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Foster Family-based Treatment Association

October 23, 2013

Dear Members of the House Ways and Means Committee:

On behalf of the national Foster Family-based Treatment Association, I respectfully submit these written comments for the official record of the hearing October 23, 2013 on Preventing and Addressing Sex Trafficking of Youth in Foster Care.

Treatment (or Therapeutic) Foster Care (TFC) is foster care for children and youth with special medical, psychological, emotional and social needs who can accept and respond to relationships within a family setting, but whose special needs require intensive therapeutic services. TFC is, therefore, distinguished from “traditional” foster care, “kinship” foster care, and “specialized” (homes contracted with Departments of Developmental Disabilities) foster care, where the fundamental need is a need for placement.

TFC is a medically necessary service for treatment and is Medicaid compensable. TFC is also the least restrictive, evidence-informed, and most cost efficient treatment option for these youth, whose only other options would be in-patient, group homes or the juvenile justice pipeline.

When Treatment Foster Care (TFC) is conducted according to the Program Standards of the Foster Family-based Treatment Association, TFC demonstrates specific outcomes for safety, permanency, and well being for this highly fragile population. TFC is delivered by licensed child-placing agencies whose staffs are trained in distinguishing mental health and trauma-induced sequelae, are accredited to provide evidence-informed treatment for these disabilities, and are held to defined measures of outcomes, research, and accountability.

In particular, treatment foster care is a system of care for youth who have experienced complex trauma. TFC homes provide intensive treatment from the agency clinicians as well as intensive training and supervision of TFC foster parents.

When victims of domestic minor sex trafficking (DMST) are identified, they may be best served through the level of care, preparation, and intervention of TFC in order to deal with their trauma and to begin a path of well being and recovery.

Experience of TFC providers across the states suggests that some of the biggest challenges for victims of DMST are:

1. State child welfare agencies not recognizing the prevalence of the issue (and therefore, the public does not know about this abuse; likewise, child welfare field workers lack needed awareness, training and support)
2. Even if a youth is identified, many state child welfare agencies are unable to enter data into SACWIS or other state databases accurately or in a timely manner,
3. Appropriate matching and referral to foster homes (e.g. TFC homes) does not occur.

4. Training guidelines for treating DMST survivors need to be established, both for foster care agencies and in the case of treatment foster care, for TFC foster parents.
5. Outcomes unique to this population should be developed according to the unique needs of this population. The typical treatment and placement outcomes measured for foster youth do not apply to this population, e.g. Running away and returning may not be a 'negative' for these youth. Outcomes need to go beyond current benchmarks for traditional foster youth.
6. Treatment must be trauma-informed.
7. A national, uniform definition of TFC would greatly enhance quality and 'credibility' for treating the DMST population.
8. Since homelessness is a frequent precursor to entering trafficking, more resources for displaced/homeless teens in local communities before they come to the attention of child welfare or law enforcement is paramount.

FFTA is interested in providing treatment foster care for this population. Note that TFC is a treatment, not just a placement. Youth typically have to meet some defined "medical necessity criteria" (e.g. mental health diagnosis, etc.) in order to have access. Each state determines their own 'medical necessity criteria', but there are close similarities among the states. FFTA is in the process of identifying FFTA agencies with experience treating trafficked youth. We have begun a specialized issues work group on trafficked youth and TFC and will gladly share findings and recommendations as they continue to be developed.

In summary, some of the key differences in treatment foster care vs. traditional foster care and out-patient wrap-around services include the training of TFC foster parents, placement in homes in the community (no more than 1 or 2 TFC youth per home), use of trauma informed and evidence informed interventions, and inclusion of bio-family/relatives if appropriate and possible. Youth live in communities in specially trained foster homes. In general, TFC foster parents have twice the training of traditional foster parents. They must keep a daily log of activities and "interventions," all of which are tied to the treatment plan by the youth's clinical therapist, who is a state licensed behavioral health professional. Foster parents and clinical staff must be available 24/7 if needed for crisis intervention and support.

Interventions, daily activities, outcomes, and foster parent logs should all reflect specialized training for DMST survivors.

Going forward, we welcome the opportunity to address the treatment needs of trafficked youth through treatment foster care. Reimbursement rates for this specific niche of care should be carefully examined. Specialized training costs must also be addressed.

Respectfully submitted,

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