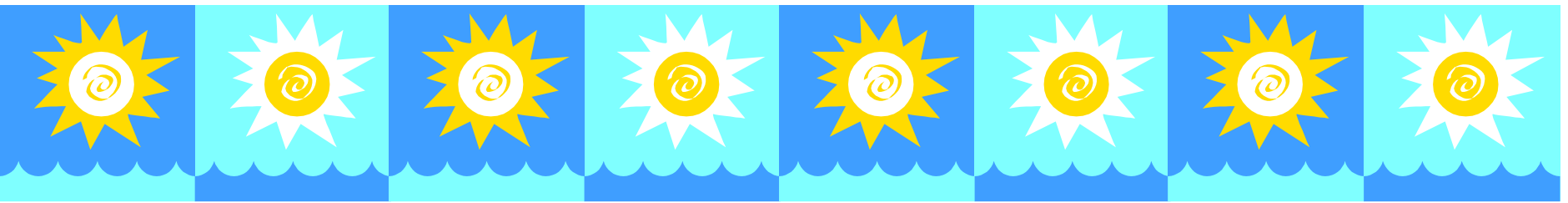


# Washington State CASA Conference

Spokane, WA  
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# Focus of Presentation

- Introduction
- What is FCAP
- How to refer
- Common myths for Children in care
- Evidence-based treatment
- Best Practice Interventions



# Foster Care Assessment Program

Services to achieve permanency  
and well-being for children &  
youth



# What is the Foster Care Assessment Program (FCAP)?

- Created in 1998 through collaboration between Children's Administration & Harborview Center for Sexual Assault & Traumatic Stress.
- Available in every region including rural areas.
- Provides a comprehensive assessment of the child/youth's level of functioning with focus on well-being and permanency.

# What is FCAP - continued

- Provides free training seminars with continuing education credit for DCFS staff, FCAP evaluators, CASAs, and others.
- Contact information for training seminars is: [fcap@seattlechildrens.org](mailto:fcap@seattlechildrens.org). Seminar slides are posted on website.
- Program is a contract so caseworkers do not need to complete financial paperwork or obtain funding through approval process.

# Who does FCAP Serve?

- Children/youth having one or more of these issues:
  - Chronic behavioral, emotional, physical, or educational problems
  - Assessments/evaluations completed in past, but best treatment/placement options unknown
  - Multiple out-of-home placements
  - Over 90 days in out-of-home care without a permanent plan
  - Unsuccessful efforts to place with a permanent family
  - At risk of foster care drift
  - Inability of youth to comply with court order, treatment, or
  - Youth engages in repetitive criminal actions



# What services are provided?

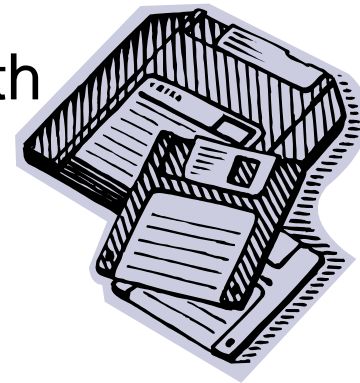
- Comprehensive assessments for child/youth, additional specialized assessments if appropriate, i.e. psychological evaluation.
- Standardized tests to evaluate the emotional status of child/youth at the time of referral and when FCAP services are completed.  
(CAFAS/PECFAS, CSBI, CBCL, TRF, TSCC, PSI)
- Team of experts who review cases, participate in team review, & provide consultation to social workers.
- Detailed written report including a review of the child's history and specific recommendations for well-being and permanency –the “**FCAP SPAR.**”

# Services Provided - continued

- Six months support service assists to link the child to services identified in the Service & Permanency Assessment Report (SPAR).
- Identify specialized treatment provider in the child's community & coordinate with the child's DCFS social worker and caregiver.
- If FCAP recommends an additional evaluation, FCAP will fund as needed.
- Provides 6 months of consultation.

# Who completes assessments?

- FCAP evaluators (Masters Level Clinicians) complete assessments and do:
  - Comprehensive case review
  - Interviews of child/caregivers
  - Standardized testing of child/youth
  - Write the Preliminary Service & Permanency Report
  - Coordinate the Team Review & Key Person Staffing
  - Provide 6 months of support services to DCFS social workers



# Team Review Participants:

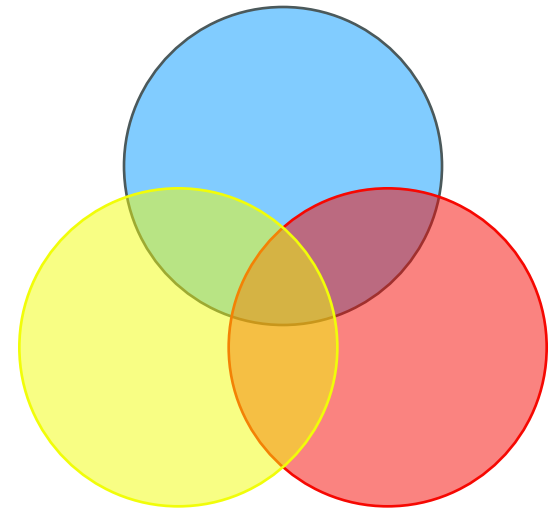
- FCAP Evaluator
- DCFS Social Worker (can be via conference call)
- Pediatrician
- Psychologist
- Psychiatrist
- Cultural Consultant (optional for some cases)
- Permanency Consultant (when available & appropriate)

\*\* Because this is a 30 minute consultation for the evaluator, the *CASA* is not invited. However, they are a primary participant in the Key Person Staffing.

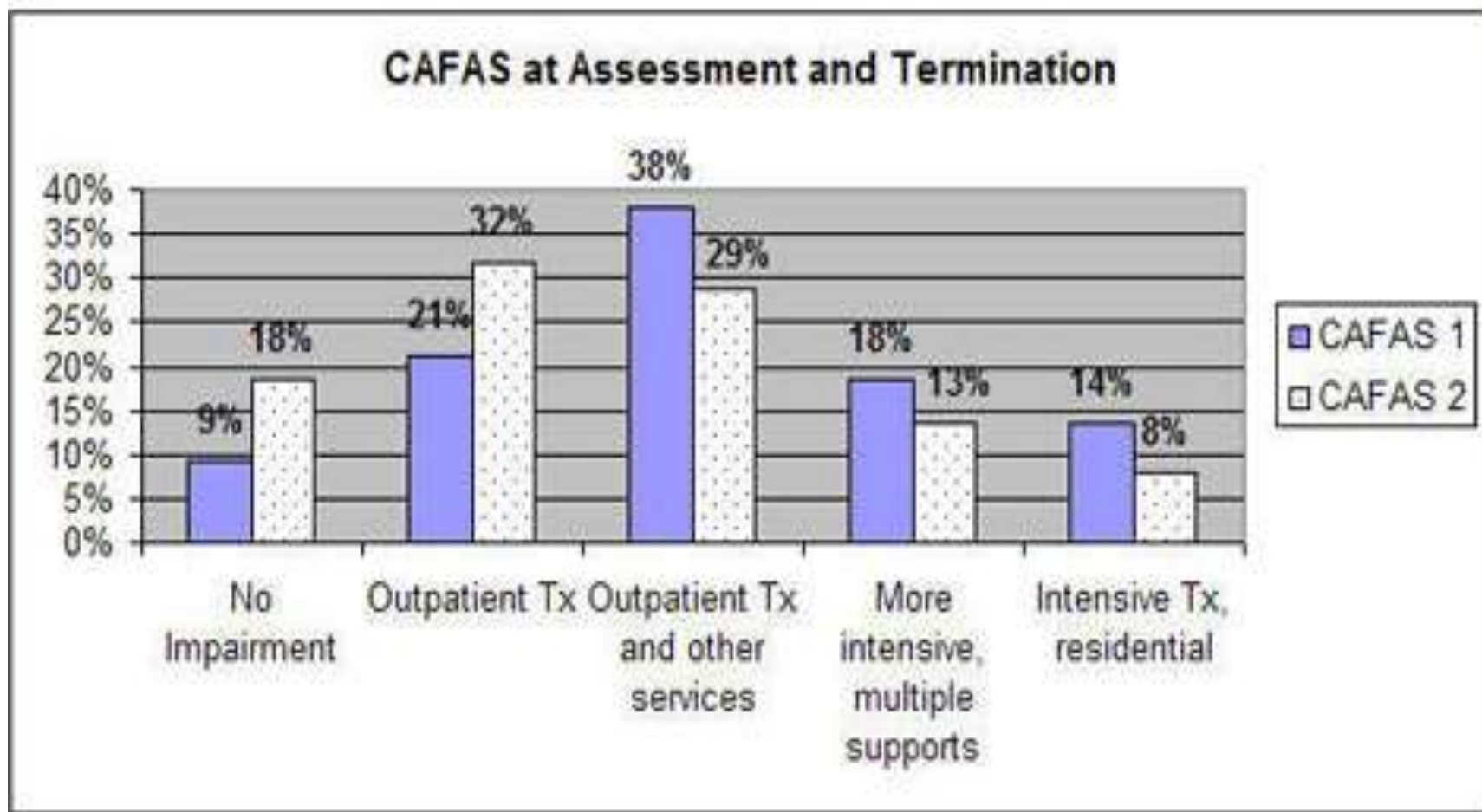


# Who provides FCAP?

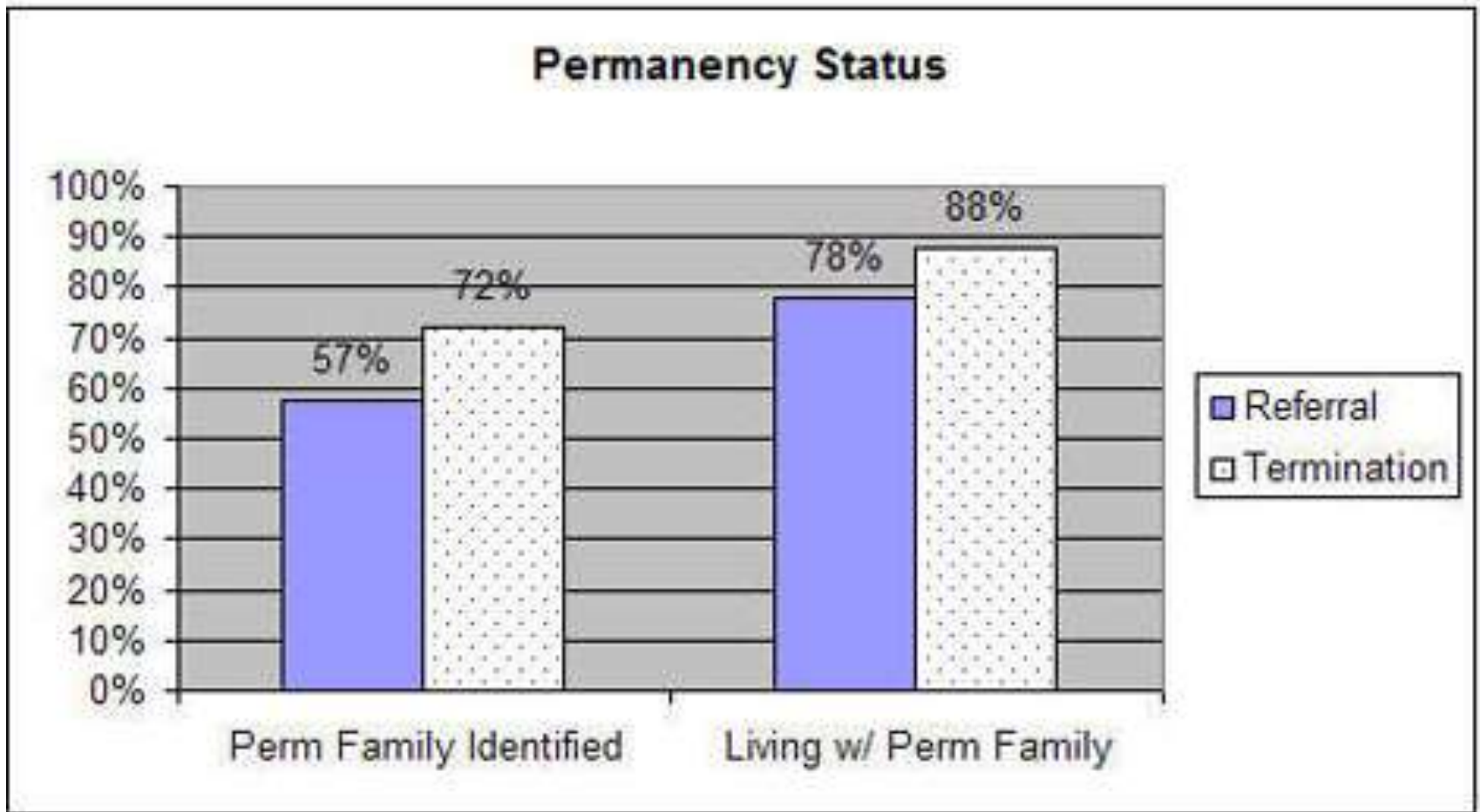
- The agencies providing oversight to the FCAP evaluators are:
- Region 1 = Lutheran Community Services Northwest
- Region 2 = Children's Hospital
- Region 3 = Lutheran Community Services NW & Brigid Collins House
- Region 4 = Harborview & Children's Home Society
- Region 5 = Children's Home Society & Mary Bridge Hospital
- Region 6 = Children's Hospital



# Program Outcomes – Child and Adolescent Functional Assessment (CAFAS)



# Moving Towards Permanency



# What to do if you think your child should be referred?

- Talk with your Area Program Manager or call me to determine if your case would be a good referral.
- Encourage the DCFS social worker to complete a referral by going on line to the FCAP website:  
**[depts.washington.edu/hcsats/FCAP/](https://depts.washington.edu/hcsats/FCAP/)**
- The caseworker may not be familiar with FCAP, so you may need to provide education.
- As a last resort, request the judge to court-order an FCAP assessment.



# Common qualities of kids we assess:

- Chronic trauma; rarely a specific incident
- History of exposure to DV, drug use, physical neglect
- 8-12 placements is common
- Multiple years spent in therapy
- Little involvement in treatment from caregivers
- Vague disclosure of sexual abuse
- Sexualized behaviors
- Described as “bright” despite low and low-average IQs

# Common Myths We've Seen Include:

- The belief that **pre-natal drug exposure** is the cause for the child's behavioral problems.
- Use of **FAS** label when child has not been diagnosed.
- The assumption that a history of physical or sexual abuse is more problematic than **neglect**.
- The impression that **encopresis** is a behavioral problem.
- The belief that a child with **sexual behaviors** is dangerous.
- The belief that **behavior problems** can be treated with "talk therapy."

# Myth and Reality

Prenatal cocaine exposure causes children to be **impulsive**, **aggressive**, **retarded**, **hyperactive**, etc. etc.

Prenatal cocaine exposure in and of itself causes no effect or only a very small effect.

# Evidence

<u>Outcome Type</u>	Effect Seen	No effect
Growth	0	2
Cognitive Ability	1	7
Language	0	1
Motor Skills	2	2
Behavior	8	7

From JAMA, Frank et al, 2001, adapted by Steve Ondersma, PhD

# Substance use does impact kids (of course!)

- Decreased parental availability and neglect (drugs are the priority, not children)
- Criminal activity in the home
- Higher incidence of domestic violence
- Higher incidence of parental mental health problems
- Financial problems

**The environment created by parental drug dependence is more harmful to the child than the physical effects of the drug.**

# Myth and Reality

A child who exhibits developmental and behavioral problems and are believed to have been exposed to alcohol in utero *has* FAS.

The diagnosis is overused and can negatively impact chances for permanency.

Prenatal alcohol exposure presents more risk to fetus than any other drug.

# Myth and Reality

Children with encopresis are exhibiting deep-seated emotional problems and are trying to make people angry.



The large majority of children with encopresis have physical reasons for their symptoms.

Encopresis can be effectively treated if managed as a physical, medical problem.

# Understanding Encopresis

- Encopresis begins with constipation that can be due to many different factors.
- Constipation causes painful elimination which leads to additional withholding.
- Leakage and soiling are secondary to the constipation and child's fear.
- Successful treatment entails ending the constipation, reconditioning an over-stretched colon, and addressing the child's fear.
- Avoiding blame and anger will help treatment succeed.

# Myth and Reality

Children who misbehave or are delinquent need therapy.

Disruptive and oppositional behaviors respond best to behavior management programs or Multi-Systemic Therapy.

Specific skill training may be useful.

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# Myth and Reality

If a child engages in sexual behavior, you know that child was sexually abused.

Children who have been sexually abused will prey on others.

Most children at some time show interest in sex or engage in sexual behaviors.

It is not always easy to distinguish normal from abnormal behavior.

# Normal Sexual Behaviors

(a few examples)

- Child is interested in sexual differences and will look at nude people when opportunity arises.
- Child thinks nakedness or bathroom functions are interesting and funny.
- Child rubs or touches him or herself when bored, anxious, or excited.
- Child “plays doctor” with same-age peers.

# Disturbing Sexual Behaviors

- Child attempts or succeeds in sexual activity with a much younger child.
- Child approaches older children or adults for sexual activity.
- Child attempts to engage others in sexual activity forcefully.
- Child shows genitals in public after being told not to.

# Myth and Reality

If a child is acting out and has been in multiple placements he has RAD

Children with attachment issues will be unable to attach to a new family

True RAD is actually quite rare. A diagnosis from the DSM-IV. Think of it as a spectrum disorder

Like any environmentally caused disorder, when the environment is corrected the disorder improves or goes away.

# Treatment for Attachment Problems

- Corrective experience is the most effective treatment: children learn new ways to relate through appropriate parenting.
- The “therapy” happens primarily in the home.
- Child-centered family therapy or Parent-Child Interaction Therapy (PCIT) can help caregivers respond in the most effective ways.

The Problem with **MYTHS**  
is that they lead to  
treatments that do not  
work.

The child's problems may  
not get better, or may  
get worse. Everyone  
gets **frustrated**.

Understanding which  
treatment works  
means that the  
problem gets **effective  
treatment**.

# Internalizing vs. Externalizing Behaviors

*Understanding the difference can help when assessing whether treatment matches behaviors.*

- Internalizing: depression, anxiety, somatic complaints, withdrawal, etc.
- Externalizing: aggression, delinquency, defiance, etc.

# Evidenced-Based Treatment

***A child does not need (or qualify) for therapy because she or he has had a difficult life.***

1. A child needs therapy if there are specific problems to be addressed.
2. Use a type of treatment that has been proven to be effective. (Be a good consumer.)



# Evidence Based Treatment

For.....

Anxiety

Trauma Symptoms

Depression

Oppositional Behavior

Aggressive Behavior

Use.....

Cognitive Behavioral  
Therapy (CBT)

Trauma Focused (TF-CBT)

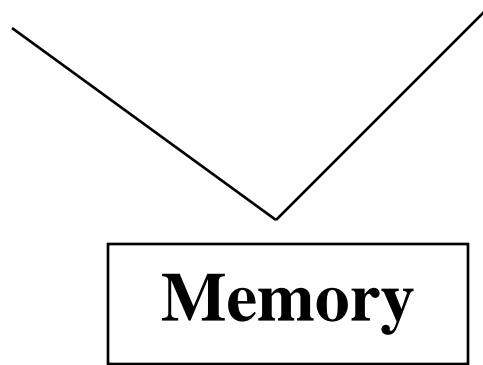
CBT and/or medication

Behavior management and  
PCIT

Aggression replacement or  
Multi-systemic treatment

# Cognitive Behavioral Therapy

Events → Thoughts → Behavior



# Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

- Evidence-based intervention for Trauma in children 3 – 18 years old
- Short-term intervention typically 12- 18 sessions depending on severity of trauma
- Treats the child, parent, and relationship
- Sessions are both individual and with parent present

# Parent-Child Interaction Therapy -- PCIT

- For children 2 – 7 years old
- Usually requires 12-22 sessions
- Evidenced-based
- Most effective for children with disruptive behaviors and parents who struggle to manage those behaviors
- Improves both behaviors and parent/child relationship.

# Advocating for Appropriate Mental Health Treatment

How do you know if a child's treatment is meeting their needs?

1. Does the therapist including the parents in sessions?
2. Does the diagnosis match the treatment?
3. Are the treatment goals relevant? Do you and/or the child have the same goals?

# Caregivers and Therapy...

- Research shows that the younger the child the more important it is that caregivers be a part of the therapy session.
- Children cannot create change in the home, parents do.
- Parents alone cannot change their child, or they would not be in therapy.
- The two together, with the help of a caring professional, can do wonders.

Questions?

# The Foster Care Assessment Program



# Zeb

- 12 year old African American boy
- Three years in residential treatment
- Mental health treatment since age 2 for aggression
- Spent time in detention and hospital for aggression
- Extremely explicit sexual behavior since 7
- Plan reunification with mother and sibs.
- IQ roughly 80 (low normal)

# Recommendations for Zeb

- Specialized treatment for sexualized behaviors and probable history of sexual abuse.
- Providers should know about Zeb's low cognitive functioning.
- Obtain formal IQ testing from school.
- Ensure a recent IEP is completed.
- Reconceptualize “reunification” to mean normalizing contact with family. Family Support Meetings should be held regularly.
- Explore in-home group care as an option.
- Refer for Big Brother program with bi-racial or African-American mentor.

# Mandy

- 7 year old Caucasian girl
- Sexual abuse of Mandy by mom's boyfriend
- In placement 3 years with foster parents
- In therapy for 2 years with "no progress"
- FM feels like single mom due to FF's concern re: allegations
- FP want guardianship due to negative experience with older adopted children

# Recommendations for Mandy

- Ensure permanency. Encourage DCFS to agree to guardianship with current FP rather than moving to pre-adopt placement.
- Begin time-limited therapy to increase Mandy's skills re: boundaries, self-management, and privacy. Provide psycho-educational material/counseling to parents. Increase foster father's confidence to become a more participatory parent.
- Continue to support extra-curricular activities.
- Request that current DCFS worker and CASA continue involvement in case. (CASA supports guardianship.)

# Websites for further information

- <http://pcit.phhp.ufl.edu/>
- <http://depts.washington.edu/hcsats/FCAP/>
- <http://www.childwelfare.gov/pubs/trauma/trauma.pdf>
- <http://tfcbt.musc.edu/>

