C.A.S.E. *the nonprofit* **CENTER FOR ADOPTION SUPPORT AND EDUCATION** *since 1998*

September 16, 2013

Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen
Washington, DC 20510

Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
219 Dirksen
Washington, DC 20510

Re: Improving mental health services for foster and adoptive families

Dear Chairman Baucus and Ranking Member Hatch:

The Center for Adoption Support and Education (C.A.S.E.) is pleased to respond to the Senate Finance Committee's request for suggestions on how to improve mental health services. As Chief Executive Officer of C.A.S.E., I was very happy to participate on the Roundtable discussion related to psychotropic drug use in foster care, which has significant implications for children adopted from the foster care system as well. I continue to believe that one of the driving forces behind over-use of these medications is a lack of adoptive families' access to adoption competent mental health services. We greatly appreciate the opportunity that the Senate Finance Committee, with primary jurisdiction over both child welfare and Medicaid, has provided the field the opportunity to identify the most significant barriers to quality mental health care and to make suggestions as how these barriers can be addressed through thoughtful and deliberative policy changes.

C.A.S.E. was created in May 1998, to provide pre and post-adoption counseling and educational services to families, educators, child welfare staff, and mental health providers in Maryland, Northern Virginia, and Washington, D.C. In addition, C.A.S.E. is a national resource for families and professionals through its training, publications, and consultations. From this experience, C.A.S.E. has a unique perspective on how the mental health care system can and should better address the mental health needs of children in foster care and children who are adopted from the foster care system.

Underlying all of our recommendations below are (1) the need for a trained, highly qualified mental health workforce to serve the nation's young people with foster care experiences and

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(2) foster and adoptive families' needs to both identify and affordably access mental health professionals that are trained to meet their unique needs.

The Need for Specialized Adoption Competent Training for Mental Health Practitioners

The need for specialized adoption competent training for mental health practitioners is clear. It is important to note that the term "adoption competent" does not limit the scope of adoption competency training for mental health professionals to serving adoptive families as the knowledge, values and skills that evidence-informed training programs teach are equally applicable in serving children and youth in foster care and with kinship families. "Adoption competent" is a term of art used in the field of mental health services to designate a clinical provider with specialized expertise in working with children with child maltreatment, foster care and adoption histories. The term reflects the child welfare system's goal to achieve permanent families for all children in foster care, including the 376,000 children adopted from foster care since FY 2004.

The Child Welfare League of America reports, "Approximately 60 percent of all children in out-of-home care have moderate to severe mental health problems [...] Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders than those living with their own families." 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 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.

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 at C.A.S.E. routinely. Adoptive and foster families often come to us after seeing multiple therapists who are not adoption competent, making our job more difficult as we address both the core issues of the underlying trauma and the impact of behavior modification and other techniques utilized by earlier therapists that further added 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 and the lack of access to adoption competent mental health services in particular 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.

The majority of 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 they were of the opinion that 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. 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.

The Lack of Quality Mental Health Services for Dually-Involved Youth

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 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.[1]

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 serious mental health problems, more than double the rates of those who were in foster care only.[2] 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.[3]

Meeting the Need for Adoption Competent Mental Health Services: Training for Adoption Competency

To address the significant needs of adoptive and foster families, C.A.S.E. has developed the standardized, manualized Training for Adoption Competency (TAC), an evidence-informed, intensive, post-graduate training program for clinicians. With the support of major national foundations – the Freddie Mac Foundation, the Dave Thomas Foundation for Adoption, the W.W. Kellogg Foundation, and the Annie E. Casey Foundation – C.A.S.E. developed the 78-hour training and case consultation program for licensed mental health professionals in order to expand community capacity to provide adoption competent clinical services. The TAC is currently being implemented in 9 sites across the country, including five of the national Wendy's Wonderful Kids (WWK) sites.

Prior to developing the TAC, C.A.S.E. convened nationally recognized experts – 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

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[1] 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

[2] Conrad N. Hilton Foundation. (2011). Hilton Foundation funds groundbreaking study on outcomes among youth in both foster care and juvenile justice systems. Retrieved September 10, 2013 from http://www.hiltonfoundation.org/foster-care-and-juvenile-justice

[3] 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

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.

Using this definition of an adoption competent mental health professional and 18 consensus-defined adoption competencies, C.A.S.E. developed the TAC to train clinicians in adoption-specific issues and interventions and build community capacity across the United States to provide adoption competent mental health services.

C.A.S.E. also has charted new territory in examining the feasibility of a national certification program for adoption competent clinicians. Recognizing that consumers often rely on objective external assessments regarding the credentials of mental health professionals whom they consult (through licensing, board certification or other means), C.A.S.E. has undertaken a broad-based feasibility study regarding such a national certification, consulting with stakeholders across the country. Currently, C.A.S.E. is developing a business plan to guide the implementation of a national credential specifically for adoption competent mental health professionals.

C.A.S.E.'s Responses to the Senate Finance Committee's Questions

In light of the burdens placed on adoptive, foster and kinship families as well as on the child welfare systems to access quality adoption competent mental health services, C.A.S.E. appreciates the opportunity to respond to the Senate Finance Committee's questions:

1. *What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?*

Our focus is on Medicaid as it is the primary health care coverage for children in foster care and for children adopted from foster 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 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% of California children who enter foster care receive the medically necessary mental health services to which they are entitled. Treatment rates range from 6% in some counties to 30% in others, and from 7% to 19% among the state's largest counties.[4]

2. *What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?*

We recommend 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

[4] 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

children with histories of maltreatment and foster care.[5] 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 propose the following reforms to enhance the positive outcomes for children and youth in foster care and those adopted from foster care, the majority of whom are Medicaid eligible:

Promote 1915(b) Managed Care Waivers to Provide Adoption Competent Services in Foster Care

A few states (Virginia, Wisconsin, Kentucky, and New Jersey) have begun to serve children in foster care through Medicaid managed care organizations (MCO's). Unfortunately, there are limited data to demonstrate the overall effectiveness of MCO's on children's mental health. However, because MCO's create provider networks that must meet access standards, provider credentialing requirements and practice standards, there are significant opportunities to assess the mental health outcomes for children served by providers who have met strict credentialing requirements. There are significant downstream cost savings inherent in providing foster and adoptive families with adoption competent mental health services, and, as a result, managed care could be a favorable alternative for families seeking adoption competent services. Yet, for MCO's to be able to provide an adequate network of adoption competent mental health professionals, there must exist a trained workforce to meet that need. Therefore, we recommend that as part of any waiver application to cover children in foster care under MCO's, the state applicant be required to demonstrate workforce adequacy to meet children's mental health needs or specify the state's plan to develop adoption competency clinical capacity.

A positive example is Catawba County, North Carolina. In Catawba County, licensed mental health professionals seeking to treat children in foster care/adopted from foster care are required to successfully complete the Training for Adoption Competency (TAC) which the county offers in partnership with C.A.S.E. Similarly, MCO's could develop credentialing requirements regarding successful completion of evidence-informed adoption competency training for providers seeking to join the MCO network.

We strongly recommend, as the Senate Finance Committee explores the potential of integrated care within the Medicaid system to serve foster families and those adopting children from the foster care system, that the Committee take a leadership role in ensuring that states take advantage of the tools provided by the Fostering Connections to Success and Increasing Adoptions Act of 2008 to train an adoption competent workforce, as discussed below.

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

3. *How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?*

With a focus on Medicaid, C.A.S.E. strongly recommends that the Senate Finance Committee give special attention to the mental health needs of children in foster care/adopted from foster care and the needs of their foster, adoptive, and kinship families. Given the disproportionately high rate of mental and behavioral health needs among these children, action is needed to improve their well-being (an outcome mandated by the Adoption and Safe Families Act of 1997) and to support the stability of their foster, adoptive and guardianship families. Such action would reduce costs associated with long term stays in residential treatment facilities and juvenile justice and adult criminal justice costs.

Congress should urge the Administration for Children and Families (ACF) to provide clear guidance to state child welfare agencies on allowable uses of Title IV-E funds to train mental health professionals working in private child welfare agencies.

Building the capacity for a network of adoption competent mental health providers in each state is not only possible, but is facilitated by the availability of federal training funds. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCA) recognized the importance of a quality workforce to children's well-being and the role of training in developing and sustaining a qualified workforce. Under section 474 (a)(3)(B) of the Act, federal financial participation is available at 75 percent "...for the short-term training of current or prospective foster or adoptive parents and the members of the *staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part*, in ways that increase the ability of such current or prospective parents, *staff members*, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract." [italics added].

To date, many states have evidenced confusion about the allowable use of training funds under the FCA training extension. They have been reluctant to offer adoption competency training – including the TAC -- for staff in private child welfare agencies with the support of Title IV-E funding. It is important to know that the TAC is being implemented in Minnesota through the Center for Advanced Child Welfare Practice (CACWP) at the University of Minnesota which has a Title IV-E training contract with the State of Minnesota. The CACWP worked with C.A.S.E. in developing an analysis of the TAC's content in relation to Title IV-E allowable training topics and then submitted the analysis to the State, which reviewed it and accepted/approved it within the contract with the CACWP. The State will include the TAC in the State Training Plan for submission to the federal Region V Office. We have continued to urge ACF to share this best practice from Minnesota with other states to provide a clear example of how the FCA expanded training provision can be implemented to provide higher quality mental health services to children in foster care and to children adopted from foster care and their families.

Congress should develop a specialized Medicaid waiver program to test different models of mental/behavioral service delivery for children in foster care, children adopted from foster care, and children placed in permanent relative guardianship post-foster care.

It can be expected that adoption competent mental health services will be effective in mitigating the costs of higher levels of care (particularly inpatient psychiatric care) for this child population. We recommend that Congress develop a specialized Medicaid waiver permitting states to compare the use of adoption competent clinicians with usual clinical care to demonstrate the difference in outcomes and overall costs, considering specifically the reduced use of psychotropic medications and lower utilization of higher levels of care such as residential treatment. We also strongly recommend the design of a cost-benefit analysis to include interactions with the juvenile justice system.

Wisconsin is implementing a waiver that allows children in foster care and adopted from foster care to receive continuous competent clinical services through the Medicaid system. The State of Wisconsin offers a good example of how a waiver can also be tool for recruiting adoptive families:

> *A Wisconsin couple adopted a child with severe autism and shared their story. They had cared for Mathew for over three years prior to adopting him. As much as they loved Mathew, they had to think hard before committing to adopting him because his needs were intense...After the family fully understood that the waiver services would continue after the adoption and that additional waiver services would be available to Mathew as an adult, the family was able to feel confident about adopting Mathew and providing for all his needs.*

We urge Congress to create incentives for all states to provide similarly consistent clinical services, including adoption competent mental health services through Medicaid to children in foster care; children who leave foster care through adoption or guardianship and are eligible for Medicaid; and young people who are aging out of foster care.

We urge Congress to provide incentives for community mental health center-based clinicians to receive Training in Adoption Competency (TAC) with Medicaid funding to ensure that one or more clinicians in each site is adoption competent.

The Community Mental Health Centers Act provides for professional training for those working in community mental health centers. We recommend that Congress create incentives for community mental health centers to utilize in staff positions clinicians who are adoption competent. Doing so may require that the Senate Finance Committee and the Senate Health Education Labor and Pensions Committee to work together to develop guidance to the Substance Abuse and Mental Health Services Administration (SAMHSA). That guidance would be designed to increase the quality and availability of adoption competent mental health services through SAMHSA's existing programs for awarding grants that support the development of community-based services for children with mental health conditions, including children in foster care. Given that children in foster care/adopted from foster care are disproportionately represented in the mental health care system already, there is already existing need for adoption competent mental health professionals, and the demand for their services is likely to grow. A key component in building an adoption competent workforce can be achieved through ensuring that community mental health centers are staffed with adoption competent professionals.

C.A.S.E. thanks the Senate Finance Committee for this opportunity to provide suggestions on how to improve mental health services under Medicaid for children and youth in foster care, who are adopted from foster care and who leave care to permanent guardianship with relatives. We have made every effort to identify the most significant barriers to quality mental health care for this population of vulnerable children and strongly support the Committee's work in addressing these barriers through thoughtful and deliberative policy changes.

Sincerely,

Debbie Riley, LCMFT
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