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Testimony of Debbie Riley

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U.S. House Committee on Ways and Means

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I appreciate this opportunity to submit written testimony for the Hearing on America's Mental Health Crisis held on February 2, 2022. My name is Debbie Riley, LCMFT, and I am the Chief Executive Officer of the Center for Adoption Support and Education (C.A.S.E.). 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 of the children's mental health crisis that is occurring in our country. In December, the U.S. Surgeon General released an advisory on Protecting youth Mental Health that outlined steps to support the mental health needs of youth involved in the child welfare system. This followed pediatricians, child and adolescent psychiatrists and children's hospitals declaring a National State of Emergency in Children's Mental Health. 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 for Congress to advance real, tangible solutions for populations most at risk – children in foster, adoptive and guardianship families.

First, please know we strongly support efforts to provide additional resources to ensure a seamless transition to the Families First Prevention Services Act so that all children and families can maximize the law's full potential. However, being on the front lines of this work to create forever families, it is vital to recognize that no program can truly be delivered effectively without a competent workforce that understands the unique needs of foster and adopted children and families. At the time of passage of the Families First Act, we were assured that building an

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adoption-competent workforce would be a priority to ensure that professionals serving children and families in need were appropriately trained. 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 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 parents may place their children in residential treatment facilities and/or wilderness programs — choices they make when they lack access to the appropriate resources.

We are frustrated that Families First has not prioritized improving the competency of the child welfare workforce. For programs to be covered under the Act, the Title IV-E Prevention Services Clearinghouse established by the Administration for Children and Families (ACF) must rate programs and services as promising, supported, and well-supported practices, including mental health. After a decades-long push to commit to the mental health needs of children and families adopted and in foster care, Families First was a leap forward to ensure the delivery of much-needed mental health services when children are most at risk. Yet, despite going through the steps required for coverage, the Training for Adoption Competency (TAC) has not had its application reviewed. It was submitted October 30, 2019 —over two years ago.

Prior to developing 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).

¹ Atkinson & Gonet, 2007; Smith, 2014, Brodzinsky, 2013

² Casey Center for Effective Child Welfare Practice, 2003

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

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.

C.A.S.E. received accreditation of its TAC curriculum 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 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-master's 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.

Congress should direct the Title IV-E Prevention Services Clearinghouse to prioritize mental health: The Clearinghouse established by the Administration for Children and Families (ACF) must rate programs and services as promising, supported, and well-supported practices. Training for Adoption Competency should be a priority to ensure that the workforce delivering these programs are competent and have the knowledge needed to appropriately serve foster and adoptive families.

Second, The National Adoption Competency Mental Health Training Initiative should be the Standard of Care for the workforce serving foster, adoptive, and kinship families. The National Adoption Competency Mental Health Training Initiative (NTI), a cooperative agreement between the Children's Bureau, Office of Administration for Children and Families 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. 85 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 Senate version of the legislation reauthorizing CAPTA includes a new provision within Adoption Opportunities that supports the mission of the National Adoption Competency Mental Health Training Initiative. It states “adoption competency training that supports the mental health needs of adoptive families to promote permanency, including the evaluation and updating of adoption competency training curricula for child welfare and mental health professionals.” We strongly support this new authority to ensure the curriculums developed for child welfare caseworkers and mental health professionals are standardized across states and represent best practices and up-to-date knowledge essential for professionals serving foster youth to have the core competencies needed to achieve permanency.

Congress should pass legislation as part of CAPTA reauthorization that explicitly authorizes the Adoption Opportunities program to focus efforts on adoption competency training that supports the mental health needs of adoptive families to promote permanency. This includes the evaluation and updating of adoption competency training curricula for child welfare and mental health professionals. We support the language included in the Managers Amendment to S. 1927 CAPTA Reauthorization Act of 2021.

Additionally, 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 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

We urge consideration of a pilot or demonstration project in a specified number of states/counties to enroll a target number of adoption-competent clinicians (defined as successful graduates of nationally recognized adoption-competent post graduate training programs that include a clinical case consultation component) as EPSDT clinical providers. Using random assignment of children, CMMI could evaluate the mental health outcomes for children in foster care with adoption goals who are served by these adoption-competent clinicians through EPSDT and those who are not. In certain states, C.A.S.E. has built a workforce of adoption-competent clinicians that could form the basis for this type of demonstration.

We also urge the use of identified valid and reliable clinical screening and testing tools for designated conditions present in children in foster care, including those with adoption goals (such as attachment disorders, PTSD, developmental trauma) in conjunction with adoption-competent clinical interventions by adoption-competent clinicians. The primary focus would be on (1) children in foster care being prepared for adoption; and (2) children adopted from foster care receiving adoption assistance and Medicaid coverage.

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 TAC. As policymakers seek

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

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.

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

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 they may suffer from conditions 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."

We believe that this report underscores an inherent and fundamental challenge in our Medicaid system around access to adoption-competent mental health services.

We urge Congress to consider developing a pilot or demonstration project in a certain number of states/counties in which selected children in foster care with an adoption goal (experimental group) are assigned a treatment team consisting of a psychiatrist and an adoption-competent clinician who coordinate clinical care for the child. CMMI would then assess the impact on the usage levels of psychotropic medications as compared to children in foster care who do not have this treatment team (comparison group).

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 accreditation/ 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

- 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). According to some reports, the percentage of adopted children in residential treatment centers is reported to be between 30 and 40 percent and is even higher in centers specializing in attachment disorder treatment and developmental trauma treatment. 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

We recommend that higher reimbursement rates through Medicaid and private insurance be provided for mental health providers who complete the 72-hour accreditation program through *Training for Adoption Competency*. This would create an incentive for clinicians who work with the child welfare/adoption community to be adoption-competent and would

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/EPSTDT-Realign-RevV21-FINAL_1_.pdf

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>


create an incentive for highly trained, adoption- competent clinicians to accept Medicaid rates.

In general, C.A.S.E. recommends a stronger research focus on the impact of integrated care models on achieving positive mental health outcomes for children in foster care and children and youth adopted from the foster care system. Studies indicate that continuous mental health treatment is beneficial for children with histories of maltreatment and foster care.¹⁰ Medicaid managed care organizations (MCO's) with adequate networks of adoption-competent mental health professionals, could demonstrate more positive outcomes for foster youth. Therefore, we suggest reforms that will enhance the positive outcomes for children and youth in foster care and those adopted from foster care, the majority of whom are Medicaid eligible.

I look forward to working with Congress on improving access to, and quality of, the mental health services provided to children in foster care and those in adoptive families. Innovative strategies to improve the lives of our most vulnerable children should not be delayed. C.A.S.E. has already begun the process of developing the adoption-competent workforce through its existing TAC program and the continuing cooperative agreement with ACF on the National Adoption Competency Mental Health Training Initiative as well as direct services in Maryland, Virginia, and Washington, D.C. Now is the time to take action to ensure the continued building of an adoption-competent workforce and formalized network of those providers who can be connected to foster and adoptive families. The good news is that we have existing innovative training programs ready to bolster the competency of the child welfare and mental health workforce nationally. Together we can connect this underrepresented population to providers trained to meet their needs.

I appreciate the opportunity to provide this testimony.

Sincerely,



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¹⁰ Child Welfare Information Gateway. (2012). *Mental health*. Retrieved September 10, 2013, from <https://www.childwelfare.gov/systemwide/mentalhealth/>