

The Parent Child Assistance Program

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 Category: **Best Practice**

BACKGROUND

Alcohol and drug abuse among American women is a serious problem across all socioeconomic strata (SAMHSA, 2002), and co-occurs with mental disorders at high rates. Substance abuse among pregnant women remains a particular concern, with approximately 1.8% of pregnant women reporting binge alcohol use (CDC, 2005) and 4.4% reporting drug use during the previous month on population-based surveys (SAMHSA, 2010). Maternal alcohol and drug abuse during pregnancy is a serious public health concern that incurs risk for both mother and child.

Women who fit the eligibility profile for the Parent Child Assistance Program (PCAP) have been vilified in a social and political climate suggesting that alcohol/drug-addicted mothers are responsible for a variety of social ills. They have been labeled unmotivated and difficult to reach, and many professionals have come to view them as a hopeless population. Not surprisingly, chronic substance-abusing women become distrustful of “helping” agencies. Yet alienation from community resources only exacerbates the problem.

The PCAP model was developed because we understand that these mothers *were themselves* the abused and neglected children of just a decade or two ago. They were born into troubled families, and grew into young women who used alcohol and drugs and delivered babies born into the same circumstances as their mothers had been. The PCAP model is informed by research on effective home visiting interventions for low income populations that has demonstrated the success of strategies including comprehensive focus, frequent visits, and well-trained staff. The PCAP intervention uses these general lessons and applies them specifically to women who abuse alcohol and drugs during pregnancy, an underserved population.

TITLE VMCH BLOCK GRANT MEASURES ADDRESSED

- #14:** A) Percent of women who smoke during pregnancy and
 B) Percent of children who live in households where someone smokes
- #15:** Percent of children 0 through 17 years who are adequately insured

PROGRAM OBJECTIVES

PCAP’s goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs. PCAP’s primary aims are:

1. To assist substance-abusing pregnant and parenting mothers in obtaining alcohol and drug treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse;
2. To assure that the children are in safe, stable home environments and receiving appropriate health care;
3. To link mothers to community resources that will help them build and maintain healthy, independent family lives;
4. To prevent the future births of alcohol and drug-affected children.

TARGET POPULATION SERVED

Originally a federal research demonstration grant to the University of Washington Fetal Alcohol and Drug Unit, PCAP has served over 2,400 families in Washington State since 1991. In addition to serving families in Washington, PCAP has nearly forty sites in the Canadian provinces of Alberta, British Columbia, and Manitoba.

The original research demonstration (1991-1995) included 96 women (n=65 intervention, n=31 control) in Seattle, WA. In 1996 PCAP obtained state funding to replicate the intervention in Seattle and Tacoma. Since 1997 the Washington State Legislature has funded PCAP to serve a capacity of 730 families at any time in nine counties throughout Washington State (King, Pierce, Yakima, Grant, Spokane, Cowlitz, Skagit, Clallam, and Kitsap counties). State funding has allowed the program to broaden its focus to include women who have a child with fetal alcohol spectrum disorders (FASD).

PROGRAM ACTIVITIES

PCAP is a 3-year advocacy/case management model with high-risk mothers and their children. Mothers are enrolled during pregnancy or up to 6 months postpartum, and participate with their families for 3 years after enrollment. Three theoretical bases—Relational Theory, Stages of Change, and Harm Reduction—guide the PCAP intervention. Throughout the PCAP intervention, staff are trained in these theoretical approaches in order to develop effective practices that contribute to positive program outcomes.

Intervention activities are undertaken by paraprofessional case managers who have successfully overcome difficult personal, family, or community life circumstances similar to those experienced by their clients. The case managers use explicit methods to help clients identify personal goals that are meaningful, relevant, and achievable, and they work with clients to take steps toward meeting goals. Working with caseloads of 16 families, they conduct regular home visits, connect families with services, and coordinate services among community providers. Case managers have a positive influence on clients' efficacy expectations, motivational states, and ultimately, behavior by:

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

PCAP also developed a tool called the *Difference Game* to teach and reinforce the practice of setting and achieving goals. Adapted from a scale developed by Dunst et al. (1988), the game is a card sort instrument that has been described elsewhere (Grant et al. 1997). After completing the Difference Game, and using motivational strategies, the case manager works with her client to identify a few specific, meaningful goals she would like to work on in the next two to four months. Together they agree on realistic, incremental steps they would each take toward meeting the goals, and who will be responsible for accomplishing each task.

PROGRAM OUTCOMES/EVALUATION DATA

In terms of quality improvement, throughout PCAP and at exit from the program, clients are asked to assess the relationship with their case manager using the Advocate-Client Relationship Inventory, a 27-item instrument adapted with permission (Barnard 1998; Sikma and Barnard 1992). PCAP supervisors share client responses with case managers in group staffing meetings and in individual

supervision in order to use client feedback to continually improve the quality of the program.

PCAP evaluation examines multidimensional outcomes, improved overall social functioning, and reduction of risk to the mother and target child. PCAP has been evaluated using blended evaluation designs; outcomes have been published in four peer-reviewed papers. Other aspects of the model (e.g., administrative and intervention strategies) have been described in peer-reviewed journals as well.

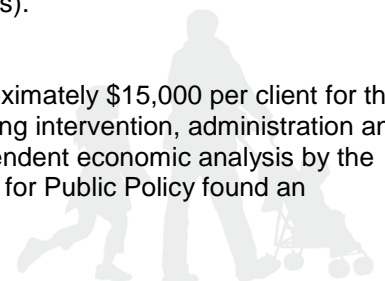
PCAP outcome evaluation focuses primarily on six areas where changes are expected as a result of PCAP intervention. These include: alcohol/drug treatment; abstinence from alcohol/drugs; family planning & subsequent birth; health & well-being of target child; family connection with services; and stability indicators: education, source of income, employment. 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.

The original PCAP demonstration project in 1991-1995 used evaluation data to compare outcomes between program participants and a comparison group, and demonstrated that the intervention was effective in producing higher rates of use of alcohol/drug treatment, abstinence from alcohol and drugs, family planning, health and well-being of target child (health care, custody) and appropriate connection with community services at 36 months. Post-program follow-up studies on PCAP clients' status 2.5 years after they graduated showed sustained, significant improvements in: increased abstinence from alcohol and drugs; increase in stable, permanent housing; decrease in mothers with a subsequent pregnancy; and decrease in mothers with an incarceration.

Evaluation of replication sites found that the positive outcomes were maintained (for regular use of contraception and use of reliable method; and number of subsequent deliveries), or improved (for alcohol/drug treatment completed; alcohol/drug abstinence; subsequent delivery unexposed to alcohol/drugs).

PROGRAM COST

The cost of PCAP is approximately \$15,000 per client for the three-year program including intervention, administration and evaluation. A 2004 independent economic analysis by the Washington State Institute for Public Policy found an



average net benefit of \$6,197 per client among selected well researched home visiting programs, including PCAP, for at-risk families in the U.S.

Funders for PCAP Washington include the Washington State Department of Social and Health Services Division of Behavioral Health and Recovery, SAMHSA Center for Substance Abuse Prevention, U.S. DHHS Indian Health Service, Washington Families Fund, March of Dimes Birth Defects Foundation, Nesholm Family Foundation, and Private Philanthropy.

ASSETS & CHALLENGES

Assets

In the mid-1980's when cocaine was a popular drug of choice, Dr. Ann Streissguth and her research team at the University of Washington Fetal Alcohol and Drug Unit were awarded a federal grant to study the effects of prenatal cocaine exposure on infants and young children. Study findings confirmed that prenatal cocaine exposure is not a good thing, but the most important lessons were learned directly from the mothers themselves. These mothers wanted to be "good mothers" but they were instead giving their babies the same kind of upbringing they had experienced as children. Under Dr. Streissguth's mentorship, the Parent Child Assistance Program model was developed from the understanding that these mothers were themselves the abused, neglected, and deprived children. 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.

Challenges

Case manager turnover was a challenge, and the resulting transfer of clients to different case managers can compromise program outcomes because the intervention is based on the development of a consistent, trusting relationship between case manager and client. When a case manager leaves the program, her clients may take months to re-engage with someone new, or they may drop out entirely. Additionally, nearly every new PCAP site had the experience of some community providers initially misunderstanding or questioning the approach. The model was perceived as 'enabling', and they thought the focus should be on the child, and believed the solution to "bad" mothers is to remove the children from their care.

Overcoming Challenges

To address personnel turnover, we identified characteristics of successful and unsuccessful case managers, and hired with these in mind. To address community misunderstanding we first reassured community providers that PCAP workers are mandated to report child abuse and neglect, then explained that most of the mothers in PCAP were

themselves abused and neglected children just a decade or two ago. PCAP collaborates closely with other service providers and connects clients to services. As cases proceed, we stay in close touch and keep the provider aware of progress the client is making. Finally, we inform providers that PCAP does not expect clients to get special treatment because they are enrolled in the program.

LESSONS LEARNED

If we were creating the practice now, we would keep the strong theoretical foundations and core components of the model we began with. In addition, below are program aspects that we would place greater emphasis on from the beginning of program implementation.

Evaluation feedback loop: From a day-to-day perspective, it can be difficult for case managers to see the effect they are having on clients' lives. PCAP created a dynamic evaluation feedback loop that gives staff the opportunity to examine the data, to see specifically how they are helping clients make gains, and to identify areas for improvement.

Monitoring balance of time with clients: Balancing time among a caseload of 16 high-risk women in home-based settings can be extremely difficult, and supervisors must be alert to these challenges. The supervisor's role is to help the case manager examine and avoid extremes. PCAP case managers complete a form weekly that documents time spent in direct contact with and on behalf of each client. Using this data, the supervisor is able to objectively monitor the time the case manager spends with each client on her caseload.

Preventing case manager 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. It is critical for the PCAP clinical supervisor to assist case managers in recognizing and understanding these normal responses, and initiating self-care strategies to decrease the risk of burnout.

FUTURE STEPS

PCAP has been in operation in Washington State since 1991 with funding from diverse sources including: Federal grants, Private philanthropy, State legislative appropriation, and Private foundations. PCAP believes there are four elements that are critical to the success of sustaining a PCAP site: 1) hiring intelligent, committed, and hard-working people; 2) developing a well-run organization; 3) building a reputation for excellence in the community; and 4) using data to demonstrate positive, consistent outcomes.

PCAP has been able to maintain state legislative appropriation for PCAP implementation through cost-effectiveness arguments and continued dissemination of positive evaluation data. Determining precise cost-savings

of home visitation programs to the public over the long-term is difficult and requires complex statistical modeling. However, PCAP staff have been able to craft cost-effectiveness arguments by illustrating PCAP's impact on reduced future births of alcohol- and drug-affected children as a result either of the mother's abstinence from alcohol and drugs or use of effective birth control; decreased welfare costs as women stay in recovery and become able to work; decreased foster care costs as more women become able to care for their children; decreased child abuse and neglect as a result of improved parenting or safe and stable child placement; decreased costs of crime as alcohol and drug abuse decreases; and decreased use of emergency room services as alcohol and drug abuse decreases.

COLLABORATIONS

Washington State PCAP has been implemented with many partners. Host agencies include: the University of Washington School of Medicine (Seattle and Tacoma), Triumph Treatment Services (Yakima), New Horizons Care Centers (Spokane), Department of Health and Human Service (Spokane Tribe of Indians), Grant County Prevention and Recovery Center (Grant Co), Drug Abuse Prevention Center (Cowlitz Co), Skagit Recovery Center (Skagit), First Step Family Support Center (Clallam), and Agape Unlimited (Kitsap Co).

Other partners include Willow Housing, Community Psychiatric Clinic, Mercy Housing Northwest, King County Shelter Plus Care – Plymouth Housing Group, King County Mental Health, Chemical Abuse and Dependency Services Division, University of Washington School of Medicine, University of Washington School of Social Work, University of Washington School of Nursing, University of Washington Department of Psychology, University of Washington Alcohol and Drug Abuse Institute, University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network, and DatStat, Inc.

PEER REVIEW & REPLICATION

The PCAP model has undergone significant peer-review. Evaluative articles on the model have been published in peer-reviewed journals including *the Community Mental Health Journal*, *the American Journal of Drug and Alcohol Abuse*, *the Children and Youth Services Review*, and *the Mental Health Aspects of Development Disabilities*. In addition, aspects of the model have been extensively described in chapters in books. Presentations about PCAP have been given at multiple international, national, and regional conferences and meeting venues. In addition, PCAP has been recognized by the California Evidence-Based Clearinghouse for Child Welfare; the Healthy Community Institute Promising Practices Library; the Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide; and the National Registry of Effective Programs and Practices. Full citations and information can

be found on the PCAP website at <http://depts.washington.edu/pcapuw/>.

In terms of replication, the PCAP intervention was scaled up across Washington State throughout the 1990s and 2000s, and now operates at ten sites in nine Washington Counties. In addition, SAMHSA and HRSA have funded PCAP replication sites in Michigan, California, Missouri, Texas, Nevada, Pennsylvania, and Louisiana. Health Canada and provincial governments have funded nearly forty replication sites in Canada, and New Zealand and Tasmania have implemented adaptations of the model. The PCAP model has been implemented in Native American and First Peoples communities in the United States and Canada.

RESOURCES PROVIDED

There are many resources available on the PCAP website: <http://depts.washington.edu/pcapuw/>. These include:

- The PCAP implementation manual (Summer 2010)
- A power point presentation on the PCAP model
- Administrative forms and protocols
- Evaluation protocols
- A pre-implementation checklist (to assess readiness for the PCAP intervention)
- Training videos on PCAP methods (including Breaking the Cycle, Building New Lives; the Difference Game and Setting Goals with clients; example of PCAP paraprofessional supervision methods; example of PCAP intake interview)

In addition, the website provides the complete list of publications on the PCAP model. This list can be found at: <http://depts.washington.edu/pcapuw/publications>.

Key words: Substance & Tobacco Use, Birth Defects Prevention, Birth Outcomes, Home Visiting, Family/Consumer Involvement, Service Coordination & Integration, Chronic Disease

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★ This program was highlighted at AMCHP's 2013 Annual Conference with a Best Practice award.

