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Foster Family-based Treatment Association

Beyond Safety and Permanency:

Promoting Social and Emotional Well-Being *for* Youth in Treatment Foster Care

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This paper describes Treatment Foster Care (TFC), an evidence-informed and community-based intervention for care of foster youth exhibiting severe behavior disorders, mental illness conditions, symptoms of complex trauma, and/or medically fragile conditions. It provides empirical support for treatment foster care's impact on improving social and emotional well-being for vulnerable children and youth. The stories of two treatment foster care programs, which operate in accordance with the FFTA Program Standards for Treatment Foster Care, illustrate the ways in which Treatment Foster Care can promote social and emotional well-being across the country. Unique foster care services and training, offered only within a TFC context, are highlighted. Current challenges to the field are discussed with recommendations that address those challenges, including expanded guidance from ACYF and CMS to address services, qualifications of programs and outcomes for children and youth in Treatment Foster Care.

INTRODUCTION

Those in the field of child welfare have long discussed safety, permanency, and well-being as essential areas of focus for youth in foster care. Without debate our first responsibility is to provide safety (physical, emotional, and psychological) for all children. Additionally, practitioners in foster care share a common goal of permanency for each youth, whether through reunification, adoption, or established permanent connections for youth transitioning to independence and self-sufficiency.

Until recently the concept of "well-being" has remained nebulous and highly subjective. Important guidance to understanding and measuring the concept of well-being for children and youth receiving child welfare services was published in an Information Memorandum (ACYF-CB-IM-12-04) in April 2012 by the Administration on Children, Youth and Families (ACYF; U.S. Department of Health and Human Services, 2012). Research in child welfare and in behavioral health demonstrates that adverse effects of maltreatment, through abuse or neglect or both, may impact a child's level of well-being over a lifetime. Adult living situations for youth who were in foster care often demonstrate high levels of dysfunction, including domestic violence, the presence of illicit drugs, overdependence on substances and various medications, and intergenerational child abuse and neglect. Factors such as these jeopardize safety and permanency far beyond the childhood circumstances that led foster youth to initial entry into the welfare system. Self-sufficiency outcomes for emancipated foster youth in terms of employment, post-secondary education, financial ability, housing stability, and healthy peer and romantic relationships are dismal and unacceptable.

Regardless of whether a youth's maltreatment took place before entry into the child welfare system or resulted from an event or events within the child welfare system, it is not enough to remove a child from the conditions of harm following complex negative events. Emotional, physical, cognitive, and social trauma must be addressed through effective treatment.

The purpose of this paper is to describe Treatment Foster Care (TFC), an evidence-informed and community-based intervention for care of youth in foster care exhibiting severe behavior disorders, mental illness conditions, symptoms of complex trauma, and/or medically fragile conditions.

The Foster Family-based Treatment Association (FFTA) is the only North American provider association of agencies providing Treatment Foster Care. FFTA recognizes the importance of assessment and outcome measures of well-being. Accordingly, FFTA offers technical assistance to any state, to federal authorities, and to other governmental entities in establishing criteria and policy considerations for service delivery to those high-needs youth who can benefit from Treatment Foster Care.

The impact of TFC services on well-being measures of these challenged youth is discussed below, with examples from the Treatment Foster Care programs of two premier private agencies.

WELL BEING

The Administration on Children, Youth and Families (ACYF) has identified four primary domains for measuring deficits and improved outcomes in well-being: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning. In the Information Memorandum, ACYF describes these domains as "those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways" (USDHHS, p. 1). In particular, emphasis is focused appropriately on each youth's ability to achieve "social competence"—that is, the ability to form attachments, make friends, and eventually engage in a healthy romantic relationship.

Well-being is not an "add-on" to the goals of safety and permanency. It should be integrated into every aspect of treatment planning and intervention for youth in out-of-home care. Explicit efforts to address traumatic events in each youth's life, and to regularly assess that youth's increased functioning in the domains listed above, are crucial to achieving the intended outcomes of well-being.

Treatment Foster Care

Unlike traditional foster care, Treatment Foster Care is a strengths-based, evidence-informed, and trauma-sensitive intervention for the care of maltreated youth, many of whom have suffered multiple traumatic events and experiences. TFC is *not* a placement. TFC is a state-authorized treatment specialty centered on clinical interventions to assess, address, and ameliorate the damage of traumatic events or experiences of abuse and neglect, or both. Member agencies of FFTA are strongly encouraged to create programs that reflect those accepted principles and best practices of the Foster Family-based Treatment Association and its *Program Standards for Treatment Foster Care*.

TFC focuses on identified outcomes for individual youths who live in treatment foster homes in their communities and who receive the assistance and supervision of foster parents trained in special paraprofessional skills. These foster parents are supported 24/7 by clinical staff from licensed TFC agencies.

Following an assessment for trauma and mental health issues, children who are in TFC have access to services where their clinical-level behavioral problems, mental health needs, and trauma-induced symptoms can be met in a setting that addresses and promotes well-being and relational competence. Both clinicians and the treatment foster parents provide these services.

An accurate determination is made for services to the child, foster family, and biological family (when possible) in a treatment plan that meets conditions of safety, goals for permanency, and a process for the development of well-being.

Kennedy Krieger Institute

Twenty-five years ago Carl did not know where his next meal was coming from. His father was in jail for murder, and his mother was struggling with addiction. Carl had been abused and neglected. A tumor developed in his neck, and by the time his mother took him to the hospital, he had developed advanced throat cancer. Carl was close to death. His mother abandoned him, as she could not handle the diagnosis. Carl described this as "trauma on top of trauma." Carl began medical treatment and was discharged to a group home. Soon he was back in the hospital, where he thought, "Dying from cancer would be God's way out of this mess." Carl stabilized medically and was discharged to William and Millie Shaw, treatment foster

parents from the Treatment Foster Care Program at the Kennedy Krieger Institute (KKI-TFC). The Shaws, along with the KKI-TFC Clinical Social Worker and the KKI-TFC treatment team, coordinated Carl's medical treatment and addressed his trauma experiences using home-based, trauma-informed interventions. Carl successfully completed college and entered the navy. Currently Carl has reconnected with his mother. He is a successful IT professional and co-owner of an investment holding company. Carl is a member of the KKI-TFC Advisory Committee, co-leads its alumni support group, mentors transition-age youth, and has conducted training sessions and workshops throughout Maryland. Carl recently testified in a Congressional Hearing on Treatment Foster Care.

The Kennedy Krieger Institute's Therapeutic Foster Care (KKI-TFC) Program is located in Baltimore, Maryland. The Kennedy Krieger Institute (KKI) is a Center of Excellence for Developmental Disabilities and is affiliated with Johns Hopkins University School of Medicine. The KKI-TFC Program, along with its outpatient mental health program, is one of the programs that make up The Family Center, a department within the Kennedy Krieger Institute. The Family Center is an affiliate member of the National Child Traumatic Stress Network (NCTSN) and as such provides multiple evidence-based treatments for childhood traumatic stress and trauma.

For over 25 years, the KKI-TFC Program has treated children and youth in foster care who have experienced complex trauma and have a variety of developmental disorders and medically fragile conditions. In a recent study reported in the *Journal of Child and Adolescent Trauma*, children and youth served by the program had significantly more diagnoses and adverse childhood experiences (ACE) than did children in standard foster care (Jamora et al., 2009). The most common diagnoses (in descending order) are ADHD, Oppositional Defiant Disorder, various developmental disabilities (most commonly intellectual disability, autism spectrum disorder, and communication disorder), PTSD, and depressive disorders. On average, each child or youth had 3.5 diagnoses. Children on average experienced over five ACE markers. The most prevalent, in descending order, were neglect, physical abuse, sexual abuse, abandonment, and witnessing domestic violence. Children were almost 2.5 times as likely to experience physical abuse or neglect. Children and youth had an overall exposure to a greater number and variety of ACE markers. Over 69% had mothers with histories of illicit substance abuse, 20% had histories of mental health disorders, and 20% had histories of incarceration. In addition, there was a positive correlation between the number of ACE types and the number of psychiatric disorders.

The KKI-TFC Program developed the Trauma Integrative Model (TIM) to treat the complex trauma of children and youth with special needs and thereby address their well-being. The TIM is an evidence-informed practice model, integrating the basic elements of Treatment Foster Care (proactive behavior interventions and treatment parent supervision, support, and training) with best-practice treatments for complex trauma, developmental disabilities, medically fragile conditions, and achieving permanency. The TIM integrates the Attachment, Self-Regulation, and Competency (ARC) Framework for treating complex trauma developed by Margaret Blaustein and Kristine Kinniburgh (Blaustein & Kinniburgh, 2010). The ARC framework is a research-supported best-practice model that addresses the three areas most affected by childhood complex trauma: the ability of children and youth to create attachments, to regulate their emotions, and to competently achieve developmental tasks. The program also has integrated the Transition to Independence Process (TIP) developed by Hewitt B. Clark (Clark, Deschenes, & Jones, 2000). The model addresses the needs of transition-age youth in the context of the family and community. By integrating the ARC and TIP frameworks into the Trauma Integrated Model, life skills and the needs of transition-age youth are addressed through the development of an individualized trauma-informed approach.

Unique to the Trauma Integrated Model is the role of the TFC Clinical Social Worker (CSW). The focus of change is the therapeutic relationship, which is necessary for recovery from complex trauma to occur for the child or youth and his or her family. These relationships underscore the crucial connections between the treatment parent(s) and the child or youth, the treatment parent(s) and the child's or youth's birth family, and the child or youth and her or his birth family. The Clinical Social Worker's primary role is to facilitate the development of these relationships. This process includes the use of a therapeutic visitation protocol as outlined in the child's or youth's treatment plan. In addition to fulfilling a clinical role, the CSW integrates other treatment team roles, such as case manager, treatment parent/trainer, supervisor, and treatment team leader. The TFC CSW also has a significant role in supporting and facilitating permanency planning and integrating evidence-based outpatient treatment of trauma (i.e., Trauma-Focused Cognitive-Behavioral Therapy, Structured Psychotherapy for Adolescents Responding to Chronic Stress, Parent-Child Interaction Therapy), psychiatric services, and specialty medical treatment, as well as community-based supportive services. Comprehensive assessment and effective use of psychotropic medication by KKI psychiatric staff is constant.

Treatment foster parents are integral to the treatment team. Their roles are to: develop a safe and secure environment through nurturing and supervision; respond appropriately to trauma trigger behaviors, thereby creating opportunities for "therapeutic emotional experiences"; navigate and advocate with systems (i.e., education, medical, mental health, legal, etc.) on behalf of the child or youth; function as essential members of the treatment team; develop supportive relationships with birth family/kin; support permanency; and support the relationship between the child or youth and his or her birth family/kin.

In addition, services are available post-discharge. Adoptive families are linked to post-adoption services and can take advantage of KKI-TFC's adoption support groups and continued support. Transition-age youth either are linked to independent living programs or adult services systems or can remain in the agency's adult Individual Family Service program if qualified for developmental disabilities funding. In all situations, transition-age youth are linked to an existing program for foster care alumni youth, such as KKI-TFC's alumni support group, co-led by program alumni.

Training for the professional development of treatment foster parents is integrated throughout the program, beginning in the recruitment and selection process. Treatment parents are trained in the components of the ARC Framework (Attachment, Self-Regulation, and Competency Clinical Services), the Transition to Independence Process, best practices in permanency, positive behavioral management, and various competencies to meet the special needs of children and youth with developmental disabilities and medically fragile conditions.

When a child enters the KKI-TFC Program, he or she receives psychosocial and comprehensive medical assessments in accordance with the DSM-IV-R. At KKI-TFC the primary tool used in the assessment of children and youth to support treatment planning and measure change over time is the Child and Adolescent Needs and Strengths (CANS). The CANS assesses the child's or youth's function in the family and community and her or his responses to the exposure to trauma. All children and youth are assessed using the CANS at intake and every 3 months thereafter. The CANS drives the development of the goals of the child's or youth's individual treatment/service plan. In addition, the CANS is now being used by Maryland's public child welfare system, which allows for the KKI-TFC child or youth and family treatment plan to be integrated into Maryland's Family Centered Practice Model, including Family Team Decision Making.

The program uses the CANS to measure the relationship between the functioning of the child or youth and child's or youth's characteristics, diagnosis, permanency, placement stability, and restrictiveness of the discharge environment. The CANS–Trauma Version is used to assess symptoms of complex trauma and to tailor specific trauma interventions based on the ARC Framework.

The KKI-TFC Trauma Integrative Model has demonstrated its effectiveness in addressing the well-being of children and youth. Children and youth placed in the TFC program from more restrictive placement environments were twice as likely to be discharged to less restrictive environments (Jamora et al., 2009). The majority of children and youth served (60%) were discharged to permanent families (adoptive, biological, and kin). This percentage of discharges to permanency increased to 77% in fiscal year 2011 and to 75% in fiscal year 2012. The rates of adoption were 28% and 25% for the respective years compared to 20% for those in standard foster care. The rate of placement change of youth served is 53% lower than these same youth experienced prior to placement in the KKI-TFC Program.

Anu Family Services

Anu Family Services Inc. is a nonprofit agency in Wisconsin and Minnesota focused on family-based services for youth. Anu is dedicated to being the last placement prior to permanence (adoption or reunification) for the youth it serves. Anu Family Services began its focus on permanence and well-being in 2006 when agency leaders set a goal of being the last placement prior to permanence for 90% of the children served. Achievement of this goal is measured daily within the agency. Currently 66% of youth are discharged to permanence from Anu through reunification with parents or adoption. In addition to permanency, well-being is a strong focus within Anu. To ensure that youth achieve well-being, Anu focuses on keeping youth safe, finding permanent families for youth, and ensuring that youth are healthy in all aspects of their development, including emotional, physical, spiritual, cognitive, and social/emotional. Anu uses the two models described below in addition to the integration of trauma-related services.

One of the models all Anu Family Services staff use is Darla Henry's *3-5-7 Model* (http://www.darlahenry.org/3-5-7Model.html). This model focuses on the grief work that youth need to do in order to achieve overall well-being both now and for their future. The goal in using the *3-5-7 Model* is to assist youth in working through their grief and loss with the support of their TFC Permanence Specialist (caseworker) and their foster parents. When youth can successfully address and be supported through their grief and loss, they can more successfully manage and maintain healthy relationships into and throughout their adulthood. Assisting them through their grief using the *3-5-7 Model* helps them determine their story; identify who they are and who they want to be based on what happened to them, where they've come from, and where they want to go; recognize when they belong somewhere and with someone; and gain the knowledge and emotional readiness to understand when they've achieved this level of relationship. These primary goals of the *3-5-7 Model* help ensure the emotional and social well-being of youth in care.

The second model used at Anu that is important for the well-being of children is trauma-informed parenting. Anu foster parents complete the "Foundation Training for Foster Parents" curriculum developed and taught by the University of Wisconsin–Madison (http://southernpartnership.wisc.edu). The course explains the basic tenets of fostering and includes specialized modules in trauma symptoms and triggers. The model also uses Therapeutic Crisis Intervention for Families (TCIF), a program that was developed in 1979 with a grant from the National Center on Child Abuse and Neglect (NCCAN)

by staff of the Family Life Development Center (FLDC) at Cornell University to help children and families understand their behaviors as they relate to prior traumatic events (http://rccp.cornell.edu/tcifoverview.html).

Trauma-informed parents understand that all behavior has meaning. Parenting is used in the context of trauma, not control. Trauma-informed parenting focuses on what happened to children to cause their behaviors. It does not blame children for their experiences/behaviors; instead trauma-informed parents and practitioners encourage the children to work through their grief/loss/trauma in a safe environment utilizing safe relationships or clinical therapies or both. Trauma-informed parenting changes the primary approach with kids from "what's wrong with you" to "what happened to you." It focuses on helping the child to heal by using his or her built-in support systems through connections the child has already made.

Anu Family Services uses two tools to measure well-being. The Child and Adolescent Needs and Strengths (CANS) assessment is administered within 30 days of placement in the agency's TFC program and is readministered every 6 months until the youth is discharged from care. The CANS, an assessment tool developed and copyrighted by the Buddin Praed Foundation, measures nine areas: trauma, life domain functioning, school, child/youth family acculturation, child/youth behavioral/emotional needs, child/youth risk behaviors, child/youth strengths, current caregiver, and identified permanent resource needs and strengths (http://www.praedfoundation.org).

The other tool used routinely is the Youth Connections Scale (YCS), which was collaboratively developed by the University of Minnesota's Center for Advanced Studies in Child Welfare and Anu Family Services. The scale is evidenced-based, and the University of Minnesota has scientifically affirmed its validity. This tool centers on emotional/relational connectedness as a social well-being indicator. The Youth Connections Scale focuses on the youth's social connections, particularly those individuals who will be present for the youth throughout his or her life. It provides information to the youth's worker about areas of the youth's life that are missing supports. YCS provides a framework to help identify individuals with whom the child may have lost contact and how significant contacts can support the youth in his or her future (www.anufs.org/forms/conference/Youth_Connections_Scale_one_page_summary_final.pdf).

As a youth's CANS score decreases and the Youth Connections Scale score increases from placement to discharge, Anu demonstrates an improvement in well-being: trauma/grief/loss work has begun as demonstrated by a decrease in the CANS score, and the number of the youth's lifelong connections has increased as demonstrated by a higher YCS score.

For example, "David" was in out-of-home care from the age of 8 to 15 and placed in several different residential and treatment facilities as a consequence of the trauma he endured in conjunction with his mental health needs. Some of his mental health needs were a result of genetics, while others were a product of the severe physical abuse and neglect he endured from his birth parents. When placed in an Anu TFC foster home in October 2009 at age 15, he was diagnosed with Anxiety Disorder, Conduct Disorder, and Reactive Attachment Disorder. He was prescribed 200 mg of Seroquel to manage his multiple diagnoses. During his stay in the Anu TFC foster home through August 2012, when he reached the age of majority, he was able to discontinue his use of prescription medication and use only a small dose of Melatonin to help him sleep at night. With the assistance of his Anu social worker and foster family, David was able to reconnect with his birth mother, whose parental rights had been terminated. He reconnected with his stepmother, half-brother, half-sister, and several extended family members.

His worker and therapist helped him to process his losses and assisted him in rebuilding these relationships in a healthy manner. Like many of today's youth, David used Facebook to stay in contact with his family. At the time of his discharge, he had expanded his support network to include other stable adults who had verbally committed to remain supportive of him into his adulthood. He was discharged and began attending a 4-year Christian college to pursue a law enforcement degree. This young man began his TFC journey at Anu full of anger and rage with no formal supports, multiple diagnoses, and a substantial psychotropic medication regime. Today he is a law-abiding, college-bound young man with multiple adults and extended family members in his life providing ongoing support.

Anu Family Services is dedicated to ensuring the well-being of every youth served. Every aspect of training for the staff and families is focused on the trauma the youth has endured. Trauma examination provides an explanation for the youth's problematic behaviors and needs without blaming the youth but instead focusing on what has happened to the youth. By focusing on the child's needs based on what has happened to her or him, the healing work can be done. According to Dr. Darla Henry, "It is the youths' work to be done, but it's up to us to provide them with the tools to do the work." Anu Family Services has the tools, services, and dedication to assist youth in working through their traumas and losses, so that they have a successful future. By providing these tools and helping youth work through their trauma, Anu Family Services ensures youth can begin to heal and experience all aspects of social and emotional well-being.

Challenges and Strategies for Success

TFC success with high-needs, mentally and behaviorally impaired foster youth is notable and admirable. The preceding examples from Kennedy Krieger TFC and from Anu Family Services demonstrate that programs adhering to the FFTA P*rogram Standards for Treatment Foster Care* typically report an increase in the well-being of youth, increased discharges to permanency, decreased disruptions in foster care placements, and decreased staff and foster parent turnover. Precious time for a child to experience healing and safety, as well as the potential for a future with a "forever family," whether through reunification or through another permanency option, become realistic options for youth whose permanency outcomes were at one time highly uncertain.

Yet challenges remain. Although all states offer treatment or therapeutic foster care, or some other level of intensive treatment services to this same population of high-needs, mentally and behaviorally disoriented, acting-out youth, there is no uniform federal definition for Treatment Foster Care. Similarly, there is no federally supported standard for programs or providers. As a result, both services and quality of services vary, sometimes substantially, from state to state. FFTA has identified and published Program Standards and encourages accreditation of TFC programs by a nationally recognized accrediting body; however, federal guidance from the Administration on Children, Youth and Families (ACYF) and the Centers for Medicare and Medicaid Services (CMS) concerning services, qualifications of programs, and outcomes for youth is still needed.

Medicaid rules set by CMS allow states to reimburse for clinical services to this category of foster youth through "wrap-around" and "systems of care." Yet research also shows that generic counseling for foster youth demonstrates no real outcomes or improvement in well-being (McCrae, Barth, and Guo, 2010). Treatment foster care provides specialized counseling for trauma symptoms and for mental health diagnosed disabilities. FFTA believes it is important and appropriate that CMS define baseline services and provider qualifications for TFC and then reimburse the service of TFC accordingly.

Those states using "regular" or traditional foster care for this high-needs population and offering only outpatient "wrap-around" services miss the crucial opportunity to have highly trained, supportive foster parents for TFC-level youth within a community-based clinical home environment present 24/7 to treat the complex trauma that these youth must address. This is often the only opportunity for these youth to experience an environment with nurturing and supportive parental behaviors that are consistently present so that traumatized children have a chance to explore new behaviors and trusting relationships that will put them on the path to lifelong well-being and social competency (Horwitz, Chamberlain, Landsverk, & Mullican, 2010).

Noted authors and researchers Elizabeth M. Z. Farmer and Eric Bruns recommend that "real-world" TFC programs need to develop hybrid models that incorporate elements of the current evidence-based and evidence-informed Treatment Foster Care models with the treatment of trauma while addressing the needs of transition-age youth (Farmer, Allred, Breland-Noble, Elhagen, & Burns, 2004; Bruns & Brylske, 2005). However, the current low level and method of funding for TFC create disincentives or make it impossible for programs to secure sufficient resources to fully address well-being outcomes for children and youth in foster care who have increasingly complex needs. Although demands for demonstrating well-being outcomes continue to increase, fiscal support for research and evaluation programs is minimal and disproportionate to the needs.

The FFTA *Program Standards for Treatment Foster Care* encourage national accreditation of TFC provider agencies. Accreditation establishes a benchmark of training, service capacity, and supervision for both treatment staff and foster parents, ensuring evidence-informed, complex trauma skills from all participants in the TFC system of care. However, the cost of such accreditation is significant and sometimes prohibitive for agencies. The state of Illinois requires national accreditation from the Council on Accreditation (COA) for each of its child-placing foster care agencies. Uniquely, Illinois reimburses costs after an agency has successfully achieved accreditation (www.state.il.us/dcfs/docs/ocfp/policy/Policy_Guide_2000.10.pdf). FFTA encourages more such consideration from federal, state, and county governments and authorities.

Treatment Foster Care is evidence-informed. Programs conducted according to the FFTA *Program Standards for Treatment Foster Care* provide a level of evidence-informed or evidence-based care, such as that described in the examples from the Kennedy Krieger Institute and Anu Family Services. Yet more funding is needed for training, research, and programs (provider salaries, foster parent reimbursement, and administration). A new system of federal IV-E waivers authorized by the U.S. Department of Health and Human Services (HHS) can help some states address these challenges. Formal support from HHS is needed if these foster youth are to be served in communities and families, rather than in higher levels of institutional care, unless appropriate, so that they have access to the services and specially trained caregivers that are sufficient for providing safety, permanency, and well-being.

Summary

FFTA published updated *Program Standards for Treatment Foster Care* in January 2013. In accordance with these recommended practices, Treatment Foster Care is committed to achieving outcomes of safety, permanency, and well-being for every foster child. Children entering TFC are assessed at intake and at regular intervals throughout their foster care stay to determine clinical protocols for trauma care, mental health treatment, and progress toward specified outcomes.

Treatment Foster Care staff and foster parents are trained in child welfare rules and private agency requirements (both state/public child welfare departments and private TFC child-placing agencies) as well as in skills to address trauma, the use of medication with TFC youth, independent or transitional living goals for older youth, and enhancement of social/emotional functioning.

In accordance with best practices, life-skills training correlates with defined behavioral outcomes through individualized evaluation and planning. Mental health services are provided based on assessed strengths and deficits and on best practices in clinical intervention. Caregivers are trained in specialized skills to address the emotional, behavioral, and relational needs of each youth in their care and are supported and monitored in achieving measurable goals by TFC professionals. Unique populations of youth—whether LGBT, aging-out-of-care teens, sexually abused or acting-out youth, Oppositional Defiant diagnosed children, or those who are developmentally delayed and medically fragile—receive specialized interventions and support to reach identified treatment outcomes.

Traditional foster care rarely provides any of these intense responses. Treatment Foster Care routinely addresses each of these elements and needs when delivered according to the FFTA *Program Standards for Treatment Foster Care*.

Most importantly, the specialized services and supports offered by treatment foster parents and by clinical staff create an environment in which youth can experience the nurturing and supportive behaviors typically provided in homes with healthy parents and relationships. In this setting of consistent and available support and age-appropriate boundaries, TFC youth develop the confidence to explore new behaviors and relationships that will promote their well-being into young adulthood and beyond. ❖

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