



# Therapeutic Foster Care: Exceptional Care for Complex, Trauma-Impacted Youth in Foster Care

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## Introduction

Therapeutic or treatment foster care (TFC) is a clinical intervention, which includes placement in specifically trained foster parent homes, for youth in foster youth with severe mental, emotional, or behavioral health needs. This includes medically fragile or developmentally delayed youth whose physical and emotional health needs require more intensive clinical and medical intervention than can be accommodated in traditional foster care.

In and of itself, TFC is not a placement. It includes placement of a child in a specialized TFC home. TFC is a medically necessary treatment, which must be authorized by public state agencies (child welfare and/or Medicaid) in order for treatment services to be available and reimbursable.

TFC serves youth age infant to 18 (or older if the state Medicaid plan allows). States contract with private, state-licensed child placing agencies for care of youth in TFC. These agencies recruit, train, and support TFC foster parents and provide licensed clinical staff to oversee a youth's individualized treatment plan and to provide therapeutic services such as individual and family therapy, crisis intervention, case coordination, and medication support.

Traditional Foster Care

Traditional foster care is a placement for children who have to be taken from their parents because of neglect or abuse, but it is thought that there is hope that the parents' behavior can be changed enough for family reunification. While the child is being fostered, the parents will go through re-education and/or therapy. The parents' behaviors and progress should be closely monitored by the state social services department.

Typical services provided by the state in addition to placement in a foster home:

- Family visitation
- Discharge planning
- Crisis intervention
- Recreational activities
- Medication monitoring
- Coordination of all routine and emergency medical needs

Focus:

1. Care and protection of youth who must be placed outside their homes.
2. Behavioral change of parents
3. Basic foster parent training

Treatment Foster Care

Treatment Foster Care is a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In Treatment Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Treatment Foster Programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.

Children are referred to Treatment Foster Care programs to address their serious levels of emotional, behavioral and medical problems. Treatment Foster Care is active and structured, and occurs in the foster family home.

Focus:

1. Safety and well-being of youth
2. Clinical treatment of child's serious emotional, behavioral and medical problems in a specialized foster home.
3. Basic plus intensive training on mental & behavioral health

Residential Treatment

A residential treatment center (RTC), is a live-in health care facility. Most use a behavior-modification paradigm. Others are relationally oriented. Some utilize a community or positive peer-culture model.

Different RTCs work with different types of problems, and the structure and methods of RTCs varies. Some RTCs are lock-down facilities; that is, the residents are locked inside the premises. In a locked residential treatment facility, clients' movements are severely restricted, usually to a single room or cell. By comparison, an unlocked residential treatment facility allows them to move about the facility with relative freedom, but they are only allowed to leave the facility under specific conditions.

Focus:

1. Restricted movement by youth.
2. Mental health and educational services are dependent on each separate facility/program.
3. Services provided within institutional setting.

## Best Practices in Therapeutic Foster Care

Best practices in TFC provide an array of clinical services and interventions similar to the services typically available in more restrictive, congregate, and residential care settings. However, TFC services are provided in specially trained and supervised foster homes in local communities. Most often, youth in TFC attend local public schools. For most of these youth, living in a TFC home is their first exposure to a family living environment where healthy adult-to-adult and adult-to-child communication and behaviors exist.

When a state child welfare entity believes a youth is appropriate for TFC and that child meets the medically necessary requirements of the state Medicaid authority, the process of entry to TFC begins. Each child is assessed on the basis of his/her developmental stage, trauma experiences, current physical and emotional health, educational and behavioral deficits, and individual strengths and interests. This assessment is then compiled to make a match for that child with a specific TFC home and TFC parents whose training, experience, and professional competence maximize an appropriate fit for the youth's success and healing.

Best practice dictates that only one or two youth in TFC are placed in a home unless special consideration is made for sibling groups or other unique circumstances.

TFC foster parents in most states receive at least two times the initial training of traditional foster parents, as well as required continuing education training throughout the year. TFC foster parents are the change agent. They are available to the youth in foster care 24/7 for support, treatment intervention, crisis stabilization, and connection to the community and school. TFC foster parents are considered to be professional participants of the clinical treatment team. Their role includes conducting specific life skills and social skills training, daily interventions, and recording those interventions in the youth's treatment log. TFC parents receive specialized training in various mental health and trauma disorders as well as in cultural sensitivity as is appropriate for each child.

Key to the success of the TFC foster parents is the 24/7 supervision and support available to the foster family by the contracting TFC agency. The TFC therapist supports the child and the foster family. He/she contacts or meets with the TFC family weekly, and can be called upon at any time. Agency staff create and monitor the youth's treatment plan. These state-licensed mental health professionals provide crisis intervention if necessary and they encourage respite for TFC foster parents.

Creation of the treatment plan is the responsibility of the staff of the TFC agency. The treatment plan is specific to the needs of each youth. It is monitored regularly for compliance and is subject to on-going assessment and evaluation. Authorization of the treatment plan by state auditing bodies occurs no less than every 90 days.

TFC agency staff provide individual and family therapy for the foster family and the biological family when possible. Group therapy may also be provided, especially with sibling groups. Consultation and collaboration with child welfare workers, Court Appointed Special Advocate volunteers, and other invested professionals in designing, implementing, and evaluating the clinical treatment plan is also a best practice of care.

Additional detail and guidance can be found in the 2013 publication of the Foster Family-based Treatment Association (FFTA) Program Standards for Treatment Foster Care.<sup>1</sup> FFTA is the only professional association of providers of the TFC services, servicing TFC providers in all 50 states and throughout Canada.

FFTA



Foster Family-based Treatment Association

**Highlights of what's new in the 4<sup>th</sup> Edition of the FFTA *Program Standards for Treatment Foster Care***

**Updates to the Program Statement Standard**

**Expanded Standard on pre-service training**

**Expanded Standards on the role of Treatment Foster Parents in treatment implementation and team meetings**

**New Standard on Organizational Performance**

**New Standard on Quality Improvement**

**Guidance on tracking process, outcomes, and consumer satisfaction data**

**New Standard on Incorporating Evidence-based Practice and trauma-informed care**

**Considerations in promoting social and emotional well-being**

**New Standard on working with special populations**

**New Standard on social media and technology**

## Essential Partners

Every state provides TFC or some equivalent of intensive services for these highly complex youth.<sup>2</sup>

In order to maximize opportunities for TFC, partnerships between providers, the state child welfare agency, the state mental health agency, each state Medicaid administrator, and if applicable, the state managed care entity, are crucial. It is important for each partner to understand the needs, constraints, and opportunities that each of these other partners can bring to discussion and implementation.

Child welfare or the juvenile justice systems retains legal authority for children in custody. These agencies must work within the parameters required by federal Child and Family Services Reviews standards, child welfare leadership and philosophy, and state legislature support and dictates.

State Medicaid administering authorities must comply with and amend, as needed, the state's Medicaid plan in conjunction with the Centers for Medicare and Medicaid Services. Additionally, these authorities are responsible for auditing provider billing on behalf of taxpayers and the federal government.

The state mental health agency is also a partner. Whether or not TFC services or other behavioral health services for youth in foster care are contracted through mental health or only child welfare, this agency has a state constitutional interest in the mental and behavioral health of all its citizens.

Another key partner in some states is the state managed care entity, which is contracted to oversee and administer Medicaid and eligible services within states utilizing managed care for foster care and/or behavioral health.

Many states have provider organizations/associations that represent their membership to child welfare, Medicaid, legislatures, and other entities. However, in many states, TFC providers must 'go it alone.' The Foster Family-based Treatment Association has seventeen state chapters. Chapters and individual agency members of FFTA have access to a wealth of research and best-practices guidance from FFTA.

For all providers in any state, it is paramount that an active, evolving relationship and dialogue be maintained among key players. Youth in TFC care are complex, and so are the funding and oversight entities, whose responsibility it is to provide needed access and quality services for foster youth.

Creating or enhancing these partners is not complicated. As therapists and providers so well know, it is all about relationships. The basic steps in forming these critical relationships are simple for child welfare advocates, as well as for professionals in the foster care and adoption fields:

## Building Relationships 101 for Provider Agencies and Child Advocates

### Providers

- Familiarize yourself with the organizational structure of your state's child welfare agency, Medicaid agency, mental health agency, juvenile justice agency, and managed care entity.
- Ask to meet in person with the head of each agency and the leadership of the appropriate unit: for human services – agency Director and director of child welfare; for Medicaid –agency Administrator and director of behavioral health or similar office; for Mental Health – agency director and head of children's programs; for Juvenile Justice – agency director and treatment services director; and for managed care – head of behavioral health.
- If appropriate, invite these agency leaders to a membership meeting of TFC providers in your state.
- Ask for biannual meetings to keep abreast of changes, challenges, and needs.
- Send thank you notes for every meeting and key conversation.
- Ask how you can support the mission of each of these entities. Follow through on any commitments.
- If you do not hear back on initial inquiries and requests to meet, ask again...politely.

### Child Advocates

- Identify your State Senator and state Representative. Let them know about you and/or your agency. Offer to be a resource for them on foster care from your personal experience or your own area of interest.
- Send them congratulations emails upon election/re-election, remind them that you are a voting constituent when the legislative session begins, and congratulate them when the legislative session ends.
- Identify your US Senators and Congressmen in your district. Ask to meet with district offices to introduce yourself and your interest as a child advocate.
- Monitor legislation that is introduced at both the federal and state levels. When a bill has been filed about which you have an opinion, email that office (state or federal) and share your opinion. One paragraph to one-page is enough commentary.
- Join with other child advocates through a non-profit agency of advocates, through civic clubs that have adopted 'children' as one of their missions, through churches, or any of the many community or national child abuse and neglect prevention organizations.
- Send Letters to the Editor often.
- Share electronic media as a reader and contributor: twitter, Facebook, etc.

Does that sound like a lot? Maybe. However, TFC providers are experts in relationship building and these steps are a similar process for anyone exercising their professional or civic responsibilities. Agencies especially cannot afford to overlook these connections no matter how demanding our time and attention is to the families and children we serve. Remember: these partners set the rules and hold the purse strings. These are essential relationships.

## Special Mentions and Unique Practices

Many states have unique relationships and programs with the partners mentioned above. The state programs described in this section are some of many examples. These particular programs are highlighted in that they

point to unique practices for TFC providers that could and should be replicated in other states, and which are under discussion in national public policy consideration.

**Illinois:** An FFTA program recommendation is that agencies providing TFC be nationally accredited by the Council on Accreditation, the Commission on Accreditation of Residential Facilities, The Joint Commission, or an equivalent national accrediting body. The State of Illinois reimburses child-placing agencies for the cost of accreditation (by COA) once the agency has successfully completed requirements and received accreditation. Illinois' practice of reimbursing by COA is important given that agencies know that certification is an intense and expensive process. At the same time, national accreditation offers a baseline standard of quality measure for TFC agencies across states and counties. Expanding this example to include other national accrediting organizations in other states is strongly recommended.

**Michigan:** Michigan contracts for TFC services with licensed child-placing agencies only if those agencies are also members of FFTA. It is assumed that those agencies will follow the recommended FFTA Program Standards, the only national program standards for TFC.

**Oklahoma:** Oklahoma is one of only five states to define the role of therapeutic foster parents (qualifications, training, and duties) in their state Medicaid plan. With a desire to recognize the professional contributions of TFC foster parents, authorities created the classification of Treatment Parent Specialist. Inclusion of this service provider, the TFC foster parent/Treatment Parent Specialist, in the state Medicaid plan makes it possible to bill for services provided by these members of the TFC team under Medicaid.

**Nebraska:** Behavioral health services for youth in foster youth will be administered in Nebraska through managed care as part of a major reform effort in child

## Caleb and Eve

In 1999, Jim and Sandy Smith became a licensed foster family with our agency. At that time they had three children of their own (high school and middle school aged). That same year, Caleb and Eve were removed from their young mother in Corpus Christi and put into the State's Care. After multiple placements, Caleb (age 4) and Eve (age 3) were placed in the Smith foster home.

Caleb, born deaf, was placed in the State's care at age 4. While in his mother's care, Caleb never learned to communicate. After six foster care placements in three months and no attachment to a caring adult, Caleb had no communication skills, no exposure to rules or structure, and no social skills. Caleb also arrived heavily medicated.

Eve was 3-years-old, had been in nine foster homes (including psychiatric hospitalizations) in six months and also appeared to be deaf. It wasn't until a thorough medical exam was completed that we were told her hearing was fine. She was also heavily medicated.

Within the first couple of years, the entire Smith family became fluent in sign language. Caleb was beginning to communicate and Eve's eyes were showing signs of life and love. While Caleb continued to struggle with his disability, social skills, and many developmental delays, he was beginning the process of healing.

In July 2008 at our Annual Summer Celebration, in walked two lanky, well-adjusted, not medicated, much loved, and very beautiful, young teenagers. The haunting picture of Eve, broken by such a wounded spirit, was erased. And there sat Caleb, as if completing the cycle of healing, holding his 18-month-old foster sister, a beautiful little girl, also a victim of child abuse and neglect. The Smiths have now adopted both Caleb and Eve.

Gone are the wild, primal little boy and the little girl so wounded she showed no spirit.

-Stacy Bruce, Austin, TX

welfare and Medicaid in that state. The managed care entity in Nebraska has already held meetings and discussions with providers (as well as legislators) to assess what services exist and where service gaps occur. The managed care entity has indicated a need for more access to services offered in TFC. This partnership between providers, agencies, and the managed care company demonstrates what is possible when communications are enhanced and system partners collaborate.

**Connecticut:** The Connecticut Department of Children and Families has recruited and trained specific TFC homes to become treatment, healing homes for girls who are victims of domestic sex trafficking. They are working toward a model of care and training of TFC foster parents to serve Connecticut youth, but also a model that might be replicated in other states. The Obama Administration and both parties in Congress have great interest in addressing this issue of domestic sex trafficking of minors. Looking forward, collaborations between child welfare and TFC entities to address the trauma of these victims are both promising and exciting.

## Beyond Safety and Permanency: Well-Being for Youth in Therapeutic Foster Care

In April 2012, the Administration on Children, Youth, and Families (ACYF) published an important information memorandum on measures of well-being for youth in foster care.<sup>3</sup> Prior to this guidance, the public and private child welfare and foster care communities had developed fairly comprehensive understandings and operations toward improving the safety and permanency of youth in care. However, the concepts and measures of well-being remained ambiguous and elusive.

ACYF proposed four basic domains for measuring social and emotional well-being: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning. The information memorandum noted that the adverse effects of maltreatment might impact a child over a lifetime.

Regardless of whether that maltreatment originated prior to entry into the child welfare system or as an event(s) 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.

Unlike traditional foster care and many state child welfare systems, TFC is a strengths-based, evidence-informed, and trauma-sensitive system of care for maltreated, complex-trauma impacted youth. Providers of TFC believe that when it is not possible for children to safely remain in their own homes, children who are moved to out-of-home care should have access to TFC in a setting where their clinical-level behavioral problems and mental health needs can be met in a setting that addresses and promotes self-regulation and healthy relationships.



When TFC is done correctly, children are appropriately assessed for trauma and mental health issues and an accurate determination is made for in-home services for child and family or for out-of-home services that meet conditions of safety, a service plan for permanency, and a process for the development of well-being. Life-skills training is correlated with defined behavioral outcomes through an individualized treatment plan. Mental health services are provided based on assessed strengths, deficits, and best practices in clinical intervention. Caregivers are trained in specialized skills to address emotional, behavioral, and relational needs of individual youth in their care and are supported and monitored toward measurable goals by TFC professionals. Specialized populations of youth; whether GLBT, 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 intervention and support.

## Robert

Robert has been in child welfare custody since age 6. He is now 17 and has grown up in care. When he came to our TFC agency he presented with a diagnosis of Oppositional Defiant Disorder and an array of severe oppositional behaviors and poor academic performance. Since achieving a more stable placement in TFC care, Robert improved his academic performance and was able to attend concurrent college courses while finishing his high school courses his senior year. He graduated high school this year and is currently enrolled full time in college next year. He plans to live in the dorms. He has a job and has held employment of some kind for the past year and a half. He was stepped down to a lower level of care this May and we continue to surround him with a support system to further teach independent living skills while he remains in the foster home.

-Mary Belcher, Checotah, OK

Traditional foster care rarely provides any of these intense responses. Therapeutic foster care routinely does, when delivered according to FFTA standards of practice.

Precious time for the child to experience relief and options for healing, the accountability for limited state and federal dollars, needed service coordination between public and private resources, and the potential for a future with a forever family, whether through reunification or through another permanency option, become realistic goals for previously 'unadoptable' youth.

## Expanding the Focus of Well-Being for Youth in Therapeutic Foster Care

As mentioned previously, the informational memorandum from ACYF provides a framework for considering the overall physical and emotional well-being of youth in care. Several consequences of prior maltreatment that impact future well-being and development are worth highlighting for the TFC population of youth.

All youth in foster care experience some level of trauma when removed from their original homes and placed with strangers or relatives. The severity of conditions requiring removal from their birth families, the temperance and resilience of each individual child, the experience itself of moving, and the competence of the family unit receiving the child all combine to impact the child's sense of trust, vulnerability, and connection.

Obviously, children grow up. Whether they are restored developmentally and emotionally to meet the challenges of self-confidence, career selection and satisfaction, and relationship competence with a spouse, partner, and/or social and business contemporaries should be of major attention. These areas of functioning will determine the course of their lives for their lifetimes.

Clinicians, public agencies, and state legislators must provide assessment tools and fiscal resources to assist these youth and families at least until age 21 and not simply age 18, the age of legal majority. Assessing youth for relational competence is possible and imperative. Amelioration cannot be limited to educational or training deficits. Self-confidence and personal competence for independent living exceeds knowing about managing finances and obtaining a driver's license. Helping youth to identify their innate strengths and weaknesses through access to counseling resources between ages 18 to 25 is crucial to their abilities to maintain healthy relationships with biological family members, relatives, friends, coworkers, and intimate personal connections.

Accomplishing these important tasks is most possible when:

- Providers have created the essential partnerships described earlier with child welfare, mental health, legislators, and other agencies responsible for youth in state care.
- Independent living and transitional living supports and curricula are extensive, outcomes focused, adaptable to the unique needs and considerations of each individual youth in foster care, and are provided by a consistent person or team of people to the transitioning-to-adulthood youth.
- Youth are encouraged to access counseling services with professionals who have training in trauma-informed care and who will accurately diagnose and treat issues of traumatic response and/or mental illness as presented in the youth.
- Providers access guidance and protocols for functional assessments of youth to help those youth understand their behaviors and to increase positive behavioral supports. Such guidance is easily obtained through national associations and networks.

## Current Challenges

When TFC is conducted according to best practices, it demonstrates positive outcomes and cost savings for this highly fragile population of youth.<sup>4,5</sup> However, as with most child welfare practices, challenges remain:

- Across the states there is wide variation in TFC programs and services. A national, baseline definition of TFC and quality standards is critical for guaranteeing access and quality to this medically necessary service.
- Reimbursement rates for TFC services, provider costs, and foster parent pay need to reflect the additional training requirements and treatment plan services provided in TFC. Too often funding restrictions state-by-state limit severely who will have access to quality TFC and who is capable of providing such care.
- FFTA Program Standards recommend that TFC treatment be trauma-based. Costs for trauma-based training must be accounted for by state legislatures and public child welfare agencies.
- FFTA Program Standards support evidence-informed behavioral health care for youth in TFC. However, current research and publications reflect limited studies of evidence-based programs for

TFC. Cost of research is again an impediment to be addressed by policy makers and national child welfare/mental health leaders.

- One recommendation from a technical expert research panel on TFC (conducted by SAMHSA in September 2012, findings not officially published at this time)<sup>6</sup> states that mental health therapy should be embedded in the TFC model rather than referring youth in TFC out for mental health treatment. In other words, TFC is a separate and distinct intervention and service model. It is not “wrap-around plus”.
- As states move toward health care reform in whatever approach taken and with implementation of health care exchanges, it is important that children and youth in TFC are not be overlooked and inadvertently moved into a provider delivery system that will disrupt current therapeutic relationships and treatment plans.

The public policy unit of FFTA is monitoring and addressing each of these challenges in its national representation and in its work with individual states and member agencies.

## An Increasingly Important Dialogue on Youth in Foster Care with Complex Needs

In the past two years, children in foster care have received much attention from key federal agencies: the Center for Medicare and Medicaid Services,<sup>7</sup> the U.S. Government Accountability Office,<sup>8,9</sup> the U.S. Office of Inspector General<sup>10</sup>, and the Administration on Children, Youth, and Families<sup>11</sup>. Published reports and state Medicaid Directors’ letters<sup>12</sup> confirm lack of access to therapeutic and clinical services for foster youth, overutilization of psychotropic medications for youth in foster care, and for the first time, direction on benchmarks for determining well-being of youth in foster care in addition to the familiar goals of safety and permanency.

Equally pertinent to this dialogue is the new effort to remove the stigma of mental health needs and services. This discussion was launched publicly by the Obama Administration June 3<sup>rd</sup>, 2013, through a White House Conference on Mental Health.

The confluence of recognition by both the child welfare and the mental health communities of needed access to quality clinical services, of appropriate use of psychotropic medications, and of addressing mental illness and traumatic events as treatable conditions, will lead to appropriate services and more measurable outcomes for youth in foster care who have mental and behavioral health dysfunctions and/or medically fragile conditions, any of which require the out-of-home, intensive treatment available in TFC.

FFTA and its member agencies are engaged in providing high quality services and exceptional care for complex, trauma impacted youth in foster care. Leaders are engaged in discussions across the country to provide a uniform, baseline definition of TFC components, outcomes, and quality measures. In addition, TFC agencies are engaged in delivering intensive in-home services in efforts to avoid a child’s initial removal from their homes. With the support of a grant from the Annie E. Casey Foundation, FFTA is engaged in

FFTA



## Foster Family-based Treatment Association

### Expanded Endeavors Engaging FFTA

- Community based care and TFC professionals – in-home services to avoid removal; post-permanency and reunification stabilization
- Relative placements for TFC youth
- Post-permanency/post-adoption services
- Domestic minor sex trafficking

research and development of recommendations for successful relative placements of youth in TFC and enhancement of placement stability for these youth and relative homes when state involvement ends.

Other unique projects underway involve program development TFC agencies in post-adoption skills training for professionals and in pilot programs for the treatment of youth victims of domestic sex trafficking.

As the United States continues to recognize the plight of children in need of protection from abuse, neglect, and violence, the unique skills and training of TFC professionals offer key opportunities for treatment and healing across the continuum of care. With the support of many national partnering organizations, we maintain our commitment to serving vulnerable youth and families with the goals of safety, a permanent connection, and skills to enable well-being for each and every youth in America.



*The State Policy Advocacy and Reform Center (SPARC), an initiative funded by the Annie E. Casey Foundation and Jim Casey Youth Opportunities Initiative, aims to improve outcomes for children and families involved with the child welfare system by building the capacity of and connections between state child welfare advocates. SPARC is managed by First Focus. You can visit us online at [www.childwelfaresparc.org](http://www.childwelfaresparc.org) or on Twitter at @ChildWelfareHub..*

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<sup>1</sup> FFTA Program Standards can be accessed at <http://ffta.org/standards/index.html>.

<sup>2</sup> Information on each individual state can be found: <http://www.bu.edu/ssw/usfostercare/>

<sup>3</sup> <http://www.acf.hhs.gov/programs/cb/resource/im1204>.

<sup>4</sup> <http://www.mtfc.com/2008%20Magellan%20RTC%20White%20Paper.pdf>.

<sup>5</sup> Robst, J; Armstrong, M; Dollard, N. Comparing Outcomes for Youth Served in Treatment Foster Care and Treatment Group Care. The Journal of Child and Family Studies. (2011) 20:696–705.

<sup>6</sup> Preliminary data by Dr. Larke Huang, Senior Advisor on Children’s Policy, SAMHSA presented May 6, 2013, at the 11<sup>th</sup> Annual FFTA Public Policy Institute, Washington, D.C.

<sup>7</sup> Joint letter from CMS, ACF, and SAMHSA to State Medicaid Directors:  
<https://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf>

<sup>8</sup> OIG 2013 Work Plan: <http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf>.

<sup>9</sup> GAO Report Dec. 2012: Children’s Mental Health – Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care: <http://www.gao.gov/assets/660/650716.pdf>.

<sup>10</sup> GAO Report Dec. 1, 2011: Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions: <http://www.gao.gov/assets/590/586570.pdf>.

<sup>11</sup> ACYF-CB-IM-12-04: Well-Being 4.17.12 . [http://www.acf.hhs.gov/programs/cb/laws\\_policies/policy/im/2012/im1204.pdf](http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf).

<sup>12</sup> Beyond Safety and Permanency: Promoting Social and Emotional Well-Being for Youth in Treatment Foster Care (FFTA January, 2013) [http://ffta.org/publicpolicy\\_advocacy/Beyond\\_Safety\\_and\\_Permanency.pdf](http://ffta.org/publicpolicy_advocacy/Beyond_Safety_and_Permanency.pdf).