine 1) how the individual would benefit from PCAP services; 2) which additional comprehensive mental health and other services the prospective client would need in order to recover and/or stabilize; and 3) the mental health

providers who are available and who would commit to work as a team with PCAP on this case throughout the 3 year intervention.

Client Recruitment

> *"PCAP's best recruitment strategy is to have a good reputation in the community…positive word of mouth is what really matters."*
>
> *–PCAP Supervisor*

Generating Referrals

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

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

The PCAP clinical supervisor is responsible for:

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

Strategies for generating referrals:

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

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.

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Screening and Accepting Referrals

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

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

- Making final decisions about eligibility and determining who will be enrolled in PCAP. Supervisors often consult with other supervisors if they are unsure about whether potential clients meet enrollment criteria.
- Contacting eligible individuals to invite them to participate, ask them to come to the office for an intake interview, and inform them about the data collection and evaluation component of PCAP.
- Assigning new referrals to case managers who will contact clients and transport them to the PCAP office do intake interviews with the clinical supervisor.

The Community Referral Screening Questionnaire (CRSQ)

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

It may take time to obtain enough information to determine whether someone is eligible. During this time, referral sources may wish to know the prospective client's status (e.g., whether eligible; has refused PCAP; is missing and unreachable, etc.). **Referral sources should be made aware that PCAP is subject to 42 CFR Part 2.** As such, PCAP cannot provide status updates without a signed ROI by the client. **Referral sources should be advised to assume that the prospective client has NOT enrolled in PCAP, unless the prospective client personally tells them otherwise.**

For eligible, consenting clients who sign an ROI: *Inform the referral source of enrollment and name of client's case manager.*

For eligible individuals who refuse the program or can't be located: *Document all procedures used to contact the potential client and keep copies of all correspondence.*

For ineligible individuals: *Refer to alternative, appropriate service provider.*

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

Addressing Common Recruitment Challenges

Challenge: Community misconceptions about PCAP.

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

Here are some examples:

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

Addressing the Challenge:

First, referral sources need to understand that PCAP is not a substitute for child welfare supports, e.g., CPS. Referring to PCAP should not be construed as lightening the load of CPS. It is not PCAP's role to monitor the welfare of clients' children. Nonetheless, community providers should be reassured that PCAP workers are mandated to report child abuse and neglect. Although PCAP does not actively monitor children for evidence of abuse or neglect, any observed evidence is promptly reported to CPS, according to state law, WITHOUT EXCEPTION.

"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."

– PCAP case manager

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-using parents, most were physically or sexually abused, and most didn't finish school. No one intervened then, and these children grew into adults who may have no template for what a "normal" home or healthy parenting looks like. In most cases, they're simply parenting the way they were parented. An important role of PCAP is to show clients another way and break intergenerational cycles of substance use and dysfunction.

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

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

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Challenge: How can you enroll someone who – at the time of referral-- denies or seriously underreports substance use?

If the referral source says the prospective client used alcohol and drugs heavily during pregnancy but the person completely denies use, that person cannot be enrolled in PCAP. Those enrolled in PCAP must **self-report at-risk substance use during pregnancy**. At-risk means a level of substance use that would place the mother or her child(ren) at risk of harm. Why? There are two reasons. First, if we enroll people who deny substance use at intake, at program exit, we will not be able to measure a reduction in substance use, which is a key outcome indicator of success in the PCAP intervention. Secondly, those who deny having an alcohol or drug problem *have no reason to be involved in PCAP, a* program whose primary aim is to help mothers address substance use disorders and build healthy families.

Addressing the Challenge:
At referral, to know whether a prospective client is eligible, the clinical supervisor must attempt to gain trust to set the stage for disclosure of alcohol and drug use during pregnancy. To gain a necessary level of trust, the supervisor should do these things:

- Talk with prospective clients **directly**.
- Assure confidentiality. Be clear that we are not part of child welfare services.
- Describe the services PCAP offers. Explain that case managers work clients to help them turn their lives around. Many of our case managers have had similar life histories and have overcome similar challenges.
- DO NOT try to persuade prospective clients by offering inducements (e.g., the possibility of housing). Clients' interest in PCAP should be because they want to stop substance use and make changes in their lives.
- If prospective clients appear to feel shame or guilt because of using substances during pregnancy, tell them that especially in early pregnancy most don't know they're pregnant, and so they have no pregnancy-related reason to stop. When people have an addiction, it is very hard to stop without help.
- If a prospective client continues to deny substantial alcohol or drug use, the supervisor can say: "It sounds like substance use isn't a problem for you. That's good. However, it does mean you aren't eligible for PCAP because PCAP is for those who **do** have a problem with alcohol or drugs and would like our help getting their lives together. Please feel free to give me a call if you'd like to talk more about this." In many cases, the person will call back a day or two later and tell the supervisor, "Okay I've got more to tell you…"

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Challenge: Community providers may refer prospective clients to PCAP primarily because they need housing or transportation services, not because they have problematic substance use.

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

> *"When I get a call from a referring agency and hear, 'She really needs housing; can you help?' -that's my first clue that this woman may not fit PCAP eligibility criteria. I give the caller housing resource phone numbers."*
>
> *–PCAP Clinical Supervisor*

Challenge: How long do we look for someone who has been referred but can't be located?

Addressing the Challenge:
Prospective clients are eligible for PCAP until the target child is 12 months old, and we continue to look for difficult-to-locate referrals until that time. If a client who was referred earlier responds to outreach efforts after 12 months postpartum, and there are open slots on the PCAP caseload, we will enroll up to 24 months postpartum.

Challenge: How much time and energy should PCAP staff spend locating difficult to find referrals?

Addressing the Challenge:
Clinical supervisors determine this depending on the capacity of the site.

- If the PCAP site is close to full capacity and has steady incoming referrals, or if the site has a waiting list already, then locating missing referrals has a lower priority.
- If the PCAP site is new or has many openings and is in the process of establishing an identity in the community, then the staff has more time to pursue these referrals (up to 12 months postpartum, or 24 months if space allows).

Challenge: In order to look for someone who has been referred but can't be located, do we need signed releases of information?

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 the person. The responsibility for proper disclosure procedures is on the referring party, not the PCAP site. Referral sources are responsible for letting prospective clients know that they have been referred to PCAP and confirming that it's alright if someone from PCAP contacts them to talk about PCAP.

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

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

The closer prospective clients are to the birth of their babies, the easier it usually is to engage them in PCAP. Individuals who are beyond 6 months postpartum often feel they can handle taking care of their child without any extra help. Additionally, prospective clients this far postpartum may have already had their children taken away. If a person hasn't enrolled earlier, enrolling near the time of delivery is a good time because a mother is more likely to want and need extra help at that time.

Challenge: Are clients ever enrolled in PCAP for a second round of intervention?

Addressing the Challenge:

PCAP has enrolled clients for a second round. For example, a client who completes PCAP but did not do well or whose recovery was not stable, may be referred one, two or three years later if the former client is again pregnant and using. To be enrolled again, a former client must currently meet all three eligibility criteria. In addition, the supervisor must have a frank and honest conversation with the former client about why an additional three years in PCAP would be of benefit. What has changed? Why should PCAP give the former client a slot in the program after already having demonstrated that our help did not bring about lasting change? Based on this information, and consultation with other supervisors, if necessary, supervisors may enroll former clients for a second round of PCAP. In our experience, about half of clients re-enrolled succeed in the program.

Client Intake Process

The PCAP intake interview process:

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

PCAP Clinical Supervisor Role

1. Welcome the client and explain PCAP. Ask the client if they have preferred pronouns.
2. Tell the client that relapses or setbacks are not grounds to be dismissed from the program; in these situations, the client should call the case manager for help.
3. Review in detail, and have the client sign and date the Client Service Agreement and research consent form (in Washington State).
4. Administer PCAP Addiction Severity Index (ASI) intake interview.

Case Manager Role

1. Schedule interview with the clinical supervisor and the client.
    a. Be sure to learn and use the client's preferred pronouns.
    b. The ideal interview location is the PCAP office. If the client is in a treatment or hospital facility, the interview may be conducted there **only if there is a private setting where they will not be overheard.**
2. Inform client that the consent and interview process will take about 2 hours.
3. Transport client to the PCAP office for the interview. If a client offers to drive, offer thanks and explain we cannot do that (over 90% of these are no-shows).
4. Provide childcare at the PCAP office if the client brings one or more children.

Frequently Asked Questions about Client Intake

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

An intake interview should 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 completing the intake interview?
A: Remind clients that our system is like going to a doctor's office-- before patients can go into an exam room for physician services, they have to fill out the paperwork in the waiting room.

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

Staying Organized: The PCAP Client File

The purpose of the client file is to hold and organize information the case manager collects and uses during the intervention. Each client has a separate file. Information in the client file should always be kept up to date so that it is relevant and useful to the case manager and the 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

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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 Service 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

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

Client Service Agreement

Keep a copy of the Client Service Agreement (signed by the client and supervisor at the intake interview).

2nd Section:

Service Coordination Form

Every client is involved with different community service providers. The Service Coordination Form is used to organize this information.

Case manager Service Coordination tasks:

- At enrollment, using input from the supervisor (based on information obtained on the ASI intake interview) and input from the client, the case manager records the names and complete contact information for service providers with whom the client is already working.
- In addition, based on PCAP assessments done with the client (e.g., Difference Game, Goals, DLC), the case manager identifies new service providers with whom to link the client, to help 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 the case (see below). Signed ROIs are kept in the Service Coordination section (section 2) of the client file.
- Contacts service providers on the list, introduces themselves and explains PCAP, and describes the role of a case manager. Explains that case managers help their clients manage multiple life problems that might otherwise complicate and interfere with service provision by the professionals.
- The service provider may ask the case manager to scan/fax the ROI before they talk.
- As necessary, and with permission of the client, links providers with each other by organizing case consultations or conference calls and acts as a liaison for communication within this network to avoid duplication of services or working at cross-purposes, and to alleviate manipulation by the client. Supervisors are often involved in these case consultation conferences.
- Continually updates Service Coordination forms so that another case manager or supervisor could pick up the client file and make important contacts if necessary; dates all new entries.
- Maintains a color-coded “dot” or other system to indicate which providers are current and actively working with the client (green dot), and which providers the client is longer involved with (red dot).
- Keeps prior Service Coordination contact pages in this section of the files, and never discards old information as it may be valuable in tracing.

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- *Note: Clients' service networks change over time. Early in the intervention, services commonly include alcohol/ drug assessment and treatment, CPS, legal services including management of child custody issues, family healthcare, housing, family planning services, and basic needs. Later, clients in recovery begin to utilize education and vocational training resources in the community.*

Releases of Information (ROI)

The purpose of ROIs is to give permission for the PCAP case manager to exchange information with the client's other service providers, and to coordinate the efforts of the client's service providers to help the client meet goals.

- Before asking a client to sign a ROI, read it carefully to the client and answer any questions.
- Introduce the ROI to the client by saying, "I'm asking you to sign this so I can talk to your other providers about how to better help you. It does not mean that I tell them everything. *But without it I can't let them know what you need or tell them how well you're doing!*"
- Ask for ROIs as soon as you can after enrollment.
  Supervisors: consider asking client to sign basic ROIs at intake interview.
- Clients are <u>not required</u> 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 <u>should</u> 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)*
- *Anyone you communicate with about the client's situation.*

You <u>do not</u> need ROIs:

- *to report or cooperate with a report of abuse/neglect to child welfare (case managers are mandated reporters)*

Filling out the ROI:

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

3rd Section:

Mother and Target Child Medications

Mother Medications:

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

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

Target Child Medications:

Case managers

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

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

4th Section:

Assessments and Goals

Assessments

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

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

Case managers:

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

5th Section:

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

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

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

Case Notes: Do's and Don'ts

- DO write case notes neatly, in ink. If you type case notes, they must be kept up to date, printed out weekly, signed, and put in client file.

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

Format for Writing PCAP Case Notes

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

Use the Description, Assessment, Plan "D.A.P." system:

DESCRIPTION: *An objective description of pertinent information*

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

ASSESSMENT:
How is the client doing? Describe status, progress toward goals.

PLAN:
Make a plan for next step, a date for next visit. What needs to be done? When and by whom? Note any upcoming major changes/issues.

Electronic Case Note Security

Case managers may write their case notes on the computer. If they do, they should follow these security protocols:

- Client and target child names or other identifiable information are never put into an electronic case note; instead, use the client ID # at the top of the page. Full names of others should not be in the case notes. Use initials or descriptor (e.g., "landlord" or "older sister").
- Case notes must be printed out weekly, signed, and filed in the chart.
- The computer used or the case note file should be password protected.

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- Notes may temporarily be saved on a thumb drive; they should never be saved to the hard drive.
- Case notes should be deleted from the thumb drive after they are printed out and filed.
- Because deleted files can easily be recovered, it is more secure to delete the text from the file before the final save (i.e., save an empty file). Then delete the file.
- Thumb drives should ideally have the capacity to be password protected and to have the data encrypted in case the thumb drive is lost.

6th Section:

Correspondence

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

Best Practices: "Carry File"

- Create a "Carry File" containing blank pages of the forms you usually need in the field (e.g., ROIs, Service Coordination forms, Tracing Information Update form, Goals forms, Case Note pages, Medications Information forms, CRSQ).
- Biannual Assessment time is a good time to update everything in the client's file.

Client File Supervisor Responsibilities

- The supervisor is ultimately responsible for content and quality of client files.
- Supervisors are required by contract to complete Client File Reviews (audits) every 4 months. (See Section Three: The Role of the Clinical Supervisor)
- Client file audit results may be used in personnel actions.

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Delivering the Intervention

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The Intervention Part I: The Case Manager and the Client

Components of the Intervention

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

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

Establishing a Relationship

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

"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

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

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

- Stay in contact with clients: regular face-to-face contact (twice/month minimum), provided through home visits whenever possible, in addition calls, texts, emails, and letters.
- Trace clients who disappear, make weekly attempts to contact, and continually seek to obtain updated contact information.
- Continue to work with the client after an unpleasant incident, discussing each person's behavior (both the case manager's and the client's), so each can learn to respond in ways that are more appropriate and effective.
- Understand that relapse is part of addictive behavior; tell the client that relapse or setbacks are not grounds for dismissal from the program.

Maintaining Healthy Boundaries

PCAP work involves close working relationships with clients over a long period of time, in home and community settings. Having healthy relationships between case managers and clients requires that boundaries be articulated and maintained. Early in the development of the PCAP model, we used a focus group process with case managers to identify essential home visitor boundaries. We require that these guidelines be followed (they are not suggestions) and we continue to refine them based on case managers' field experiences, both good and bad. The boundaries touch not only on the content of conversations, but also on situations that arise in the course of the work. As a rule, ask yourself, "whose needs are being met?" If not the client's needs, this is a red flag that boundaries are being violated. Examples:

- Case managers will role model/discuss aspects of their personal lives they believe are beneficial/relevant to a client's progress and well-being but will not discuss other aspects of their own personal lives.
- Case managers will not buy goods or services from clients. PCAP staff will not hire clients for any service.

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

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

Case managers who think they may have overstepped their boundaries should talk to their supervisor to reduce potential consequences and prevent future boundary issues.

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Home Visitation

Though voluntary, home visitation plays a valuable role in the PCAP intervention.

- The purpose is to see clients in their home environments, to better understand their needs and goals.
- While PCAP case managers are mandated reporters of abuse or neglect, our purpose is not to *monitor* PCAP clients or their children.
- When home visitation is not possible due to homelessness or non-consenting household members, case managers may meet with clients elsewhere in their communities.

Through home visitation and/or other in-person contacts, the case manager can "meet the client where she's at" while providing ongoing support.

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 the 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 the client several to distribute to providers. Clients can put cards in their purse, on the refrigerator, in the diaper bag, etc.

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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 confidentiality; remind the client you are a mandated reporter, but you are not a child welfare worker.

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

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

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

Establishing Ground Rules with Clients

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

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

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

The Ground Rules

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

They let the client know:

1. *I'll always be truthful with you. I won't lie to you, or for you.*
2. *I'll always be truthful with you. I won't lie to you, or for you.*
3. *You can trust that I will be with you through ups and downs: there will be times you don't like me. It's okay if you disagree with me, but we have to keep communication open.*
4. *Please stay in touch with me and respond to my calls and texts, even if you're using or not ready to meet with me in person, so I know that you're okay.*
5. *I have other clients and there may be times when someone else's emergency becomes the day's priority.*
6. *My role is not simply to respond to crisis after crisis, but to help you move beyond crisis and toward achieving your goals.*
7. *You may not engage in illegal activities when you are working with me or other PCAP staff.*
8. *I'll be on time or will call you if I'm running late. Please call me if you are running late or have to cancel.*
9. *When possible, I will let you know ahead of time if circumstances dictate that I must call CPS, but* ***my need to make a report is not negotiable.***
10. *We'll have a three-year working relationship, not a three-year friendship.*
    [Friendship: a reciprocal relationship with a close associate to whom secrets are confided or with whom private matters and problems are discussed.]
11. *You'll get as much out of the program as you put into it.*
12. *I'll let you know when you're giving me too much information (TMI) about something I don't need to know.*
13. *Here are my communication preferences/boundaries…*
    [Explain these. For example, some case managers set a specific day/time to call certain clients twice a week. Discuss when to call 911 vs. when to call the PCAP case manager.]
14. *I don't work 24-7.*
15. *If we run into each other in public, I will ignore you unless you acknowledge me; in that case it's okay to introduce me as a friend.*
16. *Please let me know if I say or do something that offends you, so I'll know not to do it again. I won't know unless you tell me. Giving me the cold shoulder does not help me do better.*

Within the First Six Weeks

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

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

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

1. Address Health Issues Early in PCAP

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

Case managers should avoid the mistake of waiting for a year or more into the intervention to realize that the client's lack of motivation and action may be related to a treatable physical or mental health problem.

Case managers should take the following steps with each client as soon as possible after enrollment in PCAP:

1. Locate key providers in the community who understand the kinds of clients we work with, and who are willing to work with them in a respectful, nonjudgmental manner. There may be only one general practice physician in your community who fits this description; if so, introduce him/her to PCAP, develop a good rapport, and send PCAP clients to him/her.
2. Obtain physical, dental, and mental health assessments *at the start of PCAP*.
3. Don't assume that what you hear from clients and others is correct. Get releases of information so you

Examples of Client Health Issues:

- *If a client is suffering from an undiagnosed or untreated depressive disorder, it may render her not only incapable of working on self-improvement or court-ordered activities, but on a more basic level it may make it nearly impossible for her to get out of bed in the morning or return phone calls.*
- *If a woman is suffering from a low-grade infection or chronic pain, she may have a very low energy level that makes it difficult for her to accomplish even the most rudimentary daily activities, much less take on the challenges of treatment, or job training.*
- *If a woman is suffering from tooth decay, other serious dental problems, or missing teeth she may be in chronic pain and/or be embarrassed to talk or appear in public.*

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can *verify* important health information (e.g., immunization status, birth control status, recommended medications).

4. *Accompany clients to important appointments* to help them communicate their symptoms and problems, and to help them understand what the provider says.
5. Help clients learn to keep a notebook and *write down* what the physician tells them.
6. Help clients get prescriptions filled.
7. Work with clients to develop a way to remember to take medications as prescribed and comply with recommendations for diet, activity, etc.

2. Difference Game and Setting Goals

Before you can begin to help clients set goals, you must learn what matters to them. In PCAP, case managers learn the client's story by using the Difference Game (Grant, et al., 1997).

In the process of establishing a trusting relationship and conducting assessments, it is critical for case managers to engage clients *in a meaningful way, so the client has a voice, and the assessment represents the client's reality.* The more individualized and accurate the assessment, the more useful it will be to the client and the worker as they create a service plan and monitor progress.

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

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

The Difference Game

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

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How to Administer the Difference Game

Clients may not understand the word "Goal". Here are other ways case managers use to describe the concept:

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

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

1. Sort the 31 cards into two piles --"yes" cards would make a difference in their lives; "no" cards would not make a difference.
2. Choose from the "yes" pile the 5 cards that are the most important to them.
3. Rank order these 5 cards (1 to 5) according to what matters most to them currently.
4. Now use these top 5 cards as the basis for a conversation to learn more about the clients' situations, discuss their needs, and plan goals/next steps you can take together. Pick up each card and ask the clients, "Please tell me about this…"

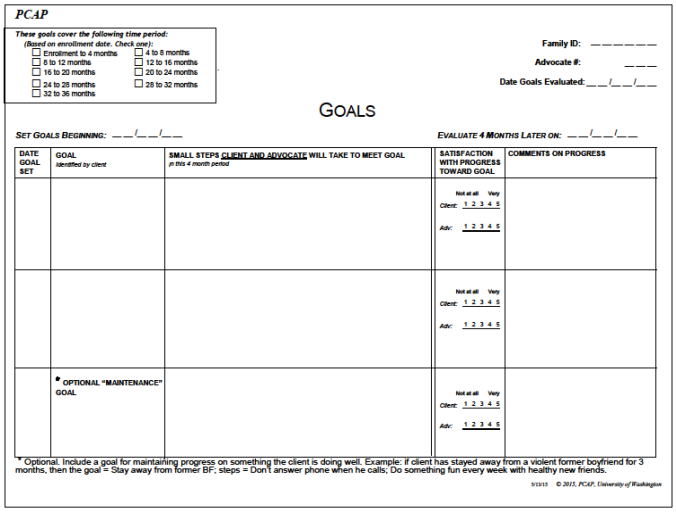
Setting the Goals You'll Work on Together & "Baby Steps" to Get There

The Goals you set need to be SMART:

S = Specific
M = Measurable
A = Achievable
R = Realistic (must consider client's intellectual and functional capacity)
T = Timely

Talk about what you learned in the Difference Game

- Use the top five cards as discussion topics; they DO NOT necessarily become Goals.
- Based on your discussion, identify one or two goals that are realistic, manageable; and identify one "maintenance goal" (see definition below).
- Break the goal(s) into very explicit "baby steps" *that are detailed,*



PCAP

These goals cover the following time period: (Based on enrollment date. Check one):
☐ Enrollment to 4 months ☐ 4 to 8 months
☐ 8 to 12 months ☐ 12 to 16 months
☐ 16 to 20 months ☐ 20 to 24 months
☐ 24 to 28 months ☐ 28 to 32 months
☐ 32 to 36 months

Family ID: _ _ _ _ _ _ _
Advocate #: _ _ _
Date Goals Evaluated: _ _ /_ _ /_ _

GOALS

SET GOALS BEGINNING: _ _ /_ _ /_ _ EVALUATE 4 MONTHS LATER ON: _ _ /_ _ /_ _

DATE GOAL SET	GOAL identified by client	SMALL STEPS CLIENT AND ADVOCATE WILL TAKE TO MEET GOAL in this 4 month period	SATISFACTION WITH PROGRESS TOWARD GOAL	COMMENTS ON PROGRESS
			Not at all Very Client: 1 2 3 4 5 Adv: 1 2 3 4 5	
			Not at all Very Client: 1 2 3 4 5 Adv: 1 2 3 4 5	
	* OPTIONAL "MAINTENANCE" GOAL		Not at all Very Client: 1 2 3 4 5 Adv: 1 2 3 4 5	

* Optional. Include a goal for maintaining progress on something the client is doing well. Example: if client has stayed away from a violent former boyfriend for 3 months, then the goal = Stay away from former BF; steps = Don't answer phone when he calls; Do something fun every week with healthy new friends.

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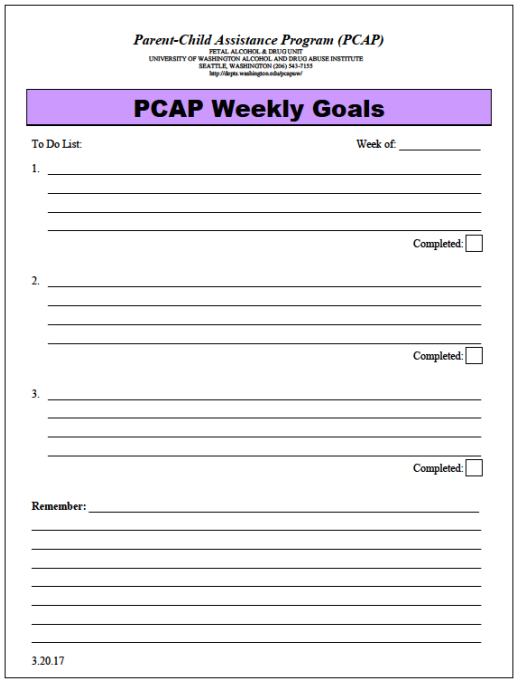
realistic, and yet attainable and **that you both will take**. Identify who will do which baby steps.

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



Parent-Child Assistance Program (PCAP)
FETAL ALCOHOL & DRUG UNIT
UNIVERSITY OF WASHINGTON ALCOHOL AND DRUG ABUSE INSTITUTE
SEATTLE, WASHINGTON (206) 543-7155
http://depts.washington.edu/pcapnw/

PCAP Weekly Goals

To Do List: Week of: _____

1. _____
Completed: ☐

2. _____
Completed: ☐

3. _____
Completed: ☐

Remember: _____

3.20.17

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

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

Self-efficacy is all about helping clients accomplish steps successfully. Reinforce every step in the right direction.

Difference Game Strategies

- Ask the client, *"What's been holding you back from doing that goal or that baby step?"* Help the client identify barriers and take steps to address them so they will no longer stand in the way.
- Don't let a client crisis disrupt your work together. **Use the crisis as an opportunity.** Help the client build self-efficacy by turning the crisis resolution into a Goal, with appropriate baby steps that need to be taken to resolve the problem.

- Based on client's situation and goals, provide a personalized Resource List (names, phone numbers of support people and providers) to have on hand so the client can solve problems as they arise.

Difference Game Reminders

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

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

—PCAP Client

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

—PCAP Client

Difference Game Example:

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

Using a Strengths - Based Approach.

A critical strategy in helping a PCAP client succeed is to **identify strengths and abilities**. Often clients have difficulty identifying their own strengths. The PCAP case manager's task is to discover what those are.

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Ask:
What do you do well?
What do you like to do?
What do your friends and family like best about you?
What are your best qualities?
What are the strengths:

- In your family?
- In your community (including cultural strengths)?
- In developing goals and action plans, focus on using and building on strengths and abilities.
- Find ways to consistently tell clients what they do well and are good at.

3. Role Modeling and Teaching

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

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

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

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

- Provide explicit "how to" direction and instruction, using multiple modes and simple step-by-step instructions (written and/or with pictures).

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- Act as a role model in everything you do.
- Demonstrate skills you would like clients to learn.
- Ask clients to demonstrate and practice the skill so you can observe.
- Always check for true understanding. Ask "What does this mean? How would you follow this? How would you complete this?"
- Praise clients for what they have done well.
- Offer constructive feedback in areas that need improvement.

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

"My advocate had a big influence on me and how I deal with things in my life."
–PCAP client

Supporting Clients in Substance Use Treatment Programs and Recovery

The Challenge

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

Stigma is a significant barrier to treatment, particularly during pregnancy. Other barriers to treatment include:

- Lack of access to gender-specific care
- Limited child-care availability at treatment facilities
- Few providers with obstetrics and addiction treatment expertise
- Fear of criminal or child welfare consequences

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

Why are completion rates low, and what are the risks?

One reason for low rates of treatment completion may be that persons with substance use disorders commonly have co-occurring psychological or neurological disorders (Choi & Ryan, 2007; Miles, Svikis, Kulstad, & Haug, 2001; Minnes, Singer, Humphrey-Wall, & Satayathum, 2008; Zilberman, Tavares, Blume, & el-Guebaly, 2003). This not only increases the likelihood of treatment dropout (Bernstein, 2000) but also puts them at risk for poor or disrupted parenting (Grant et al., 2011). When a mother who has delivered a substance-

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exposed infant does not comply with an alcohol and drug treatment regimen, the mother is at risk for two things:

- Relapse or ongoing substance use.
- Becoming pregnant and having a subsequent substance-exposed infant.

Demystifying Substance Use Treatment.

Substance use treatment services may include:

- Assessment – An interview by a health provider to decide the services a client needs.
- Brief Intervention and Referral to Treatment – Time limited, to reduce problem use.
- Withdrawal Management (Detoxification) – Help with decreasing use of alcohol or other drugs over time, until it is safe to stop using. (This service does not include hospital treatment.)
- Outpatient Treatment - Individual and group counseling sessions in the community.
- Intensive Outpatient Treatment – More frequent individual and group counseling sessions.
- Inpatient Residential Treatment – A comprehensive program of individual counseling, group counseling, and education, provided in a 24 hour-a-day supervised facility.
- Opiate Substitution Treatment Services – Provides outpatient assessment and treatment for opiate dependency. Includes approved medication and counseling.
- Case Management – Help with finding medical, social, education, and other services.

(Source: www.dshs.wa.gov)

Before Treatment: What to Consider

1. Mandated treatment may be necessary.
    a. For a case manager to tell a client "You need treatment" and for a client to say "I need treatment" are two very different things. The ideal situation is obviously for clients to decide for themselves that they need and want this help. However, many clients are unwilling to acknowledge their substance use 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 use are having a severe impact on their lives may be hesitant to take the major step of beginning treatment.
2. Drug Court and Family Treatment Court are beneficial.
3. Seek treatment where children can stay with the mother to reduce the likelihood of the mother leaving treatment.
4. Seek women-only treatment settings.
    a. The most successful treatment programs our clients are involved in are those which provide long-term inpatient care for women only and allow children. These programs provide not only drug/alcohol treatment, but a safe place for clients to

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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. Clients who are in treatment with their children are in a protected environment where they can practice their parenting skills under the watchful guidance of staff.

b. Most of our clients have lived in an atmosphere of chaos and trauma, growing up in homes affected by addiction, experiencing abuse (sexual, physical, emotional), and not feeling safe and nurtured as children. These conditions have had a severe impact on their ability to trust and to parent their own children. Long-term inpatient programs give clients time to begin to examine these issues, and to learn and practice parenting skills.

During Treatment: What to Consider

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

After Treatment: What to Consider

1. Relapse is part of the disease; be explicit and honest in discussing consequences with client. Develop a Relapse Prevention plan with the client. (See Section One under Harm Reduction).
2. Help client identify relapse triggers (e.g., people, places, special events).
3. Make specific safety plans for how to resist triggers and how to manage relapse if it occurs. This might include the client carrying a list of alternative things to do, and a list of names and phone numbers (including the case manager's).
4. Introduce client to relevant support groups.
5. Remind the client that relapse and setbacks are not grounds for dismissal from the program. Clients should call their case managers if they relapse to help mitigate potential problems associated with relapsing.

Additional Strategies for Supporting Clients in Treatment, Aftercare, and Recovery

1. Be consistent in appointment days and times, routines.
2. Prepare the client in advance for any changes in appointment times or personnel.
3. Give the client a reminder call or text the day before an appointment (there's a reason doctor's offices do this – it improves compliance!)
4. Work with the client to set reminders of when they need to leave for their appointments (not the appointment time) on their cell phone or other device.
5. Give the client a small notebook to carry around in which providers can write down appointments, instructions, etc.

6. Help set up structure. **Designate or help the client identify a trusted point person/mentor/treatment buddy for the client to call whenever a question or a problem arises, or the client does not know what to do.**

Supporting Clients in Recovery: Impulse Control

1. Help the client identify beginning signs of stress and anxiety (nervous jiggling, sweating, red face, clenched muscles.)
2. Help the client identify one or two things that are helpful when the client gets upset (taking a walk or run, ice cubes on face or wrist, deep breathing, doodling, soothing music.)
3. Talk with the client about the importance of using those techniques in the moment when the client is beginning to get upset.
    a. This can reduce aggression and the likelihood of getting thrown out of a program.
    b. Prompt them to enact their techniques if you notice they are struggling with an impulse.

Supporting Clients in Recovery: Parenting Classes

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

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

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

Supporting Clients in Family Planning

Helping clients 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

"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

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opportunity to raise a child without the fear of having to relinquish the baby.

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

When a case manager introduces the topic of family planning, the case manager often discovers that a client has already been thinking about it or has tried a method previously. We may hear comments like these:

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

Case Manager Strategies for Family Planning:

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

Supervisor Strategies for Family Planning:

- In supervision, ask about <u>each</u> client's family planning method.
- Note each client's family planning method during chart reviews (every 4 months).

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

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

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- If a case manager has a problem discussing this issue with clients, ask the case manager to accompany another case manager in the field who is more comfortable with the topic and whose clients are using family planning.

The Importance of Using Language the Client Can Understand

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

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

"Think Younger." Adjust your expectations to be more in line with the client's developmental level of functioning. Remember that it may be a case of ***can't***—not ***won't***. (Diane Malbin, FASCETS).

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

Always check for true understanding

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

Examples: Abstract vs. Concrete Language

Abstract/Difficult to Understand	Concrete/Understandable
We have concerns about your parenting skills.	Please set up a daily schedule for your child that includes: 1) When your child eats, 2) When your child takes naps, 3) When your child goes to bed. Let's write it down together.
	What makes it hard for you to keep a schedule? Let's come up with a strategy to fix that.

	Who can you call to ask for help? Where should we put their numbers? In your phone or on a paper for the refrigerator? Then help client based on answer.
You need to find an appropriate way to discipline your child.	• It's not OK to swear or yell at your child. • It's not OK to spank or hit your child.
	Let's practice some things you can do when you are upset or frustrated with your son.
	What are some things you would like to try the next time your child gets crabby? Let's make a list of those things. Where can you keep the list, so it is handy?
You need to check in regularly with your probation officer.	You need to call Diane's office every Tuesday by 10 a.m. Here's the phone number. Let's program it into your phone to help you remember.
	Where else should we write this down in case you lose your phone?
	I am going to call you the day before to remind you until you can remember on your own.

Using Hands-On, Concrete Strategies

Case managers' most effective teaching techniques are hands-on, concrete, and experiential.

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

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

This concrete checklist approach can be used in many situations.

1. Use a checklist with each step broken down and described in some detail (use photos of each step if possible).
2. Show the person how to put a check next to each step as it is done - they can see that when all the checks are competed the task is done.

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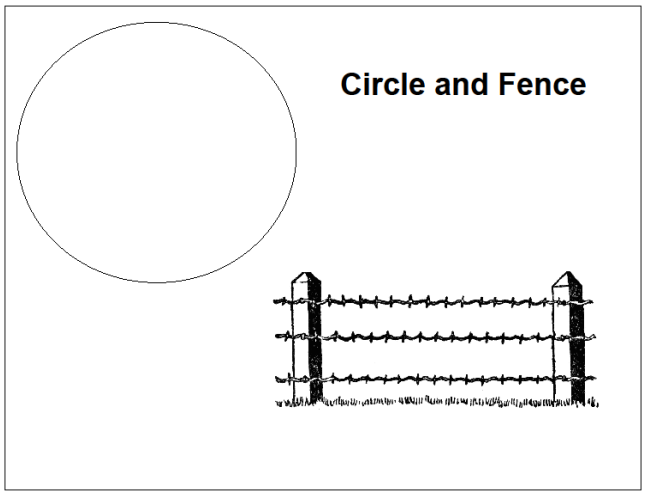
3. Check in with the client on consistent days and times. Over time clients will be able to do more and more of tasks on their own.

Vision boards, collages. Craft projects are popular with clients, and vision boards can be made with simple materials, e.g., tag board or cardboard, magazines, scissors, glue. Vision boards can be made in conjunction with goal setting, so clients can visually depict their hopes and dreams for themselves and their families. Vision boards/timelines can depict how clients' lives have changed through PCAP or how they want their lives to change.

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



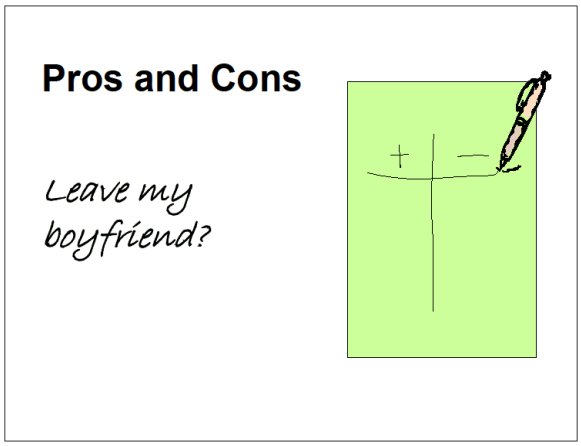
How it works:
Case managers draw a large circle. Then they discuss with clients who is "in their circle", that is, who are the people who are good for they clients, who help them stay on track and out of trouble, who are positive role models or friends. They write these names inside the circle. Case managers should accept all client contributions and record them. If case managers disagree with clients' choices, they should use motivational interviewing strategies to discuss those choices (e.g., develop discrepancy).

Next, on the same piece of paper case managers draw a fence (or brick wall or another barrier). Case managers brainstorm with clients about who should "stay behind the fence," that is, who do the clients recognize are not good for them, who do they know leads them into trouble, harms them, 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 clients' understanding of their relationships changes or as events occur that might affect clients' choice of friends, case managers do a new Circle and Fence activity with the clients. This hands-on tool:

- Helps to remind clients whom they should stay away from.
- Helps to reinforce the idea that clients can make choices about whom to allow into their lives, and that over time they can distance themselves from dysfunctional relationships.
- Helps clients identify healthy people in their lives who can be trusted and who might potentially become friends.

Pros and Cons Activity. This motivational interviewing strategy helps clients explore the positive and negative aspects of decisions they are trying to make. Record clients' actual words so that it's clear to them that that these are their own thoughts about important life decisions, not someone else's recommendations. Keep these worksheets, review them later and add to them as clients continue to work through decision processes.



Motivational Interviewing "Readiness Ruler" Activity. The Readiness Ruler is an activity that asks clients to consider how they feel about changing their current behavior (e.g., substance use, going to parenting classes, whether to use a family planning method). It examines three aspects of change:

Importance – The willingness to change/how important is it to the clients
Confidence – How confident are they in their ability to change
Readiness – A matter of priorities/are they ready to make changes

Case managers:

1) Ask clients to imagine there's a long ruler on the floor marked from 0 to 10.
2) Ask clients the questions below about any issue under discussion.
3) Ask clients to stand on the number they select.

Example:
On a scale of 1 to 10, how would you say you're doing with those parenting classes CPS asked you to take? Case manager responses:

- *You say you're at a 5. Why a 5, and not a 3? (Repeat clients' responses as they describe the positive steps they're taking, and "defends" their progress.)*
- *What would need to happen for you to get to a 6 or 7?*
- *How could I help you in getting to a 6 or 7?*

Example:

Importance: On a scale of 1 to 10, how important is it for you to make these changes?
You say you're at a 6. Why a 6, and not a 4? (Repeat back all responses)
Confidence: On a scale of 1 to 10, how confident are you that you could make a change if you wanted to?
You say you're at a 5. Why a 5, and not a 3? (Repeat back all responses)
Readiness: On a scale of 1 to 10, how ready are you to make a change?
You say you're at a 5. Why a 5, and not a 3? (Repeat back all responses)

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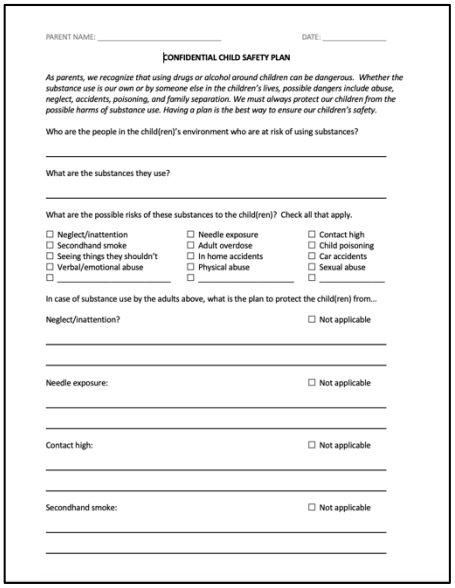
In discussions with clients:

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

(From http://www.monarchsystem.com/wp-content/uploads/2012/06/MI-Readiness-Ruler-A-Precontemplation-Stage-Tool.pdf)



PARENT NAME: _____ DATE: _____

CONFIDENTIAL CHILD SAFETY PLAN

As parents, we recognize that using drugs or alcohol around children can be dangerous. Whether the substance use is our own or by someone else in the children's lives, possible dangers include abuse, neglect, accidents, poisoning, and family separation. We must always protect our children from the possible harms of substance use. Having a plan is the best way to ensure our children's safety.

Who are the people in the child(ren)'s environment who are at risk of using substances?

What are the substances they use?

What are the possible risks of these substances to the child(ren)? Check all that apply.

☐ Neglect/inattention	☐ Needle exposure	☐ Contact high
☐ Secondhand smoke	☐ Adult overdose	☐ Child poisoning
☐ Seeing things they shouldn't	☐ In home accidents	☐ Car accidents
☐ Verbal/emotional abuse	☐ Physical abuse	☐ Sexual abuse
☐ _____	☐ _____	☐ _____

In case of substance use by the adults above, what is the plan to protect the child(ren) from...

Neglect/inattention? ☐ Not applicable

Needle exposure: ☐ Not applicable

Contact high: ☐ Not applicable

Secondhand smoke: ☐ Not applicable

Safety Plans. When people put or find themselves or their children in harm's way, it is all too easy for an observer to judge that they being careless. This is frequently not the case. Oftentimes, an unsafe situation can arise because the person wasn't anticipating it or didn't know how to handle it. PCAP case managers can be a tremendous help to their clients by helping them to identify existing or potential risky situations and to develop a strategy or plan to handle these situations effectively. Safety plans are often used with individuals experiencing intimate partner violence (for example, see http://www.ncdsv.org/images/dv_safety_plan.pdf). A similar approach can be used to protect children when parents are using substances. PCAP has developed a Child Safety Plan to use in these situations. The plan provides a template to help clients to reflect on any substance use that is happening (or risks happening) around their children, whether their own or someone else's. Using the plan, case managers can help clients to consider the potential risks involved with different patterns of substance use and to come up with strategies to keep their children safe. This activity is for the client's benefit – not the program. The completed original plan should be given to the client. The client should be encouraged to keep it somewhere that is easy to remember and access so it can be reviewed if needed. Because a completed plan can contain highly sensitive information, **do not keep a copy in the client's file.** Clients will be less likely to be honest and thorough if they think a copy will be in their program records.

Working with Clients within a Family Context

Effective case management is done within the context of a client's family. To whatever extent possible, PCAP case managers establish rapport with the older children, the husband or significant other, extended family members, and close friends. Everyone in this network

is involved in some way with the client's substance use and related problems, and they will be effected as well as the client attempts to break long established behavioral patterns. Family members may have a powerful influence over the client. Gaining their trust (and hopefully their support for the client's recovery process) is a preliminary step that allows the case manager access and the opportunity to communicate with this important group throughout the intervention. It is important to remember, though, that the family's support is not guaranteed, and they may resent and resist PCAP's "intrusion" as case managers slowly help the client disrupt dysfunctional patterns and relationships.

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

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

Case Manager Best Practices

Help Clients Clear Up Legal Warrants Early.

Case managers help clients clear up warrants early on 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 forgotten or unknown outstanding warrants in many counties.
- 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 the client's commitment to recovery. Encourage clients to write their own letters, explaining their progress and future plans and why they are asking for leniency from the court.

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- 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 the 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 the client is arrested and detained for the weekend, it could be complicated (if not impossible) to make arrangements for any children 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 a judge to allow the client a week to get affairs in order before appearing at the jail to do time.

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

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

Help Clients Enhance Safety and Improve the Quality of the Home Environment
An important role of the case manager is to teach the mother to pay attention to the quality of the home environment 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, 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 CPS. 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 the family, and to protect the children (or risk losing custody of them).
- Reduce the level of stimulation from loud music and other noise.
- Clean the house, remove trash, and keep dangerous items out of a child’s reach.
- Work with landlords to make repairs in electrical wiring or broken windows and install smoke alarms.

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Promote Development of the Mother/Infant Relationship

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

Developmental Profiles – Pre-Birth through Adolescence
K. Eileen Allen & Lynn Marotz

Synopsis
This 8th Edition text is a comprehensive, concise guide to the development milestones of children. It describes their physical, cognitive, and affective development from pre-birth through adolescence in a non-technical style, informing case managers and mothers 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 $150
http://solutions.cengage.com/brands/Delmar/
Or get used on Amazon.com for less.

Home Visitation Activity Examples

Clients are sometimes impatient and harsh with their children, but case managers rarely observe signs of deliberate injury. For example, a baby who is learning to pick up and eat Cheerios is likely to scatter the cereal and a mother may shout because he "made a mess." A case manager uses this as an opportunity to demonstrate loving playfulness. The case manager teaches the mother that the baby is developing fine motor skills and notes that picking up Cheerios is good practice. The case manager encourages the mother to do a Cheerios pick-up activity with the baby and praises the mother for doing so. Additional examples:

- Sit quietly with the mother and observe the baby playing and responding to various stimuli. Show the mother the fun and delight possible in paying attention, observing, and seeing that the baby has a unique personality and communicates with every facial expression and gesture.
- Ask the mother and baby to play for 10 minutes, while taking notes or recording a phone video of what the baby does. This "Baby Can Do" activity illustrates to the mother the diversity and complexity of the baby's behavior.

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- Give the mother a "Baby Can Do" notebook (a simple note pad, or scrap book). Ask the mother to set aside play time with the baby each day, and jot down any observations: the baby's funny faces, vocalizations, discoveries, responses, etc.
- Ask the mother to do this every other day until the next home visit, when the mother can show the case manager what's happened and how the baby is changing.

Personalizing Clients to Service Providers

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

Use Creative Outreach Strategies, Humor

To engage resistant clients, use creative outreach strategies.

Examples:

- Make a handmade coupon offering the client *Free Lunch* with the case manager – priceless!
- A case manager dropped off a half-dozen diapers on a resistant client's doorstep with a note asking if they could meet. After no response, the case manager again left six diapers and a note. Another time, four diapers and a note. Finally, the case manager left only one diaper with a note. The client called and said someone must be taking the diapers off the porch. They finally connected and met.

Minimize Distractions

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

PCAP Group Activities

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

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

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

The Intervention Part II: The Case Manager and Service Providers

> *"Half of my job is getting other people to do theirs."*
> *- PCAP case manager*

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

Case management is defined as:

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

(From: Commission for Case Manager Certification, https://ccmcertification.org/about-us/about-case-management/definition-and-philosophy-case-management)

Beginning with a new client's enrollment, and after obtaining necessary Releases of Information from the client, case managers:

1. Locate providers with whom they think the client should be connected, based on Goals and "baby steps" the client has identified, and in consideration of the service

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providers currently involved or working with the client (this information will be in the ASI intake interview).

2. Link clients with available and appropriate community services (PCAP does not provide direct treatment, health, or other services).
3. Use the PCAP Services Coordination form to record service provider information.
4. Coordinate efforts of the client's service providers by organizing regular communication and case consultation among them and including the client. The goal is to design a plan that will set clients up for success, not failure, and to prevent duplication of services, manipulation, and client falling through the cracks.

   Note: A hallmark of PCAP is to respond to phone calls, faxes, emails from other providers within 24 hours.
5. Assure that mother and baby receive and follow-up with services intended. Do not simply hand clients a list of phone numbers until clients are well into the intervention and have demonstrated that they can do this on their own.
6. If necessary, draw up formal memoranda of understanding (MOU) between PCAP and key agencies at the onset of the program. MOUs describe services an agency can be expected to provide to our clients and what the agency can expect from PCAP.

How to conduct a case consultation

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

- Helping clients organize and write down their thoughts and articulate their concerns and goals.
- Role modeling appropriate phone and social behaviors and practicing these with clients.
- Helping clients follow through with plans.

***Example of a PCAP scenario**: A client was stable in recovery and complying with family treatment court order to attend outpatient treatment five mornings a week, and a probation requirement to do urine screenings twice a week. Then, after being on a waiting list for over a year, the housing authority assigned a safe, low-income apartment for the client, but it was in a neighborhood that would require two bus transfers to get to treatment. Because the client was doing well, child welfare returned two children to the mother's custody. While these were all positive events, the client was overwhelmed and uncertain about being able to manage. The PCAP case manager organized a meeting with the client*

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and the service providers involved. When the group communicated about the realities of the situation, the providers decided on a plan that would support the mother in her recovery, rather than set the client up for another failure. They found a treatment facility (including urine screening capacity) near the client's new home.

Resolving Service Barriers

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

Identifying barriers

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

When is a "barrier" not a true barrier?

1. **When it's a personality clash.**
   Depending on the day and the personalities involved, an individual case manger's style could be interpreted as "pushy," and be met with a defensive response from agency personnel. Other agency personnel might welcome the same case manager's behavior as interested and energetic. Supervisors should be careful to note the type and frequency of barriers expressed by individual case managers.
2. **When it's a misunderstanding by the case manager about the protocol, role, or limits of the agency.**
   In these cases, the case manager apologizes for the misunderstanding/mistake, finds out the correct procedures, and educates the other PCAP staff.
3. **When it's an isolated incident.**
   Mistakes happen, and while lost files or missed appointments can be frustrating, it is not a systemic service barrier if the incident is isolated or not preventable.

"Attitude of Gratitude"

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

A hallmark of PCAP is the practice of showing our appreciation to community colleagues. When a case manager takes ten minutes of her time to write and send a note, 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 are resolved more expeditiously.

"Attitude of Gratitude" Activity

Spend a staff meeting creating fun thank you card to send to CPS social workers, public health nurses, and others with whom you work. Providers love receiving the cheery cards and feel sincerely appreciated for their work with PCAP clients.

PCAP case managers teach their clients to do the same – write personalized thank you notes to their providers.

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

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

What to do: Practical steps

1. Know agency representatives by name and face to make interactions more personal and less bureaucratic. When people have met face to face, they are more likely to develop a sense of personal responsibility to each other, and accountability for the quality of one's work.

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

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

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

5. Before an issue becomes a chronic barrier, invite an agency director or supervisor (and other staff if appropriate) to attend a PCAP staff meeting or a brown bag lunch as guests. The purpose is to:

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- Ascertain the functions and goals of both agencies.
- Discuss specific problems that have arisen.
- Devise strategies to resolve the situation.
- Develop action steps.

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

6. Ask if PCAP staff members may attend a staff meeting at the other agency. The agenda can include a brief description of PCAP's role, an acknowledgment that you are all working toward the same end, and finally, a discussion of the problems you have encountered with the agency and questions about problems they may have encountered with PCAP.

7. Airing difficulties makes it possible to address them, instead of trying to work around them or deny their existence.

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

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

Interfacing with the Child Welfare System

PCAP staff are mandated to report child abuse and neglect as outlined in the PCAP Abuse and Neglect Protocol. As regular home visitors, they are in a unique position to observe problems that may place children at grave risk in families who may have fallen off (or never been on) the radar of health and social service providers. Their mandated reports of child abuse or neglect may instigate removal of children from the home when necessary.

The issue of child custody is often a recurrent theme in clients' lives. Many clients 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 may not necessarily concur that reunification at that point is in the best interests of the child/ren—or the client.

When possible, case managers will let clients know ahead of time if they must call CPS.

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

> *"My job is to motivate my clients to THINK about their own lives, make better decisions, and take responsibility for what they do every day. I ask my clients, 'Who's driving this bus?'"*
>
> *—PCAP Case Manager*

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

When a CPS report needs to be made

Ideal scenario: Clients call CPS themselves with case managers' witnessing it and providing support. In this case, the PCAP case manager:

1. Staffs the issue with the clinical supervisor.
2. Discusses concerns with the client, explains why a report is warranted, and helps the client examine the circumstances, using motivational interviewing techniques.
3. Explains that, as a mandated reporter, the case manager must see that CPS is notified.
4. Explains that if the client calls the CPS worker to talk about these early warning signs and difficulties and ask for support/guidance, the client will be demonstrating self-awareness and the intent to take responsibility as a parent who wants to improve, which could make a positive impression with CPS.
5. Practices or role plays the call with the client before the actual call to CPS.
6. Is with the client when the client makes the call to CPS.
7. Documents activities carefully in case notes and briefs the PCAP supervisor.

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

1. Start by taking the first four steps above. If client is unwilling to make the call, the case manager does so.
2. Ideally, case manager is with the client when case manager makes the call to CPS. If this can't happen, case manager makes the call alone.
3. Document activities carefully in case notes, brief the PCAP supervisor, and inform the client of the outcome.

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

1. Case manager first staffs the issue with the PCAP clinical supervisor.
2. If the client is unable to be located or is unwilling to talk about the issues, the case manager calls CPS to make the report.

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

The turning point for successful resolution of child custody issues often occurs when mothers realistically come to terms with their ability to parent and become willing to consider the best interests of their children. 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 the child/ren. Regardless of who has custody, case managers work on behalf of the child to secure a safe home environment and regular healthcare.

How PCAP and CPS work together

In general, PCAP and CPS work closely together (with an ROI in place). However, in some locales CPS recommendations may be based on biased attitudes and beliefs or lack of information and experience.

As case managers, PCAP case managers help clients comply with their individual contracts and act as liaisons between CPS and the client. Case managers keep careful documentation and maintain ROIs so they can communicate with all parties, verify compliance or non-compliance, and advocate accordingly.

PCAP case managers count on CPS workers to:

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

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

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Interfacing with the Legal System

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

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

Note: In Washington State, PCAP research records (not clinical records) are covered by a federal Certificate of Confidentiality issued by the National Institutes of Health. This Certificate protects clients' identities in case of subpoena, providing a legal basis to refuse to provide identifiable information in research records, unless ordered to do so by a judge.

Section Six

Special Considerations and Challenges in Working with Our Population

Recognizing Potential Challenges

PCAP works with a population that inherently faces many challenges. Recognizing these challenges can enable staff to better understand behaviors they encounter and work with clients to set realistic and reasonable expectations and goals.

All PCAP clients have a significant substance use issue as evidenced by their at-risk substance use during pregnancy. Many also have partners or other family members with problematic substance use. Acute or chronic substance use can cause cognitive problems and psychiatric symptoms. Cognitive problems can include memory loss, learning problems, and impaired decision making. Psychiatric symptoms can include anxiety, impulsivity, and paranoia. Cognitive problems and psychiatric symptoms can improve and even remit when a person stops using, but this takes time because the brain needs a drug-free environment to heal. Once a client stops using and initiates treatment, brain circuits can begin to normalize. During this time, it is not uncommon for a client to appear worse cognitively or psychiatrically, but this is only temporary.

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

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

2. **Clients themselves may have been exposed prenatally to drugs or alcohol** to the extent that they have 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, and over 50% report having mothers who were alcohol users.

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

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Suicide Risk Among PCAP Clients

At program intake (2016 – 2019), approximately 9% of those enrolled in PCAP reported suicidal ideation in the past 30 days, and 42% reported suicide ideation at some time in their lives. If at any time while a client is in PCAP, the client reports thinking of suicide or self-harm or spontaneously reports such thoughts in any kind of encounter (telephone, in-person, electronic), case managers and supervisors should follow the protocols described in the links below.

Protocol for Responding to Client Suicide or Self Harm Ideation
Safety Plan Form

In addition, the following research article provides good information from a large-scale study. Researchers found that Safety Planning Intervention with follow-up was associated with reduced suicidal behavior and increased treatment engagement among suicidal patients after Emergency Room discharge. Safety Planning Intervention with follow-up may be a valuable clinical tool in health care settings.

Stanley, Brown & Brenner et al., (2018). Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry, 75(9), 894-900.

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

Fetal alcohol spectrum disorders (FASDs) are conditions caused by prenatal alcohol exposure in amounts sufficient to cause permanent impairments in brain functioning. The extent of damage depends on timing, dose, frequency, pattern of exposure, metabolism of alcohol, maternal nutrition, liver function, genetics, uterine environment, and age. Prenatal alcohol exposure during critical periods of gestation can produce varying patterns of neurocognitive and adaptive functioning deficits and behavioral challenges. The effects of prenatal alcohol exposure occur across the span of intellectual functioning and begin before most people recognize they are pregnant.

Behaviors Typical of People with an FASD

Poor Executive Functioning

- Difficulty organizing stored information to plan future activities
- Difficulty taking what is learned in one situation and applying it to another situation (e.g., cannot take what is learned in a parenting class and apply it when that situation comes up with their child a day or week later)
- Difficulty regulating and sequencing behavior
- Difficulty inhibiting responses and delaying gratification
- Lack of cognitive flexibility
- Poor judgment

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Difficulty with Incoming Stimuli

- Get overstimulated in social situation (a crowded room, or among strangers)
- Overreact to situations with surprisingly strong emotions
- Display rapid mood swings set off by seemingly small events
- Have difficulty sustaining attention
- Have difficulty completing tasks, especially when given multiple tasks, rules, directions, or instructions
- Have difficulty processing information presented verbally

Difficulty with Abstract Thinking

- Take everything very literally no matter how smart they are
- Follow instructions or directions word for word
- Have difficulty with a sense of time
- Have difficulty with the concepts of historical time and future time e.g., how long ago something happened or how long it takes to get somewhere
- Are often late for appointments because they cannot remember them at the time they need to
- Difficulty with a sense of space
- Often stand too close to someone as they don't understand the concept of personal space. Others are often uncomfortable with that closeness or see it as a challenge
- Difficulty with abstract concepts such as joking, metaphors, similes, sarcasm, proverbs, idioms
- Will laugh with others who are joking but do not understand the jokes and may think the person hates them or is making fun of them
- Cannot predict the consequences of their actions
- May get into difficulty for the same thing multiple times
- Do not benefit from reward and consequence approaches
- Difficulty managing money or hanging onto it for upcoming needs
- Difficulty recognizing danger and fear and knowing what to do

These behaviors result from the damage to the brain caused by prenatal alcohol exposure and occur regardless of the individual's intelligence.

Identifying PCAP Clients Who May Have an FASD

PCAP recommends use of the Life History Screen (Grant et al., 2013) to identify clients who may have an FASD or other neurocognitive issues that may warrant a different therapeutic approach. In addition to asking about alcohol use by the client's birth mother, the Life History Screen assesses for characteristics that are common among people with an FASD:

- Impulsivity
- Doing the same thing over and over, even if it has caused problems
- Trouble learning in school

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- Problems handling money
- Decompensation (e.g., loss of control over behavior) in the face of stress
- Engaging in crimes as a secondary participant
- Repeated minor offenses
- Not following through with intended action steps (e.g., not pursuing social services)

Grant, T. M., Brown, N. N., Graham, J. C., Whitney, N., Dubovsky, D., & Nelson, L. A. (2013). Screening in treatment programs for fetal alcohol spectrum disorders that could affect therapeutic progress. *International Journal of Alcohol and Drug Research*, *2*(3), 37-49.

If you suspect a client may have an FASD, a formal neuropsychological evaluation would be beneficial though it can be difficult to arrange.

- 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 the client learns best.
- May be critical for obtaining disability benefits.

Strategies for Working with Clients Who May Have an FASD

Determine the client's level of functioning: Does the client …

- Overreact?
- Have trouble keeping money?
- Struggle with numbers in daily life (estimating time, distance, costs)?
- Forget things a lot?
- Fly off the handle unexpectedly?
- Have "friends" who take advantage?
- Fail to follow through with appointments?

Remember that not all clients who have an FASD are alike. While it may appear at times like they ***won't*** do something, it may be the case that they ***can't*** do it. However, persons with an FASD can do very well with the right approach and supports.

What You Can Do

1. Revise your expectations based on client's level of functioning.
2. Set reasonable goals.
3. Help set up structure and consistency.
    a. Be consistent in appointment times, locations, and providers.

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   b. Be alert for changes/transitions—monitor more carefully, do advance problem-solving.
4. Alter language: use short sentences, minimize abstract, and use concrete examples.
5. Learn client's "unique" language patterns.
6. Present information strategically:
   a. Use multiple modes.
   b. Simple step-by-step instructions (written and/or with illustrations).
   c. Role-play.
7. Role-play appropriate actions and skills with the client. First play the client, modeling how you would like them to act or what you would like them to do in a situation. Then have the client role-play themselves in that situation. Do this repeatedly as working memory is impaired, and it takes a lot of consistency and repetition to get it into long-term memory.
8. Revisit important points during each session.
9. Teach generalization: Don't assume a skill learned in one context will transfer to another.
10. Help client identify physical releases when escalating emotions become overwhelming.
11. Assess client vulnerability to victimization.
12. Anytime you need to tell a client that they can't say or do something, also tell them, "*but you can* say or do this". For example, say, "When you're mad at someone, either at an adult or a child, you cannot hit them, *but you can* tell them that you are mad at them. Or when you're frustrated, you can't hit someone or curse at them or break something, *but you can* take a breather and go for a walk."
13. Identify and build on the strengths and abilities of the client.
14. Routinely tell the client what they do well and what you appreciate about them.

> *"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 do this."*
>
> *— Mother who has an FASD and two children under age 2*

Suicide Risk among Individuals Who Have an FASD

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

FASD Suicide Intervention/Prevention

1. Recognize client is at increased risk for suicide.
2. Refer client for mental health evaluation/treatment.

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   a. If the client has a probably FASD, refer client for mental health evaluation/treatment with a clinician who understands FASD.
3. Alert the provider about possible cognitive issues.
   a. Standard suicide assessment protocols do apply.
   b. Modify to accommodate neuropsychological deficits and communication impairments. For example, instead of "How does the future look to you?" ask "What are you going to do tomorrow? Next week?"
4. Check for a disconnect between the seriousness of suicidal behavior and the level of intent to die.
5. Obtain family/collateral input.
6. Address basic needs and increase stability.
   a. Treat depression.
   b. Teach distraction techniques.
   c. Remove lethal means.
   d. Increase social support.
7. Do not use suicide contracts because clients with an FASD tend to be impulsive.
   a. It is important to identify a trusted person and a trusted back-up person whom the client can call whenever they have a question or an issue. Tell the client "Anytime you feel like hurting yourself, call this trusted person or back-up person."
8. Monitor risk closely.
9. Reinforce and build reasons for living.
10. Strengthen case manager-client relationship.

Motivational Interviewing (MI) with People Who Have an FASD

- Remember that listening to clients builds relationships.
- Highlight "teachable moments" when problems occur, compassionately reflecting back to clients the consequences of their own actions.
- Keep the focus on "How can I help?" or "This is what I can do to help" (vs. "I told you so").
- Focus on clients' strengths.
- Accept interim goals: help clients step by step, taking "baby steps" toward ultimate goals.
- Note that clients' self-efficacy is influenced most powerfully by their own accomplishments. Foster ***success experiences*** for clients.

MI Modifications for Clients Who Have an FASD

Providers will need to be more active in helping clients examine their behavior.

- Discuss events immediately.
- Actively identify steps that led to the event rather than passively letting client discover them.
- Ask more close-ended questions rather than open-ended questions.

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- Offer a few solutions and have client choose best option.
- Explore choices visually if possible.
- Teach clients how to ask for what they need from the people in their lives by role-playing and modeling.
- Don't rely on verbal instructions. Use multiple senses whenever possible. For example, if you talk about the good things and not so good things about a behavior, make those lists on paper, don't just talk about them.
- Help clients think about assets that are available. "Who is helpful to you when you have a problem?"
- Teach clients to carry a notebook wherever they go for providers to write down instructions, appointment times, etc.
- Help clients find activities that are calming, comfortable, fun, and easy to access (music, swimming).

Using the Difference Game with clients who have an FASD

1. Give clients one card at a time.
2. Select one or two reasonable goals.
3. Identify "baby steps" it will take to reach each goal.
    a. Assign clients one or two baby steps at a time and have them report back.
    b. Reinforce (e.g., verbally acknowledge, praise) every step in the right direction.

The Protective Payee

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

Clients with an FASD often have a poor idea of how money works and how to manage it. PCAP case managers can assess clients' understanding of money by watching how they count money, understand their bills, and describe transactions with others. Having a protective payee is preventive: it helps clients avoid running out of money, giving money away, getting services cut off, etc. Ensure the protective payee is both trustworthy and trusted by the client. Recognize that clients with an FASD sometimes trust people who are not trustworthy.

Clients with an FASD as Parents

For clients who have an 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. Recognize that many clients may not have experienced appropriate parenting themselves and may therefore not know what bedtimes,

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mealtimes, and other components of parenting should be. Therefore, they will need modeling and hands on support to learn these techniques.

Case managers should assess the mother's ability to:

- Respond to and manage emergencies successfully
- Pick safe people to be in their children's lives
- Establish routines such as mealtimes and bed times
- Provide appropriate learning opportunities
- Pay attention to their children as individuals
- Understand children's developmental stages
- Maintain housing
- Pay their bills

Parenting classes

Parenting classes for mothers with an FASD may not be effective. Instead, working one-on-one with the mom and child is a "good fit". Why?

- Individualized intervention is tailored to the mother's learning style.
- Many opportunities for hands-on practice and role modeling.
- Since individuals with an FASD have difficulty taking what is learned in one situation and applying it to another, "in vivo parenting," where someone is working with them and their child and modeling how to respond in specific situations, is an appropriate approach.

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

To improve treatment completion among clients with an FASD, consider:

- Recommending/providing individual (focused) therapy as opposed to group (distracting) therapy. Supportive therapy is much more useful than insight-oriented psychotherapy. Approaches such as cognitive behavioral therapy (CBT) and trauma-focused CBT need to be modified to be helpful to someone with an FASD.
- Assigning a "treatment buddy" to help clients understand and comply with house rules.
- Practicing creative ways to prevent/deal with outbursts and limited impulse control (try an ice water face bath, ice cubes on wrists, jump-roping or other safe physical outlets).
- Provide short, frequent sessions rather than once a week, longer sessions.
- **Altering clients' environment to accommodate to their disability (e.g., providing a quiet room).**

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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.

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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.

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Managing Client Status Changes

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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 children to mentors, resources, and programs that will endure after graduation from PCAP. Procedures for guaranteeing children'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 during the program. This reflection can be a powerful source of self-esteem.
- How to build upon goals already achieved. Designing strategies to attain future goals is a good method for focusing attention on the future rather than on leaving PCAP.

At Client Exit

The case manager-client relationship ends after 36 months in the program. This can be positive when conceptualized as a transition to a new phase or a beginning rather than an ending. The work that the case manager and client have done over the past 3 years forms the springboard for this new phase.

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

Client Exit: 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, and up to 24 months before exit date with permission by WA state PCAP director and evaluator.*

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 and provides childcare if necessary.*

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, provided that privacy can be ensured, and childcare is arranged.*

Phone or Zoom

- *As a last resort, the interview can be done remotely, provided the client can arrange for privacy without interruption. Interviewer mails consent forms and other paperwork to be filled out and mailed back to the interviewer.*

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

Supervisor Responsibilities

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

Case Manager Responsibilities

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

Exit Interviewer Responsibilities

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

Possible Graduation Activities

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

Case Manager Letter to Client

An individualized, personal letter to the client from the case manager at the end of the program is a powerful tool. Case managers describe what their clients have meant to them, what the clients have taught them, how the clients helped them grow personally and professionally, and how they believe in the clients' 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.

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Arrange a Special Event

- Surprise clients with lunch or dinner at a special restaurant. Tell clients you'll pick them up and ask them 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 clients organize a small birthday party for the target child's third birthday.

After Client Exit

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

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

Clients Who Leave the Program Early

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

- Disengaged or disappeared and could not be located despite 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

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.

A PCAP notification of death should be documented in the online the database. We do not request death certificates from the State.

If it was a client death, we may continue for the short-term to provide PCAP services to the target child and caregivers. The focus should be on crisis management in the immediate aftermath of the client's death. After the crisis has passed, the focus should shift to connecting the family to needed services in anticipation of early exit. The client file stays active as long as we provide case management to the target child and caregivers, no longer than 6-9 months after the client's death. TC's caregiver should be asked to complete an exit interview consisting of ONLY those questions that are directly TC-related. Once the TC and family are no longer 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 term. It is not unusual for clients whose target child dies to choose to leave PCAP after a few months.

Client Unenrollment: Two Categories

Clients are not dropped from PCAP or asked to leave because of relapse or setbacks. However, if a client has moved out of the area or has not engaged despite intensive outreach, the clinical supervisor may "unenroll" the client so we can create an opening and give another person an opportunity to enroll in PCAP.

There are two categories of unenrollment: unenroll and withdrawal. A client may be unenrolled or withdrawn from the program if the client meets criteria below.

1. **Unenrollment:** A client who is not actively involved with PCAP and meets one of the conditions below:

Intake ASI never completed, client unable to be located or brought in for ASI within the eligibility window.

Intake ASI completed, but client:

- Was thought to be eligible for PCAP but is actually ineligible
- Consistently exhibits passive refusal despite at least 6 months (and a maximum of 9 months) of efforts to engage (e.g., makes appointments but no-shows or cancels)
- Never engaged with PCAP case manager
- Participated initially but later disengaged and has not engaged for at least 6 months (and a maximum of 9 months) despite intensive efforts.
- Participated initially but later was unable to be located despite at least 6 months (and a maximum of 9 months) of intensive tracing efforts
- Moved out of the area with no plans to return
- Went into long term prison

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Missing clients should always be traced and attempts made to reengage. Once a client has been missing for 6 months, the supervisor puts the client on pre-unenrollment status and case manager continues to trace. After another 3 months if client has not been found/engaged, the supervisor follows unenrollment procedures listed below.

Procedures for unenrolls: Unenrollment decisions are made by the clinical supervisor (not case managers) on a case-by-case basis and require approval by the state PCAP director or PCAP evaluator.

The clinical supervisor:

1. Prepares a short description of case details. Pertinent information includes enrollment date, whether the client completed the ASI intake, number of face to face contacts and date of last contact, location, status and custody of the target child, information about the client's whereabouts, steps the case manager has taken to try to locate and engage the client.
2. Submits the information to the state director and/or program evaluator for approval.
3. If the state director concurs that there is nothing else to be done to engage the client, a decision is made to unenroll her.

2. Withdrawal: A client who no longer wants/needs PCAP services and thus refuses to be further involved or requests to leave.

Procedures for withdrawals: The PCAP Client Service Agreement states that participation is voluntary, and clients may withdraw at any time. If a client states a desire to leave PCAP, the clinical supervisor:

1. Discusses the issue with the case manager.
2. Has a conversation with the client, if possible, to determine the reasons, how serious this desire is, and whether there is something PCAP can do to re-engage her.
3. Gives the client several weeks to consider the decision if it seems to have been impulsive or an angry response to an issue with a case manager.
4. Obtains email approval by the state PCAP director.
5. If client was mandated by CPS or the courts to participate in PCAP, notifies the appropriate people/agencies with whom there are signed ROIs.
6. Documents all steps above.

For other client exit definitions, see Client Status: Program Exit Definitions and Protocols.

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Tracing Clients Who Are Missing

Successful tracing starts on the day the client enrolls in PCAP and obtaining the necessary ROIs. If you wait until the client 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 client's home to find the client not there. Clients who are wary at the start of PCAP may be testing the case manager and the program. Case managers respond by being persistent and letting the client know that:

1. We're ready to help (and we know **how** to help) whenever the client is ready.
2. The client is worth it.
3. We'll continue to be persistent and creative in reaching out to the client, wherever the client 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 case manager 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 That Work

- Go where the client goes (methadone dosing clinic, child visits with CPS, WIC appointments, court appearances).
- References are critical. Keep record of names and phone numbers of client friends and family from client's intake interview, and ongoing new contact information obtained by the case manager throughout the intervention (e.g., new phone numbers, addresses where you've dropped the client off, the client's favorite coffee shop).
- Mine the clinic file for every bit of information (every provider, phone number, place, friend/relative, etc.).
- Send the client friendly letters/notes/birthday cards, etc.
- Put mileage on your car.
- Check with neighbors at last known address.
- Check the jail roster regularly.
- Use websites (e.g., Facebook) and databases.

For extensive, detailed Tracing tools and strategies see:
http://pcap.psychiatry.uw.edu/wp-content/uploads/2021/03/Tracing_Tips.pdf

Transferring Clients

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

Transfers between PCAP Sites:

- A site-to-site ROI must be signed between the ORIGINAL and the RECEIVING sites before a transfer can be initiated.
- 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 that 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 receiving site case manager provides courtesy visits and starts a temporary client case file where to record case notes.
- 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.
- Time spent with the client or on behalf of the client is recorded on the receiving site case manager's Time Summary Form by adding the client. Note that the client can appear on more than one time summary in a single week.

For additional details on transfer protocols and documentation, see:
https://pcap.psychiatry.uw.edu/wp-content/uploads/2023/03/Transfer_Protocols.pdf

Section Eight

PCAP Evaluation

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

Why Is Evaluation an Integral Part of PCAP?

Evaluation demonstrates whether a program works.
PCAP uses evaluation to assess the effectiveness of the model. These outcome evaluations are shared with staff and may be published 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.

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.

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.

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

Grant, TM, Graham, JC, Ernst, CC, Peavy, KM, & Brown, NN. (2014). Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births. Children and Youth Services Review, 46, 11-18.

Additional papers and chapters have been published and can be found on the PCAP website: http://pcap.psychiatry.uw.edu/what-is-pcap/publications/.

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

Evaluation allows for more effective use of public resources by monitoring funded programs. Outcome reports are generated on a regular basis for use by agency 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 funders. See 2020 PCAP Summary of Evidence as an example of a document Washington PCAP clinical supervisors present to their local state legislators to illustrate outcomes of the state's investment in PCAP.

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

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

- **The Difference Game** – Assessing needs, getting clients involved, establishing contact
- **Progress Towards Goals Form** – Taking baby steps
- **Biological Children Form / Child Log** – Assessing status and potential needs

These PCAP instruments were designed using feedback from case managers to ensure that the instrument enhances the work with clients in addition to gathering data.

Administering assessment instruments can:

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

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

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

The Two Types of Evaluation

1. Outcome Program Evaluation

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

PCAP Outcome Evaluation focuses primarily on six areas where changes are expected to result from 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

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2. Ongoing Program Evaluation

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

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

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

Evaluation is not simply filling out data forms.

Why it matters.

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

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

Using Data to Evaluate Performance

CAUTION

Do not use client outcome data as a measure of an employee's job performance. 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 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 or 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 collection platform
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 collection platform is that evaluation data 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 while performing intensive clinical work. Washington State PCAP uses REDCap to collect evaluation data.

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

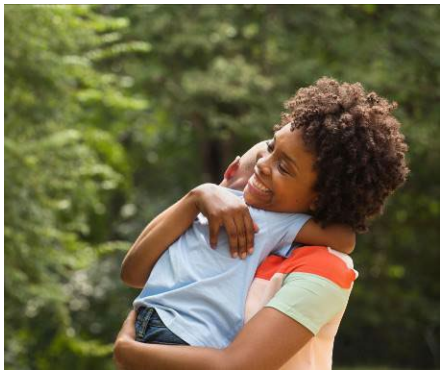
- User-friendly: easy access to forms, system for organizing evaluation activities, easy data entry.
- Access to central database from remote locations.
- Generates real-time information (reports) on the status of data entry, what forms are in, whether they are complete, what is overdue.
- Improves accuracy 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 (who is usually an office assistant), who monitors the submission of evaluation forms on a weekly or 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. Training on evaluation makes more sense to the trainee if it is after the general PCAP training so that the new case manager can see how evaluation activities fit in with, and support, what they will be doing.

Ongoing Onsite Evaluation Training

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



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 year, 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.
- Specific data reports that have been generated for other purposes.
- Annual refresher training on the Biannual and Time Summary forms.

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 clients in the program to learn how to better help clients. We want to know not only what works but also what doesn't work so that we can make improvements in the program. Essential to this goal is absolute honesty in reporting and, most importantly, a focus on good documentation habits. It is important to ensure that staff are never afraid to report

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"bad news." 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 Addiction Severity Index (ASI) accuracy

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

2. Intake ASIs are never administered by PCAP case managers. They are administered by supervisors because of the extensive training involved and because the ASIs serve as an invaluable supervisory clinical assessment tool (in addition to collecting research data). Calendars, prompts, attention to administration conditions, and assurances of confidentiality are used to enhance the accuracy of the client's self-report.

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

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

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

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Improving Biannual Assessment Accuracy

1. A copy of the biannual form should be kept in the file on which to keep notes of client progress as the 6-month period progresses. With a full caseload of clients, memory alone will not be sufficient to document what has happened with each client over the past 6 months. This also saves time over having to review the past 6 months of case notes.

2. 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 with the supervisor.

Enhancing Timely Completion of Data

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

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

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

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

Evaluation Basics that Enhance Accuracy and Integrity of Data

Evaluation Activities Should be User-Friendly and Useful to Clinical Work

PCAP ongoing program evaluation activities are geared toward making evaluation user friendly and useful. PCAP staff members need to clearly understand why and how evaluation is useful to them and their clients.

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

Important Elements to Cover in Evaluation Training

1. Explain (demystify) basic concepts of evaluation. Use analogies as necessary.

   For example: "Evaluation is like taking a picture. Evaluation methodology is like the camera used to take the picture. Input from case managers is like focusing the lens. The quality of the evaluation is measured by the quality of the picture."

2. Invest case managers in the evaluation.
   - Case managers are documenting something real: their clients' lives.
   - Their attention to detail and accurate reporting is critical and essential.
   - Honesty in reporting is essential. Don't judge what is "good" or "bad" when reporting, just report what is. Relapse is a process, sometimes something very valuable can be learned from an apparent relapse "failure."
   - Evaluation results are used; they will be applied to this program, and perhaps to programs yet to come.
   - Evaluation activities will result in something valuable that will be used by the program to enhance the work they are doing with their clients.
   - Evaluation results have wide-reaching impact.
   - Accurate documentation of your work and the clients' progress will help not only your clients, but other mothers 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 the confidentiality of their data.
   - Explain that we use numbers (not names) to identify clients on data forms as a protection for clients.
   - Explain what should and shouldn't be put on a data form (i.e., no client names, brief comments but not case note level detail).
   - Caution against completing data forms, or leave them lying about, in a location where they might be seen by others.
   - Enter data in a timely manner. Data that are entered late are never as accurate as data entered soon after the fact.
   - Write paper forms as legibly as possible. Someone may have to enter that data later.
   - Be careful to be accurate in your keystrokes when entering data online. What is entered is what will be reported as data. Online, there is no middleman data entry

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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.
- Ascertain that the client has enough time to complete the instrument.
- Make sure that the client is not distracted or in the presence of someone whose presence might preclude honest responses.
- Note that 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 to reduce the effects of bias on reporting.

4. Train (and retrain) case managers in the specifics.

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

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

External Evaluation

PCAP evaluation activities include ongoing program evaluation and evaluation training, as well as outcome evaluation. Unless you find an external contractor able to provide all 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 using an online web-based system like REDCap: 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 REDCap is used to generate reports, these reports will be using unedited, raw data and will include whatever data entry errors were made by operators. For reports to community and funders, a human evaluator needs to review the data and create the reports so that the data are as clean as possible.)

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

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

1. A Certificate of Confidentiality from the federal government that protects our client identities in 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.

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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 at-risk populations

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

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

1. ***What is the extent of the maternal substance use problem in your organization/community?***
   Communities with data available to demonstrate a significant maternal substance use 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 at-risk families or populations with substance use disorders. 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).

Agencies Hosting PCAP Sites

In Washington State, PCAP funding contracts are administered by the Health Care Authority, Division of Behavioral Health and Recovery (DBHR). Agencies interested in operating a

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PCAP site in their county may contact DBHR, and if funding is available, apply for it. Agencies are selected based on the unmet need in their catchment area and their qualifications. Agencies that operate PCAP sites are typically substance use treatment or community social service or health agencies.

For PCAP sites in Washington State, visit: https://pcap.psyciatry.uw.edu/contact-us/

PCAP Organizational Structure within a Site

The PCAP administrative structure is designed to support the case management staff and create a rewarding work environment. Full PCAP program sites employ a clinical supervisor and case managers at a ratio of 1:6. Each case manager works with up to 20 clients. When multiple PCAP sites are operating within a state or province, ideally the sites are coordinated and in close communication, supported at the program level by a director and evaluator.

Quarterly Administrative Meetings

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

Budget Considerations and Categories

Below are the basic budget categories required for operation of a PCAP site. The exact amounts of these items differ depending on the size of the PCAP site and the geographic region.

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

Appendix B

Program Fidelity, Sustainability, and Cost Savings Considerations

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Fidelity to the PCAP Model

A successful PCAP replication site:

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

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

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

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

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

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

Sustainability

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

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

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Four elements that are critical to sustaining a PCAP site include:

- Hiring intelligent, committed, and hard-working people
- Operating a well-run organization
- Building a reputation for excellence in the community
- Using data to demonstrate positive, consistent outcomes

Strategies Used to Create Visibility and Promote PCAP

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

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

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

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

Seek media/internet coverage. Pay attention to current events unfolding in your community, think about how they might relate to your PCAP work, and contact a media outlet to explain. A CPS 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 at-risk mothers raised in dysfunctional homes.

Ask former clients to write or tell their stories. Personal written or spoken testimonies from clients who have graduated successfully from PCAP are powerful tools for gaining the attention and support of community agencies, funders, and lawmakers.

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Newsletters and publications. Sending newsletters to community providers is a good way to stay visible. Create interesting informational materials that include the basics of PCAP, key client outcomes, cost-savings data, success stories about service providers working together for the benefit of clients and families, and insights about what's needed in the community.

Demonstrating Cost Effectiveness

Investment in PCAP = Reduced costs to the public

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

Nevertheless, using outcome data from your local PCAP sites along with local or regional cost information, you can develop examples that demonstrate your program's cost savings.

Among areas of expected impact are:

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

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

Fewer substance exposed births

Only 12% of mothers enrolled in PCAP had a subsequent alcohol/drug-exposed infant within three years compared to 21% of similar mothers over the same period who received typical substance use treatment alone without intensive case management. This comparison sample was from a large, randomized controlled trial in another state (Ryan et al., 2008).

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The estimated lifetime cost for every infant born with Fetal Alcohol Syndrome (FAS) is $2 million. PCAP shows over $20 million in lifetime cost savings due to effective intervention for PCAP mothers who were former binge drinkers (Casey Family Programs, 2013).

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

Reduced dependence on public assistance

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

Reduced dependence on child welfare

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

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

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

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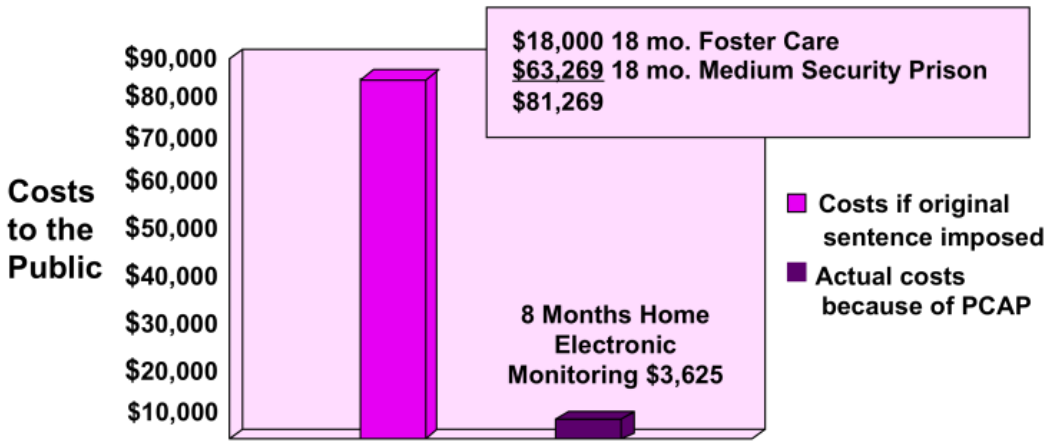
Reduced Involvement with the Criminal Justice System
= *Reduced Costs to the Public*

Example of Cost Savings



Amount Saved: $77,644

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