June 15, 2022

Sandra Jo Wilson
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Dear Ms. Wilson:

We are writing to inquire about our submissions of the Training for Adoption Competency (TAC) for review in the Title IV-E Prevention Services Clearinghouse. It was first submitted on October 30, 2019 – over two and a half years ago – by Rebecca Jones Gaston, the then Executive Director of Social Services Administration in Maryland. We understand the application was received, but the program has not been reviewed. TAC was resubmitted on December 17, 2021, following the public call for programs and services by the Clearinghouse. Again, our application was received but has not been reviewed. The following host sites have supported our resubmission of our application with letters: Children's Home Society of North Carolina, Foster & Adoptive, Foster & Adoptive Care Coalition (Missouri), Family Hope House (Oklahoma), Oregon Department of Human Services, Lutheran Family Services (Nebraska), and OhioKAN (Ohio)**.** We have not received any tangible feedback for the curriculum developers or related to our supported studies, as is indicated to be the process outlined by the Clearinghouse.[1] Therefore, we are requesting consideration and feedback from the Clearinghouse.

Adoptive Children at Risk of Entering Foster Care Due to Dissolution Require Quality Mental Health Services

Adoptive families often report that outpatient services and, in some cases, inpatient services are not effective 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 inadequate or even harmful interventions, utilized by untrained therapists that further exacerbated the underlying problems.

Adoptive parents consistently report that their greatest post-adoption support need is mental health services provided by someone who knows about 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 and stability and permanency of the placement. In a national survey of 485 individuals conducted by C.A.S.E., only 25

[1] See https://preventionservices.acf.hhs.gov/sites/default/files/Factsheet_The%20Review%20Process_April%202022.PDF

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.[2]

The Family First Title IV-E Prevention Services Clearinghouse is Not Supporting a Trained Workforce to Mitigate Risk by Addressing Mental Health

We strongly supported 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.[3] 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 mental health needs of foster and adopted children and families. At the time of passage of the Families First Act, we were assured that building an adoption-competent workforce would be a priority to ensure that professionals serving children and families in need were appropriately trained. As mentioned above, adoptive parents consistently report that their greatest post-adoption support need is mental health services provided by someone who understands adoption[4]. 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 reviewing programs to improve the competency of the child welfare and mental health workforce beyond the utilization of evidenced based practices which have not been studied on this population. 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

[2] See http://cascw.umn.edu/wp-content/uploads/2014/04/AdoptionDissolutionReport.pdf
[3] See https://thehill.com/opinion/letters/297146-adoption-competent-mental-health-services-can-make-all-the-difference/
[4] Atkinson & Gonet, 2007; Smith, 2014, Brodzinsky, 2013 2 Casey Center for Effective Child Welfare Practice, 2003

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, TAC has not had its application reviewed. It was submitted October 30, 2019 — almost 3 years ago.

C.A.S.E. received accreditation of 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. In 2019 TAC was rated ion 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.[5]

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. This study was included in our second submission in December 2021.

The Cost of Doing Nothing

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 the Clearinghouse to review Mental Health Prevention and Treatment Programs and Services for populations most at risk – children in foster, adoptive and guardianship families.

This May, USA TODAY launched a series of stories regarding failed adoptions, the majority from foster care. They found a staggering 66,000 adoptions had failed, and the children returned to foster care from

[5] See https://www.cebc4cw.org/program/training-for-adoption-competency-tac/

2008 to 2020.[6] This number represents the low end of the spectrum since some cases were left out to avoid the risk of overcounting. USA TODAY pulled data from all 50 states and the federal government. In addition, they also interviewed 100 people that were involved in the adoption process from adoptees, birth parents, adoptive parents, researchers, government officials, etc. The three biggest predictors of failed adoptions are age, race, and mental health. Sixty percent of the children that entered foster care after a dissolved adoption were because of a child's disability/behavioral problems, abandonment, or the family's inability to cope. Further, the article goes on to state that sometimes a child reentering foster care was the only way to get the mental health services they needed. From 2020 to 2021, Think of Us gathered data on 27,000 current and former foster youth. This data revealed that the children that returned to foster care after being adopted had worse outcomes than their foster care counterparts.[7]

Once children reenter care, 40% of the cases analyzed by USA TODAY resided in group homes or congregate care facilities. These placements can cost over $15,000 a month, not to mention the mental, psychological, and physical abuse that occurs in these facilities. In a Florida Department of Children and Families survey families stated that "access to and assistance with post-adoption services were top areas needing improvement." This further proves that we must invest in Post Adoption Services to train the workforce to work with children that have been separated from their family of origin. Mental health support services often end once an adoption is finalized, however children and families need ongoing support.[5]

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.*
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> *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*

[6] See https://www.msn.com/en-us/news/us/far-from-the-fairy-tale-broken-adoptions-shatter-promises-to-66000-kids-in-the-us/ar-AAXsrQk?ocid=uxbndlbing
[7] See https://www.thinkof-us.org/blog/our-lived-experience-network-in-action

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.[8]

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.[9] 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.[10]

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 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."[11] This report underscores an inherent and fundamental challenge in our Medicaid system around access to adoption-competent mental health services.

In addition, children and youth in foster care and adopted from foster care face several challenges with the Medicaid system creating barriers to adoption competent mental health care:

- 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

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[8] 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

[9] Conrad N. Hilton Foundation. (2011). Hilton Foundation funds groundbreaking study on outcomes among youth in both foster care and juvenile justice systems. Retrieved June 10, 2022 from https://www.hiltonfoundation.org/wp-content/uploads/2019/10/Young_Adult_Outcomes_of_Youth_Exiting_Fact_Sheet-3.pdf

[10] Center for Children and Youth Justice. (2012). Facts about child welfare and juvenile justice in Washington State. Retrieved September 10, 2013 from http://www.ccyj.org/uploads/publications/Issues%20fact%20sheet-rev.pdf

[11] See https://www.gao.gov/assets/gao-13-15.pdf

shortfalls, there is concern that states may opt to eliminate any optional services that they are currently covering.

- The Early and Periodic Screening, Diagnosis and Treatment (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.[12]
- 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.[13] 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.[14]

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.[15]

TAC meets the criteria for review by the Title IV-E Prevention Services Clearinghouse

TAC meets the criteria for review by the Title IV-E Prevention Services Clearinghouse. Yet, we believe that the Clearinghouse's interpretation of the law is not inclusive of the training programs for the workforce that is clearly defined in the Families First Prevention Services Act law. The statute states "(ii) 50 percent of so much of the expenditures with respect to the provision of services and programs specified in section 471(e)(1) as are for training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision and of the members of the staff of State-licensed or State-approved child welfare agencies providing services to

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[12] 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-Reallign-RevV21-FINAL_1_.pdf

[13] 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.

[14] 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/

[15] See http://dx.doi.org/10.1080/0886571X.2016.1175993

children described in section 471(e)(2) and their parents or kin caregivers, including on how to determine who are individuals eligible for the services or programs, how to identify and provide appropriate services and programs, and how to oversee and evaluate the ongoing appropriateness of the services and programs."[16]

The guidelines set by the Clearinghouse for Mental Health Prevention and Treatment Programs and Services state, "Eligible mental health programs and services include those that aim to reduce or eliminate behavioral and emotional disorders or risk for such disorders. Included programs and services may target any mental health issue. It is not required that participants in the program or service have a Diagnostic and Statistical Manual (DSM) or International Statistical Classification of Diseases (ICD) diagnosis. Eligible programs and services can be delivered to children and youth, adults, or families; can employ any therapeutic modality, including individual, family, or group; and, may have any therapeutic orientation, such as cognitive, cognitive-behavioral, psychodynamic, structural, narrative, etc. Programs and services that rely on psychotropic medications or screening procedures without a counseling or behavioral therapeutic component are not eligible (e.g., a treatment that uses methylphenidate or lisdexamfetamine for treatment of Attention Deficit Hyperactivity Disorder without an accompanying therapeutic element)."[17]

To date, the Clearinghouse has only reviewed programs and services that directly serve children, youth, and families. However, our program trains mental health professionals to directly serve children, youth, and families impacted by the child welfare system. We fit into the target outcomes of Adult Well-being specifically Parenting Practices as our comparative outcomes study has shown that clients that received services from TAC trained professionals had a higher presence of parental skills development than clients served by non-TAC trained professionals. Additionally, Family Cohesion and Attunement, Communicative Openness, as well as Parent Support and Self Care all had higher mean scale scores for families served by TAC trained clinicians. Although TAC is not directly provided to families, TAC is a training directed to the mental health workforce to competently serve the foster care, adoption, and kinship network. The TAC outcomes comparison study clearly shows that families that are served by TAC-trained clinicians have better overall outcomes than families that are served by similarly educated mental health professionals that have not been TAC trained. **The Congressional intent of the legislation for the Clearinghouse does not appear to be aligned with the standards set by the Clearinghouse and must be addressed to fully meet the mental health needs of those served by the child welfare system.**

For over a decade, TAC has proven to be a valid replicable model with licensed partner agencies in 17 states: Children's Aid Society of Alabama (Alabama), Lilliput/Wayfinder Family Services (California), UConn Health Adoption Assistance Program (Connecticut), C.A.S.E. in collaboration with Selfless Love Foundation (Florida), Georgia Division of Family Services/Georgia State University (Georgia), The Villages of Indiana (Indiana), Four Oaks (Iowa), Louisiana Department of Children and Families (Louisiana),), Foster and Adoptive Care Coalition (Missouri), Lutheran Family Services (Nebraska), C.A.S.E. in collaboration with Adoption and Foster Care Coalition of New York (New York), Children's Home Society of North Carolina and Catawba County Social Services (North Carolina), OHIOKAN (Ohio), Family Hope House (Oklahoma), Oregon Department of Human Services (Oregon), Voce (Pennsylvania), and University of Wisconsin-Milwaukee Helen Bader School of Social Work (Wisconsin). All licensed agencies sign a site agreement and comply with the TAC rigorous

[16] Public Law 115–123, Feb. 9, 2018. See https://www.congress.gov/bill/115th-congress/house-bill/1892/text?q=%7B%22search%22%3A%5B%22hr1892%22%5D%7D&r=1

[17] See https://preventionservices.acf.hhs.gov/sites/default/files/Factsheet_The%20Review%20Process_April%202022.PDF

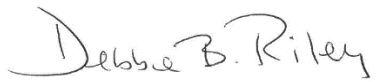
evaluation/quality assurance standards. TAC partner organizations receive a New Site Onboarding Guide, An Evaluation Replication Guide, and the Participant Manual. Trainers must meet prescribed qualifications, participate in a week-long Trainer Orientation, and participate in ongoing post-session debriefing calls. TAC Facilitators receive the slide presentation and Facilitator Guides for each module that contain a script and detailed guidance on delivery of the curriculum with a requirement of the sites to conduct fidelity observations during the delivery of the curriculum to ensure compliance. A protocol is followed in debriefing calls with trainers during which participant and trainer feedback and fidelity observation reports are reviewed. All TAC participants receive Participant Guides for each module, which include all module slide presentations and handouts. All materials are accessed through the C.A.S.E Institute Learning Management System, which tracks users and completion of the training and the TAC final assessment.

The TAC Replication Evaluation Guide details procedures for the program's ongoing evaluation that assesses program delivery, outcomes, and effectiveness. The evaluation was designed by and is being conducted by PolicyWorks, Ltd., an independent external evaluator. All sites are required to adhere to this evaluation protocol. To date more than 2,100 graduates have been trained across these 16 sites with evaluation reports showing significant results, including the most recent findings from our July 2021 report of training participants:

- On TAC pre- and post-tests, TAC participants experienced an average gain in scores of 38 points.
- All TAC participants to date report change in at least two of the six defined aspects of practice.
- 78.43 percent report change in all five aspects at the individual clinician level, a substantial increase from the prior reports of 67 percent; and
- 62.27 percent report change in procedures, programming and/or services at the organizational level, a three percent increase over past reports.

We are aware that Clearinghouse staff log and review all programs and service recommendations. It has now been almost 3 years since our original submission with no review. We are requesting a formal response regarding the status of this program's review. While we support the review of evidence-based interventions, these do not replace the need for comprehensive training around the unique needs of this population. Evidence Based Practices alone cannot mitigate the poor outcomes without the foundation and core competencies that the TAC provides. Innovative strategies to improve the lives of our most vulnerable children should not be delayed. 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 Clearinghouse reviewing TAC would create a pathway for so many at risk children and families involved in the child welfare system to access quality mental health services.

Sincerely,



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