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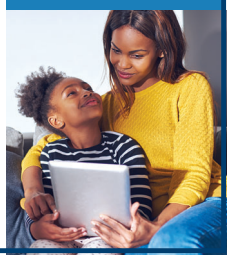
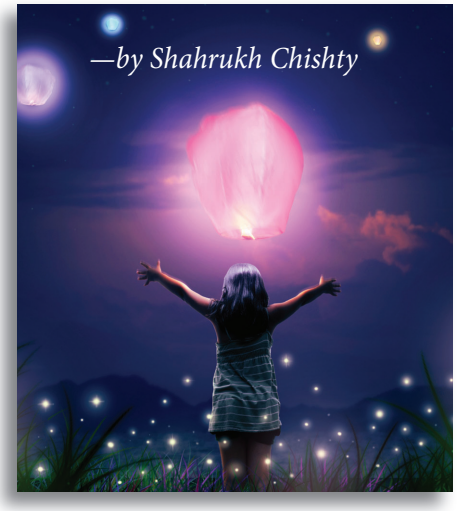


Newsletter of the Family Focused Treatment Association

FFTA Family Focused Treatment Association

WINTER 2019 • Volume 25/ Number 1

Hurting Deep...Healing Deep



The bleeding of the punched lip, the anxiety of the coming of the night, or the triggering of hearing the name of a child's molester... all are forms of hurt, and all need healing.

Wouldn't it be wonderful to be able to heal our deeply traumatized children deeply and someday completely? Healing doesn't just mean cleaning up the lip, having a side light on at night, or avoiding being around a perpetrator. Healing is understanding the complexities of trauma and how all these factors combine to form deep wounds. In order to provide relief, a very specialized and unique approach is required based on the story of each child's heartache and pain.

Such was the endeavor that Aldea Children and Family Services set out to undertake along with OLE Health. OLE Health is a medical provider that supports person-centered, high-quality health care for residents of Napa and Solano Counties in California. Its teams of medical professionals work together to provide patients with the range of services they need, when and where they need them, including women's health services, behavioral health specialists, dieticians, dental health, and more. At Aldea Children and Family Services, our hope is to empower families and at-risk youth so they may reach their personal, academic, and occupational goals through critical mental health, Treatment Foster Care and adoption, and support services.

The partnership between OLE Health and Aldea Children and Family Services aimes to ensure that county residents have access to the most comprehensive services available by utilizing an integrated model of care and innovative programs that place patients at the center of their own team of medical professionals. In particular (and the focus of this article), our partnership wanted to provide a true medical home for youth in foster care who have not had much stability in their lives. Evidence shows that coordinated care between providers increases the likelihood of better health outcomes for patients. The collaborative model of fully integrated health care was meant to be a break from the "business as usual" model and swiss cheese approach and aims for something that is meaningful, efficient, and respectful of the dignity and journey of each individual who needs assistance from both agencies. Patients have a dedicated treatment team that provides medical, dental, and behavioral health care in a single location.

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EDITOR'S COLUMN

—by Beverly Johnson, LCSW

Children in Foster Care Have a Basic Right to Quality Health Care

As much as I want to believe that we've made improvements for children in foster care over the years, I can't help but think about the recent administration's erosion of the Affordable Care Act guaranteeing basic health coverage for Americans across the country and how that affects the quality of health care services for our most vulnerable populations. Although all children in foster care are guaranteed health care coverage through the federal Medicaid program, for many children in foster care the challenge lies not only in finding medical professionals who accept Medicaid, but in finding professionals who understand the unique challenges of these children who have experienced abuse, neglect, violence and parental substance abuse. Although children in foster care make up only a small percentage of those receiving Medicaid, this population faces significantly more health needs than most, with about 50% diagnosed with mental health disorders. And let's not even discuss the unmet oral hygiene and dental care needs of children in our care.

This is ever more reason for a well-coordinated and comprehensive approach to health care delivery to our foster children and well-trained professionals who can adequately respond to the unique needs of our children. A few examples of this are highlighted in this issue of *FOCUS* as we explore unique partnerships with foster family agencies and medical clinics that are employing innovative solutions for better health outcomes. One in northern California with Aldea Children & Family Services and OLE Health. The other is with the Children's Shelter in San Antonio, TX. In addition, it is refreshing to read about Vanderbilt University Medical Center and their partnership with the state of Tennessee Department of Children's Services. Their Psychopharmacology

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The significance of this relationship is depicted in numerous disheartening statistics regarding medical needs and concerns of youth in care:

- 35–45% have chronic or untreated physical health conditions*
- 60% of children under 5 have developmental/educational delay*
- 92% have at least one abnormality on physical examination, including concerns with respiratory tract, skin, genitals, eyes, abdomen, lungs, and extremities*
- 15% have birth defects*
- 45% have special education placement/academic underachievement*
- 100% are at risk for reproductive health issues (pregnancy and sexually transmitted diseases)*
- 5% have occult fractures not suspected by social workers*
- 40–95% have mental health problems*
- 20% have significant dental conditions*
- 44% have an identified health problem, including acute infections (otitis media, STDs), anemia, and lead poisoning.

Patients would have a dedicated treatment team that would provide medical, dental, and behavioral health care in a single location.

Realizing the scope of these dreaded statistics, we understand that a very creative approach needs to be taken. There is a simplicity, yet, at the same time, a web of complexities that needs to be mitigated for this approach to be successful.

Months of building and construction yielded a beautiful clinic with eager staff ready to help! Prior to materializing our vision within the foster care program, we had a meet-and-greet to learn about each other's roles and how mutual clients may benefit from this wonderful collaboration. Our big-picture journey, without giving details of the complex issues needing to be navigated at each step, was as follows:

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*From American Academy of Pediatrics, 136(4), October 2015, and 106(4), October 2000.

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Oversight Program identifies the red flags that would trigger a review for potentially more risky prescriptions in an attempt to address the rising rates of psychotropic medications for children in care.

Hearing from former youth in foster care, like Katherine Gordon, we appreciate just how essential health care is as she relays her story of the missed opportunity that led to a revocation of vital health care services for herself when she was reunified with her family, just shy of her 18th birthday. We professionals need to think before acting to study all the ramifications of exiting foster care prematurely and continue to fight for legislation that allows children in foster care to retain vital benefits such as health care, college aid, etc., when they do exit foster care. Along this same line, check out the new legislation in the "What's Up" in Public Policy section, such as the bill sponsored by Rep. Karen Bass to allow youth who exit foster care to retain health care coverage even across state lines until the age of 26. These are steps in the right direction in addressing the children in care who approach adulthood and the high risk for multiple chronic health issues, unplanned pregnancies, and domestic violence victimization.

Children in foster care have a right to quality health care.

Here's to a healthy year for you and your loved ones as we enter 2019!

Beverly Johnson, LCSW, is the Chief Program Officer of Lilliput Children's Services. She is a member of the FFTA Board of Directors and serves as the Chair of the FFTA Editorial Committee.

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- OLE Health Clinic opened its doors within Aldea's building.
- A "Policy Council" was created with members of each organization.
- OLE Health Clinic hired a Care Coordinator to provide assessments and information and to conduct warm handoffs.
- A mechanism for tracking cross-agency referrals was created.
- Communication was established between providers to ensure that HIPAA laws and regulations are being followed.

Now we were ready to do the work! Following is the mutually agreed-upon plan for any Aldea youth in foster care being seen at OLE Health Clinic:

- Day of Medical Appointment at OLE Health Clinic (Note: For more urgent needs, same-day appointments are made available for Aldea clients.)
  - -Resource Parent/Youth identifies as part of Aldea
  - -Any injuries, abuse, or concerns will be reported to make the medical team aware of the child's abuse history, preventing any unnecessary concerns.
  - -Medical assessment is conducted with the medical provider and may involve as many care providers as appropriate, including the youth, the Resource and Biological Parent, the Aldea worker, and other support persons.
  - -Screenings are conducted:
    - ›Parent Health Questionnaire-9 (PHQ-9): The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.
    - ›OLE Child and Adolescent Needs and Strengths (CANS) Module.**
  - -Summary of visit is completed and given to the Resource Parent.
  - -Follow-up appointment or next routine appointment is scheduled.
- The Role of the OLE Health Clinic Care Coordinator
  - -Care Coordinator meets with youth and Resource Parent.
  - -Care Coordinator reviews OLE CANS Module, PHQ-9, and Visit Summary.
  - -Care Coordinator communicates with Aldea within 24 hours.
  - -OLE Health Clinic staff give the following to Aldea after appointment:
    - ›After Visit Summary
    - ›Health Progress Note
    - ›OLE CANS Module
    - ›PHQ-9

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** The Child and Adolescent Needs and Strengths (CANS) is a multipurpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives and to allow for the monitoring of outcomes of services. The OLE CANS module was created with guidance from Dr. Lyons (creator of CANS) and using existing medical CANS items. The items were selected and combined with other medical assessments. The final module was created by a Praed CANS–certified trainer and an OLE Health Clinic physician.

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- Aldea's Treatment Planning
  - -OLE CANS Module, PHQ-9, and the Health Progress Note are used to create Aldea Treatment Plan goals.
  - -OLE CANS Module is used to create quarterly updates to the Aldea Treatment Plan.
  - -The Aldea Treatment Plan is shared with the OLE Health Clinic team so that all are on the same page.
  - -OLE Health representative may attend Child and Family Team Meetings.
  - -Aldea Discharge Report includes upcoming OLE Health Clinic appointments and/or recommendations.
- Ongoing Collaboration between Aldea and OLE Health Clinic
  - -Weekly collection of Progress Notes from OLE Health Clinic
  - -Monthly review of youth needs
  - -Quarterly teaming with OLE Health Clinic, Aldea, and Aldea's Performance Quality Improvement Process
  - -Quarterly outcome tracking
  - -Aldea extends invitations to ongoing trainings to OLE Health Clinic on topics such as but not limited to Trauma Sensitivity, Grief and Loss, Child Abuse and Prevention, Commercially Sexually Exploited Children (CSEC), Intensive Services Foster Care, and other Child Permanency and Well-being Education

What this meant for us was beyond our belief! Prior to this partnership, we could barely read the doctors' handwriting! After the partnership, we had specially designed progress notes for our youth, specialized focused attention in treatment planning, and even the physician's (or representative's) attendance in child and family team meetings for youth with higher medical needs.In the end, we had youth who actively participated in their medical planning and were not terrified to visit the doctor after disclosing being raped, resource parents who were not frustrated waiting in the emergency room with their foster youth for simple medical concerns... the list can go on and on!

In a world of complexities, there are solutions. Our youth have bled and hurt deeply and may have everlasting damage in many capacities. We can make a difference by meeting them in their darkest place where their hurt is hidden. We can help them heal. We absolutely can.

Shahrukh Chishty is the Senior Director of Social Services at Aldea Children and Family Services in Napa, California.

33 Days that Changed Everything

—by Katherine Gordon

Thirty-three days is all it took to revoke the opportunities I was promised for so many years. I was in foster care from the age of 11 until 33 days before my 18th birthday when my caseworker reunified me with my family.

I had always worried I would fall through the cracks but never thought this would be the way it happened. If even one person had explained to me what I would be losing by reunifying so close to my 18th birthday, I wouldn't be struggling like I am today. If I had waited 33 more days, I would have had Medicaid until age 26 and financial support for higher education.

I remember the day I received the call from my state explaining that I did not qualify for the Department of Children and Families Education and Training Voucher (ETV) that was promised to me and that I was relying on. I spent 45 minutes explaining how I had been told for 7 years that I would get "free college." What hurt the most was to find out I did not qualify solely because of 33 days and the fact that I did not "age out" of the foster care system.

The 7 years I spent in care were filled with heartbreak, letdown, anger, frustration, and confusion. I felt like the least the system could do for me was to help me create a better life for myself by getting me on my feet. With the support of ETV funds, I would be able to go to college and pursue my dream of giving back to the child welfare system as the kind of social worker I wish I had.

Because I am a strong, independent, and passionate person, I picked myself up and moved on despite not having financial or familial support.

Because I agreed to exit care 33 days prior to my 18th birthday, I would not be eligible for health care unless I qualified by being low income or unemployed. I felt I had to choose between working as a full-time student or not working so my income would be low enough to qualify for health care. It was truly a lose-lose situation.

Had I known that those 33 days mattered so much, I would have declined reunification and stayed in foster care. I believe all youth need to know about the benefit of having Medicaid to age 26 through a provision of the Affordable Care Act. Outreach and education about health care and my other options would have informed my decision—and perhaps led to a different decision.

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Because I am a strong, independent, and passionate person, I picked myself up and moved on...

33 Days that Changed Everything

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My story shows how broken the system really is. Reunification may be the goal, but that should not mean stripping youth of resources and opportunities that so many of us rely on, such as health care and funds for school. Those 7 years of broken promises are the exact reason I choose to use my voice and give back.

Katherine Gordon is a junior at the University of Wisconsin–Stout majoring in human development and family studies. She is a 2018 FosterClub All-Star. She spent 7 years in the Wisconsin foster care system.

Resources

- Check out FosterClub's Resource Hub for youth in care at fosterclub.org.
- FosterClub has joined First Focus: SPARC and the Juvenile Law Center in promoting access to health care for foster youth at healthcareffy.org.
- For more information about FosterClub and resources for youth in foster care, contact Shannon at 503-717-1552 or shannon@fosterclub.com.
- Former Foster Youth & FREE Medicaid until Age 26!: http://healthcareffy.org/sites/default/files/page-cb_attachments/%23HealthCareFFY%20FAQ%20Sheet%20for%20youth%20%281%29.pdf
- Foster Youth Trauma Informed Patient Bill of Rights: https://www.fosterclub.com/sites/default/files/Foster%20Youth%20Trauma%20Informed%20Patient%20Bill%20of%20Rights%20-%20%23HealthCareFFY%20FC%20Workshop.pdf
- Foster Care Youth Transition Planning Timeline: https://www.fosterclub.com/sites/default/files/Foster%20Care%20Youth%20Transition%20Planning%20Timeline%20-%20%23HealthCareFFY%20FC%20Workshop%20.pdf
- In Your State—Resources by state (rights in foster care and more): https://www.fosterclub.com/your-state
- FREE Transition Toolkit Download: http://store.fosterclub.com/transition-toolkit-download/
- FYI Binder: http://store.fosterclub.com/fyi-binder/

Public Policy Progress in Medical Access and Treatment for Youth in Care

As the 115th Congress comes to a close and the newly elected 116th Congress takes over in both the House and the Senate this month, several significant accomplishments deserve our attention (and gratitude) and are the focus of this Public Policy column.

On October 24, President Trump signed the bipartisan legislation called the **SUPPORT for Patients and Communities Act (H.R. 6),** informally known as the "opioid package." In addition to numerous important opportunities for treatment of opioid and other substance abuse disorders, H.R. 6 incorporated key elements of proposed legislation by various House and Senate authors that have important ramifications for youth in care.

One key inclusion, sponsored by Congresswoman Karen Bass, **fixed a technical problem with the Affordable Care Act (ACA) regarding youth who exit foster care.** The provision will require all states to provide Medicaid coverage for former foster youth even across state lines until the age of 26. Although earlier legislation had this same intent of offering coverage to former foster youth on par with laws allowing for biological children to remain on their parents' insurance plans until age 26, some states challenged this provision if a youth formerly in foster care chose to move to another state for work, education, or other purpose. This section of the law does not take effect (i.e., it is not required) until 2023; however, states may opt in early at any time.

Statistics show that youth aging out of foster care and transitioning to adulthood are at high risk for multiple chronic health issues, unplanned pregnancies, and domestic violence victimization.

Another section of the act, sponsored by Congressman Tony Cárdenas, **allows states to suspend a juvenile's access to state Medicaid programs while incarcerated but not to end a juvenile's Medicaid eligibility**. States must restore coverage after release and not require a new application. Juvenile justice agencies in many states have faced additional barriers for youth completing state care, whether to the community, subsequent foster care, or "independence," created by states leaving to the youth the crucial task of applying anew for Medicaid coverage. No longer will eligibility be "terminated" for said youth, and the state must be sure that eligible youth have such coverage upon their release.

Again, this change in Medicaid will allow FFTA members who also work with former juvenile justice youth to provide access to Treatment Foster Care (TFC) services and for juvenile justice agencies to consider recommending youth to TFC in family homes in the community.

H.R. 6 contains several provisions related to trauma and trauma-informed care, including creating an interagency task force to study and publish best practices to identify, prevent, and mitigate the effects of trauma on children and families, and **creating a new grant program to increase access to evidence-based trauma support services for youth**. Both of these objectives are important supports to our work in family-focused care.

One last comment of note: A recently released report from Chapin Hall entitled "Missed Opportunities: Youth Homelessness in Rural America" found that 9.2% of young adults between the ages of 18 and 25 who reside predominantly in rural counties experience homelessness versus 9.6% of urban youth of the same ages. We tend to think of homelessness as an urban issue. This research suggests, however, one more demographic to keep in mind in our work with states and youth transitioning from foster care as public policy addresses the rural-urban divide.

Vanderbilt's Psychopharmacology Oversight Program

—by Molly Butler, MSN, PMHNP; Sloane Sparks, MSN, PMHNP; Skyler Jacobs, MSN, PMHNP; and Kathy Gracey, MEd

Children and youth in the child welfare and juvenile justice systems or at risk of entering them are known to have high rates of mental health problems and psychiatric disorders.

In an effort to improve access, quality, and effectiveness of behavioral health care for this vulnerable population, the state of Tennessee developed a program of regional Centers of Excellence (COEs). Based within pediatric tertiary centers across the state, the COEs provide clinical and consultative services to the state child welfare agency, the Department of Children's Services (DCS), behavioral health providers, and families.

In 2016, the COE at Vanderbilt University Medical Center created a unique program specifically aimed at addressing concerns related to dramatically rising rates of prescriptions for psychotropic medications for children in DCS custody along with supporting best practice prescribing for these vulnerable youth. The Psychopharmacology Oversight Program team consists of three psychiatric mental health nurse practitioners and one child and adolescent psychiatrist serving as consultants to the DCS regional nurses who are responsible for providing informed consent for psychotropic medications for all youth in our child welfare system.

The experts have identified "red flag" markers for potentially more risky prescriptions that are individually reviewed by the Vanderbilt COE team with heightened scrutiny. The red flags that trigger a review include any psychotropic medication prescribed for a child 5 years of age or younger, four or more medications prescribed concurrently, two or more medications prescribed in the same class, and a psychotropic medication that is prescribed which exceeds maximum dosing recommendations. The red flag prescriptions are reviewed by the team, giving attention to both psychiatric and medical diagnoses, vital signs and lab values, current placement, additional mental health services being provided, and psychotropic treatment history. A recommendation is then given to the DCS regional nurse to support the nurse's decision making related to consent. The team generally either supports the medication regimen or provides a suggestion for a more evidence-based medication change or non-pharmacological intervention.

The Vanderbilt Psychopharmacology Oversight Program team provides psychoeducation along with consultation to DCS regional nurses. The team is also available for provider consultations with prescribers working with youth in child welfare and can provide more thorough case reviews or face-to-face evaluations of youth at the request of DCS stakeholders.

Molly Butler, MSN, PMHNP, serves as the program director for the satewide Psychotropic Medication Oversight Program and as a consulting psychiatric provider at the Vanderbilt Center of Excellence for children in state custody.

INTEGRATED MEDICAL CARE

—by Yvette Sanchez, MA, LCCA, LCPAA

Children and youth often have unmet medical needs when entering the child welfare system.

These unmet medical needs, compounded by the untreated trauma, can create an unstable future. The American Academy of Pediatrics (AAP) has used data from the past 30 years to help demonstrate the high prevalence of health problems in children and youth in the foster care system. Generally, 30%–80% of children come into the foster care system with at least one physical health problem, special health care need, or other chronic condition. Additionally, up to 80% of children and youth enter the foster care system with a significant mental health need. On top of physical and mental health needs, children and youth face issues associated with oral health, child/youth development, and education. Unfortunately, multiple placement moves, uncoordinated medical care, and untreated trauma can be a recipe for lifelong challenges.

As providers, we know that children and youth in the foster care system face tremendous challenges. As noted, research shows that children in the foster care system have increased rates of chronic mental and physical health needs rooted in their history of adverse childhood experiences (ACEs). ACEs are traumatic stressors that occur during childhood, such as abuse (physical, emotional, and sexual) and neglect (physical and emotional). These ACEs can lead to lifelong health effects if left untreated; as a result, more attention is now being paid to addressing ACEs as a public health concern. A person with four or more ACEs is 2.5 times more likely to have chronic obstructive pulmonary disease, 4.6 times more likely to experience depression, and 12 times more likely to be suicidal. We also know through literature that untreated ACEs can result in the disruption of normal child development and lead to psychosocial problems. For these reasons, addressing both the physical and emotional health of children in foster care is an important part of wraparound services. Including medical professionals as part of a wraparound team will strengthen services and support the well-being of children and youth.

Many children in foster care receive fragmented medical care due to placement moves or lack of access to qualified providers. Of all the challenges that children and youth in foster care face, medical care should not be one. Children and youth in foster care should have access to a wraparound team that includes medical professionals. However, establishing a quality integrated team can be daunting, especially when you have to find a medical provider who understands how to work with children and youth from hard places. Foster parents often scramble from doctor to doctor, attempting to find a provider who not only accepts Medicaid but also understands working with children in foster care. As a provider, we have seen many children come into care without adequate medical, dental, or behavioral health care. Knowing how vulnerable our children and youth in foster care are, we often wondered what else we could do. Many of our staff and foster parents expressed concerns about access to quality health care providers to serve our children and youth.

Our agency, The Children's Shelter, is a nonprofit organization in San Antonio, Texas, founded in 1901. We serve more than 5,000 children, youth, and families each year, offering a trauma-informed continuum of services that includes emergency shelter, treatment foster care, outpatient

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INTEGRATED MEDICAL CARE

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mental health, and family preservation programming. We have held accreditation by the Council on Accreditation for more than 15 years and were certified as a trauma-informed organization in 2014. Through our work in the community and with children and families, we knew that linking a quality medical team into our wraparound services was a no-brainer. We knew that the lack of integrated medical care created a gap in our continuum of care, and so our journey began. We envisioned a place where children receive trauma-informed integrated care for medical, dental, and behavioral health services—a place where children who once feared the doctor's office now would find peace and heal from their trauma.

Many providers may see offering this service as overwhelming and unattainable. However, if we minimize the gaps in accessibility, we create efficiencies for both staff and foster parents. Most importantly, we create a space that is tailored to fit the needs of children and youth and where they can heal and build positive connections with health care providers. So what has worked for us? How long did it take? And how do you get started?

Our medical integration has changed over the course of 10 years and continues to adapt to the changing needs of our population. It didn't happen overnight and, in fact, continues to be shaped. To get started, we identified a few major medical groups in our county. We began engaging in conversations about our services, the special population we served, and concerns we had with the current fragmented medical care. We discussed the importance of medical care in our continuum and agreed that the well-being of our children in care was a priority. We were trying to find the best fit. We knew that we wanted a provider who not only enjoyed working with our special population but also understood that our children and youth come from very hard places. Anyone we chose would need to be able to help tear down walls while building trust with our children and youth. We wanted a provider who was eager to work with our population and also willing to be a partner with us. It was important that we had a shared vision as we created our own concept of integrated medical care. We went through a very similar process to locate our child psychiatrist and dental provider. Some of the immediate items we had to tackle included credentialing of satellite offices, locating the appropriate shared space, identifying the equipment needs, and creating the formal agreement.

Once we identified our partners and defined the space in our building, what came next? Together, we mapped out how the

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space would be used for both medical and dental clinics. Our partners identified their needs, and we discussed the resources needed to get started. Once we identified the resources we had and the resources we lacked, our development department worked to find small grants to help fund equipment for the medical and dental spaces. We secured funding partners who were interested in our concept of integrated care. We agreed that each provider partner would address its own billing and receive the appropriate credentialing and such. We agreed to meet weekly to discuss staff challenges and address issues for care. Our leadership teams continue to meet quarterly to discuss clinic operations. We have a great relationship and great communication with our medical and dental providers. Both our partners provide feedback on medical and oral health and assist our teams in working with children and youth. We are lucky to have such committed partners in our community. Our partners truly see their impact on our children and youth.

Our partnerships evolved, and we've changed medical and dental providers once over the past 10 years, but we are committed to ensuring that services remain seamless. We meet annually to review our contract and make revisions as needed. We continue to communicate about resources needed, and as a nonprofit, we are able to secure grants to help clinic operations. Today, we are proud partners with the Children's Hospital of San Antonio and the University of Texas Health Science Center's Department of Developmental Dentistry. We also partner with several child psychiatrists to serve the children and youth in our care.

In the end, we found that working with partners interested in the long-term well-being of children and youth in foster care plays a major role in ensuring that children and youth heal from their trauma. We encourage you to work with partners in your community who are interested in working with children and youth in foster care. There are medical, dental, and behavioral health providers out there who would consider working with our children an honor and a privilege.

As you begin your journey, we invite you to research current integrated medical care models. There is a lot to learn from established organizations. If you were at last year's FFTA conference, you might have heard from Dr. Anu Partap, the Director of the Rees-Jones Center in Fort Worth, Texas. We learned about the innovative integrated medical model in which there are constant warm handoffs between providers, providers communicate with each other, and the ultimate goal is to heal the child from trauma.

If you find yourself asking more questions, we would be happy to discuss additional details about our agency's medical care concept.

Yvette Sanchez is the Chief Operating Officer at The Children's Shelter. She serves on FFTA's Board of Directors and is a member of the FFTA Editorial Committee. Yvette can be reached via email at ysanchez@chshel.org.

FOCUS

Newsletter of the Family Focused Treatment Association

Family Focused Treatment Association

The Family Focused Treatment Association strengthens agencies that provide family focused treatment services.

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