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January 31, 2022

Nakela Cook, MD, MPH
Executive Director
Patient-Centered Outcomes Research Institute
1828 L Street NW, Suite 900
Washington, DC 20036

Dear Dr. Cook:

Thank you for the opportunity to comment on PCORI's research agenda. Since 1998, the Center for Adoption Support and Education (C.A.S.E) has created awareness of the deep need for adoption competency in mental health services and has grown to become the national leader providing mental health and child welfare professionals with training and coaching to become adoption competent. Our programs help professionals gain the skills, insight, and experience necessary to serve the needs of the adoption and foster care communities. We have been at the forefront of efforts to identify foster and adopted children and families as a population most at-risk for a mental health crisis and have sought to improve the competency of the workforce through specialized training. Our efforts stem from over a decade experience with specialized adoption-competent mental health services to over 7000 clinical clients and on average over 6800 sessions annually.

With this experience, we are very aware that a significant gap in research exists related to the specialized mental health needs of children in the child welfare system and children who are adopted. We are hopeful that PCORI will take steps to advance research that fills those gaps by, 1) prioritizing research in mental health that focuses on children in foster, kinship and adoptive families; 2) incorporating demographic questions into all PCORI-funded mental health research projects that identifies people participating in the research that have experienced foster care, kinship care or adoption; and 3) partnering with the Administration on Children and Families to advance research tailored to test the effectiveness of professional training on the mental health outcomes of children experiencing foster care, kinship care and adoption.

The Problem

Adoptive parents consistently report that their greatest post-adoption support need is mental health services provided by someone who understands adoption.¹ Some families reported seeking therapy from as many as ten different therapists before finding one who is adoption competent, if they find such a therapist at all.² Therefore, it is not surprising that studies indicate that most mental health professionals lack the training to meet the diverse, complex

¹ Atkinson & Gonet, 2007; Smith, 2014, Brodzinsky, 2013 ² Casey Center for Effective Child Welfare Practice, 2003

² Casey Center for Effective Child Welfare Practice, 2003

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clinical needs of adoptive families.³ Without access to adoption-competent mental health services, the risk of failed adoptions increases exponentially. Children may enter state child welfare agencies through “forced relinquishments,” or place their children in residential treatment facilities and/or wilderness programs — choices parents make when they lack access to the appropriate resources.

Prior to developing our Training for Adoption Competency (TAC), C.A.S.E. convened nationally recognized experts — including adoption practitioners, researchers, advocates, policy makers, and adoptive parents — to identify the core knowledge, skills, and values competencies that mental health practitioners need to serve members of the adoption kinship network. This National Advisory Board helped develop a definition of an adoption-competent mental health professional using an expert-consensus process (see text box).

Definition of an Adoption-Competent Mental Health Professional

An adoption-competent mental health professional has:

- The requisite professional education and professional licensure;
- A family-based, strengths-based, and evidence-based approach to working with adoptive families and birth families;
- A developmental and systemic approach to understanding and working with adoptive and birth families;
- Knowledge, clinical skills and experience in treating individuals with a history of abuse, neglect and/or trauma; and
- Knowledge, skills and experience in working with adoptive families and birth families.

An adoption-competent mental health professional understands the nature of adoption as a form of family formation and the different types of adoption; the clinical issues that are associated with separation and loss and attachment; the common developmental challenges in the experience of adoption; and the characteristics and skills that make adoptive families successful.

An adoption-competent mental health professional is culturally competent with respect to the racial and cultural heritage of children and families.

An adoption-competent mental health professional is skilled in using a range of therapies to effectively engage birth, kinship, and adoptive families toward the mutual goal of helping individuals to heal, empowering parents to assume parental entitlement and authority, and assisting adoptive families to strengthen or develop and practice parenting skills that support healthy family relationships.

An adoption-competent mental health professional is skilled in advocating with other service systems on behalf of birth and adoptive families.

Adoptive families often report that outpatient services — and in some cases, inpatient services — are not appropriate for children with foster care and adoption histories. An untrained therapist, for example, may use behavior modification techniques that do not address the underlying trauma and attachment challenges that a child is experiencing and can exacerbate a child’s mental health problems. We see this situation as a direct service provider routinely. Adoptive and foster families often come to us after seeing multiple therapists who are not adoption competent. This makes our job more difficult as we address both the core issues of

³ Sass & Henderson 2002, Mc Daniel & Jennings, 1997

the underlying trauma and the impact of behavior modification, as well as other techniques utilized by earlier therapists that further exacerbated to the underlying problems.

Adoptive parents consistently report that their greatest post-adoption support need is mental health services provided by someone who knows adoption. The lack of post-adoption mental health services in general, as well as the lack of access to adoption-competent mental health services, are significant barriers to recruiting adoptive families for children from the foster care system. In a national survey of 485 individuals conducted by C.A.S.E., only 25 percent of adoptive families reported that the mental health professional they saw was adoption competent. Most respondents did not know whether assistance in accessing or paying for mental health services was available in their state, and only about 25 percent could confirm the availability of such assistance. Further, only 19 percent reported insurance subsidies adequate to address their children’s mental health needs. Many respondents reported that the number of Medicaid mental health providers is quite limited and the majority of those who are available are not adoption competent. A great majority (81 percent) reported that if they had a choice, they would choose a therapist who has earned a certificate as an adoption-competent therapist.

It is an unfortunate reality that children and youth in foster care — when they are able to receive mental health services — typically receive it from the least qualified professionals due to the low reimbursement rates typical of Medicaid programs. Mental health professionals often begin their careers in publicly-funded community mental health centers that accept Medicaid — where most children in foster care and children who are adopted from foster care are seen. There are significant costs associated with the limited access to quality adoption-competent mental health care — both financially and emotionally. Studies suggest that lack of appropriate mental health services contribute to higher rates of adoption disruption and dissolution for families adopting from foster care, as well as interactions with the juvenile justice system.⁴

Addressing the Need for Workforce Training

C.A.S.E. received accreditation of its [TAC](#) from the Institute for Credentialing Excellence (ICE) for a five-year period through November 20, 2025 — making TAC part of an elite group of certificate programs dedicated to public protection and excellence in practice. TAC is now an assessment-based certificate accreditation program and is the only accredited adoption competency training program in the country. It is now on the California Evidenced-Based Clearinghouse for Child Welfare (CEBC), a nationally recognized body that applies rigorous

⁴ See <http://cascw.umn.edu/wp-content/uploads/2014/04/AdoptionDissolutionReport.pdf>

standards of review to identify effective programs. TAC was rated in the Topic Area of Child Welfare Workforce Development and Support Programs with a scientific rating of (3) Promising Research Evidence and with a Child Welfare Relevance rating of High. Of 17 programs in the Child Welfare Workforce Development and Support topic area, TAC is one of only two programs rated (3) Promising Research Evidence and no programs in the Topic Area are rated higher.

TAC is an instructor led, post-masters curriculum that includes clinical case consultation, making it the premiere national program to train mental health practitioners in adoption-competent skills. Research shows that children with traumatic experiences of abuse, neglect, loss, and abandonment are at greater risk of presenting adjustment problems within their adoptive families. Access to adoption-competent mental health services is a critical factor in the well-being of these children and their adoptive families. C.A.S.E. created TAC to strengthen adoption competency in mental health communities across the United States and have grown their TAC network to over 17 national training partners, including universities and child welfare agencies. Over 2,200 clinicians across the country have completed the 72-hour curriculum to date. An outcomes evaluation conducted in 2020 with funding from the Annie E. Casey Foundation with 159 families served by TAC-trained clinicians compared to comparably experienced but not TAC-trained clinicians, also showed that TAC produces more effective clinical practice for adoptive families. The families served by TAC-trained therapists experienced greater satisfaction with treatment, stronger therapeutic alliance, and greater family engagement over a higher number of sessions.

The National Adoption Competency Mental Health Training Initiative (NTI), a cooperative agreement between the Children's Bureau and C.A.S.E., developed two state-of-the-art, standardized, web-based trainings to build the capacity of child welfare and mental health professionals in all states, tribes, and territories to effectively support children, youth, and their foster, adoptive, and guardianship families. The trainings were piloted in eight states and with one tribe, with final versions of the trainings now available for free nationally. During the pilot evaluation over 6,000 child welfare workers enrolled in the 20-hour training with an astounding 72 percent completion rate and 2,900 mental health professionals with a 68 percent completion rate. Outcomes from the child welfare pilot evaluation indicate high ratings of participant satisfaction with the materials and trainings. Eighty-five to 90 percent of supervisors agreed that this training is applicable to their work. Child Welfare workers improved 28 percent on average from pre-test to post-test; supervisors improved 23 percent on average from pre- to post-test. Completion of NTI training indicated a high level of change in the workforce understanding of separation and loss which is a critical foundational piece of learning in the child welfare system. Pretest scores on the loss and grief module for child welfare staff were the lowest and showed the highest gain from pre to post-test. On the mental health side, the modules on attachment and understanding the impact of race and diversity had the lowest pre-test scores and the highest gains from pre to post-test. Imagine the problems that arise from child welfare workers not able to support children in their healing from loss and then referring

them to therapists that do not know how to promote attachment or understand the implications of transracial/transcultural adoption. This exemplifies the clinical implications when we are solely reliant on providers being trained in a specific EBP without having the “core” foundational knowledge that is necessary in addressing the mental health needs of the children they are serving. Even for the trauma module where such a focus has been nationally as well as the utilization of EBP in trauma treatment, we saw a gain of 15-20 percent between pre- and post-test scores.

Since its pilot, more than 17,000 professionals have enrolled in NTI Trainings and C.A.S.E. has a commitment from 26 state child welfare or mental health service systems across the country to integrate NTI into their training plans. The goal is for NTI Trainings to be the “standard” trainings throughout child welfare systems nationally. NTI’s aligned trainings assure a skilled, competent workforce as required by the FFPSA and provide the skills, strategies, and tools professionals need to:

- Support children to heal from trauma and loss.
- Provide parents with skills to parent more effectively.
- Collaborate effectively with child welfare and mental health professionals.
- Improve outcomes for permanency, child well-being, and family well-being and stability.

The Lack of Quality Mental Health Services for Dually-Involved Youth – Trauma and Justice

C.A.S.E. supports work to promote trauma-informed approaches to behavioral health. We recognize that for foster and adopted children and families, there are evidence-based approaches specific to this population that are also trauma-informed, including the TAC. As policymakers seek to increase the number of trauma-specific services and trainings, we strongly urge the inclusion of trainings that will build the adoption competency of its programs and workforce.

The impact of limited quality mental health services for children and youth in foster care — whether their permanency plan is reunification with parents, guardianships with relatives, or adoption — extends broadly. Studies confirm that the lack of quality mental health services impacts the outcomes for young people that are dually-involved in the foster care and juvenile justice systems. The Brookings Institute Center on Children and Families reported:

Although children in long-term foster care represent only a small fraction of the total child population of the United States, they represent a much bigger portion of the young people who go on to create serious disciplinary problems in schools, drop out of high school, become unemployed and homeless, bear children as unmarried teenagers, abuse drugs and alcohol, and commit crimes. A recent study of a Midwest sample of young

adults aged twenty-three or twenty-four who had aged out of foster care found that they had extremely high rates of arrest and incarceration. 81 percent of the long-term foster care males had been arrested at some point, and 59 percent had been convicted of at least one crime. This compares with 17 percent of all young men in the U.S. who had been arrested, and 10 percent who had been convicted of a crime. Likewise, 57 percent of the long-term foster care females had been arrested and 28 percent had been convicted of a crime. The comparative figures for all female young adults in the U.S. are 4 percent and 2 percent, respectively.

Former foster youth are over-represented among inmates of state and federal prisons. In 2004 there were almost 190,000 inmates of state and federal prisons in the U.S. who had a history of foster care during their childhood or adolescence. These foster care alumni represented nearly 15 percent of the inmates of state prisons and almost 8 percent of the inmates of federal prisons. The cost of incarcerating former foster youth was approximately \$5.1 billion per year.⁵

A study in Los Angeles County found that a quarter of youth formerly in foster care and two-thirds of dually involved youth have a jail stay in early adulthood. The average cumulative cost of jail stays over four years ranged from \$18,430 for a youth formerly in care to \$33,946 for a dually involved youth. The study also found that dually-involved youth were more likely than youth in care with no juvenile justice involvement to experience serious challenges, including mental health problems, more than double the rates of those who were in foster care only. Washington State found that about one-third of the youth in the state's juvenile justice system either were or had been in the foster care system.

Psychotropic Drug Use

Specific to foster care, the Government Accountability Office (GAO) issued a report in December 2012 on *Children's Mental Health: Concerns Remain About Appropriate Services for Children in Medicaid and Foster Care*. They reported that an annual average of 6.2 percent of noninstitutionalized children in Medicaid nationwide and 4.8 percent of privately insured children took one or more psychotropic medications. They also reported that 18 percent of foster children were taking psychotropic medications at the time they were surveyed, and 30 percent of foster children who may have needed mental health services did not receive them in the previous 12 months. The GAO's letter to Members of Congress stated, "Children in foster care, most of whom are eligible for Medicaid, are an especially vulnerable population because

⁵ Zill, N. (2011). *Adoption from foster care: Aiding children while saving money*. Retrieved September 10, 2013 from http://www.brookings.edu/~media/research/files/reports/2011/5/adoption%20foster%20care%20zill/05_adoption_foster_care_zill.pdf

often they have been subjected to traumatic experiences involving abuse or neglect and they may suffer from generally required to cover services to screen children for mental health problems and to provide treatment for any identified conditions, we previously reported that it can be difficult for physicians to find mental health specialists to whom they can refer children in Medicaid.”

While we strongly support appropriate access to medications, we also believe that this report underscores an inherent and fundamental challenge in our Medicaid system around access to adoption-competent mental health services.

Medicaid Challenges Impacting Children and Youth in Foster Care

As you know, children and youth in foster care and adopted from foster care face several challenges with the Medicaid system:

- Many foster, adoptive, and kinship families do not know what resources exist to help them identify and access quality mental health services in their states.
- When they access affordable mental health services, foster, adoptive, and kinship families have no assurance that these services are adoption competent. They generally are given little or no choice in providers.
- There is currently no process for identifying clinicians with special adoption-competent expertise, such as through a national certification or central registry of clinicians who have obtained adoption competency training.
- Medicaid clinical services are an “optional” not mandatory Medicaid service, meaning that States can choose to cover (or not) the services of psychologists, clinical social workers, outpatient mental health services, and substance abuse clinical services. As states are facing budget shortfalls, there is concern that states may opt to eliminate any optional services that they are currently covering.
- EPSDT is unevenly implemented across states, resulting in wide variances in terms of coverage of mental health services for children, particularly with respect to the delivery of treatment services following diagnosis and assessment. As one example, in California, access to EPSDT mental health services is inequitable for eligible youth across the state. Despite the alarming prevalence of treatable mental health problems among youth in foster care, only 60 percent of California children who enter foster care receive the medically necessary mental health services to which they are entitled. Treatment rates range from 6 percent in some counties to 30 percent in others, and from 7 percent to 19 percent among the state’s largest counties.⁶

⁶ Alliance for Children’s Rights. (2012). *Safeguard children’s rights: Require adequate funding and accountability for EPSDT realignment*. Retrieved September 10, 2013 from http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/yln/2012/02/EPSDT-Realign-RevV21-FINAL_1_.pdf

- The least experienced providers are providing services to the most complicated children with diverse clinical needs due to the low reimbursement rates.

One study by the National Institute of Mental Health found that nearly half (47.9 percent) of youth in foster care were determined to have clinically significant emotional or behavioral problems. Researchers at Casey Family Programs estimate that between one-half and three-fourths of children entering foster care exhibit behavioral or social competency problems that warrant mental health services.⁷ These children often find permanent families through adoption (ranging between 51,000 and 57,000 children each year). Adoptive families are 2 to 5 times more likely to utilize outpatient mental health services, and 4 to 7 times more likely to seek care for their children in residential treatment centers.⁸

In a most recent report, clinical program directors from 59 residential treatment facilities responded to an online survey addressing the representation of adopted youth currently being served by their organization, the extent to which adoption issues are incorporated into clinical intake and treatment processes, and the training needs of clinical staff related to adoption. Results indicated that adopted youth are disproportionately represented in these programs. Although constituting slightly more than 2 percent of the U.S. child population, 25–30 percent of youth currently enrolled in these programs were adopted. The report concluded that to meet the needs of adopted youth in care, clinical and administrative staff of residential treatment programs need to become adoption clinically competent.⁹

Recommendations

Prioritize Research on Mental Health Needs in Child Welfare and Adoptive Families

We applaud PCORI for funding research on children’s mental health. Recently, the U.S. Surgeon General’s Advisory on Protecting Youth Mental Health outlined steps to support the mental health needs of youth involved in the child welfare system.¹⁰ This followed pediatricians, child and adolescent psychiatrists and children’s hospitals declaring a National State of Emergency in Children’s Mental Health.¹¹

⁷ Landsverk, J. A., Burns, B. J., Stambaugh, L. F. & Rolls Reutz, J. A. (2006). Mental health care for children and adolescents in foster care: Review of research literature. *Casey Family Programs*. 9-30.

⁸ Smith, S. L. (2014, March). Keeping the promise: The case for adoption support and preservation. Donaldson Adoption Institute. Retrieved February 24, 2016, from <http://adoptioninstitute.org/publications/keeping-the-promise-the-case-for-adoption-support-and-preservation/>

⁹ See <http://dx.doi.org/10.1080/0886571X.2016.1175993>

¹⁰ See <https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html>

¹¹ See <https://publications.aap.org/aapnews/news/17718?autologincheck=redirected>

As the CEO of the Center for Adoption Support and Education (C.A.S.E.), I could not agree more that we are facing a crisis. COVID-19 brought a devastating impact on children that came into this pandemic with a history of trauma, loss and grief exacerbated by fear of the pandemic itself, more loss and the reality of isolation from peers, teachers, extended family and other significant supports in their lives. Our caseloads, like others, have exploded with youth and families in crisis. The Surgeon General's report and the emergency declaration must be a call to action to advance real, tangible solutions for populations most at risk – children in foster, adoptive and guardianship families.

During a national emergency in child and adolescent mental health, we should be prioritizing research that tests the comparative clinical effectiveness of strategies to address the crisis for our most vulnerable children – those that have a history of loss and grief. Comparing the efficacy of programs delivered by adoption competent therapists who understand separation and loss is critical to address the mental health challenges in this population. On the mental health side, we have found that clinicians did not understand the core concepts of attachment nor the impact of race and diversity but showed significant gains following completion of NTI Training. Today, over 20,000 child welfare and mental health providers have enrolled in NTI but we still have a long way to go.

Imagine the problems that arise from child welfare workers not being able to support children in their healing from profound loss and grief and then referring them to therapists that do not know how to promote attachment or understand the implications of transracial/transcultural adoption. We will continue to face poor outcomes if providers serving these children and youth do not acquire the foundational knowledge required to address their mental health needs. The pediatricians, psychiatrists and children's hospitals that declared a mental health emergency need to see the appropriate comparative clinical effectiveness research that guides their investments in effective professional training and programs that demonstrate they are delivering children in crisis the care they need.

Incorporate Demographic Questions Identifying Research Participants Experiencing Foster Care, Kinship Care and Adoption

We are concerned that children experiencing foster care, kinship care and adoption are not identified as a population requiring specialized mental health services, like veterans or those with substance abuse challenges. While our own research and experience demonstrates that children who have experienced foster care, kinship care or adoption are disproportionately represented in high levels of mental health care, there are few studies that identify a research participant's experience with separation from their birth family as a characteristic that may define their outcomes from treatment. We strongly support, as a matter of protocol, PCORI-funded research including the following demographic questions in any study related to mental health:

“Are you adopted, have you ever spent time in foster care or were you primarily raised by relatives?”

By including this question in studies comparing the effectiveness of mental health treatments and services, the differential impact on subpopulations of people that experienced the loss and grief of separation from a birth family will be appropriately captured. Based on our experience, we believe that any mental health study seeking to understand outcomes that matter to patients should identify people experiencing foster care, kinship care and adoption as a specified subpopulation.

Partner with the Administration on Children and Families

We believe that a strong partnership between PCORI and the Administration on Children and Families (ACF) will be important as the agency seeks to allocate resources to programs that are most effective in addressing the mental health needs of children in the child welfare system. For example, the Children’s Bureau of ACF leads the *National Adoption Competency Mental Health Training Initiative (NTI)*. Also, Congress recognized the need for a focus on mental health across child welfare systems when it passed the Family First Act. For programs such as NTI to achieve recognition as “evidence-based” requires research that demonstrates the effectiveness of adoption competent clinicians in achieving mental health outcomes that matter to children in the child welfare system, particularly in achieving permanency in a foster, kinship or adoptive family.

I look forward to PCORI continuing to fund mental health studies and hope that PCORI will target its funding to studies that seek to demonstrate the importance of the competency of mental health professionals and the types of programs that are most beneficial for children in the child welfare system. Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in cursive script that reads "Debbie B. Riley".

Debbie B. Riley LCMFT, CEO
Center for Adoption Support and Education