Protecting Youth Mental Health:
Part II - Identifying and Addressing Barriers to Care
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Voice for Adoption (VFA) was established in 1996 to shape the public debate on permanency for children in the U.S. foster care system and the families who care for them. We advocate, educate, and collaborate with members of Congress, policymakers, partner organizations, agencies, and individuals to advance federal policies that promote and sustain permanence for children and youth in foster care. We envision a day when all children and youth in the U.S. foster care system will have a safe, loving, and supported permanent family through reunification, adoption, or guardianship.

In the federal fiscal year 2019, according to the Adoption and Foster Care Analysis and Reporting System (AFCARS), more than 66,000 children and teens were adopted from foster care in the U.S.—the highest number ever reported. The number of children waiting to be adopted has trended upward over the past five years, with 122,216 children in 2019 waiting to be adopted. Sadly, approximately 20,000 youth (ages 18 to 21) age out of the foster care system each year without a family.

The physical and mental health needs of children who have experienced abuse, neglect, trauma, and losses are significant. The State Policy Advocacy and Reform Center, in *Medicaid to 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care,* explains it: "Children who have been abused or neglected often experience a range of physical and mental health needs, physical disabilities and developmental delays, far greater than other high-risk populations. For example, foster children are more likely than other children who receive health coverage through Medicaid to experience emotional and psychological disorders and have more chronic medical problems."

Nearly 70 percent of children in foster care exhibit moderate to severe mental health problems and 40 to 60 percent are diagnosed with at least one psychiatric disorder. Lewis et al. explain, "Depression, reactive attachment disorders, acute stress responses, and post-traumatic stress disorders are some of the common mental health diagnoses of children in foster care." Researchers Kerker and Dore note that being taken into foster care compounds existing problems, "Although children frequently enter foster care with preexisting conditions that put them at high risk for mental health problems, . . . the very act of separating children from their biological family may affect children's mental health as well."

For many years, the conventional wisdom was that once children were adopted, any previous trauma a child experienced would be eliminated by joining a permanent family. Thus, it was generally assumed that once a child achieved legal permanence, their families would not need to seek services or support from the child welfare system. However, research has revealed that the trauma, abuse, and neglect children experience has serious, often lifelong repercussions. Childhood trauma and abuse affect brain development and have consequences throughout an individual's life. Among other things, complex trauma can affect children's ability to express and control emotions, concentrate, handle conflict, form healthy relationships, interpret social cues, and distinguish safe from threatening situations.

As a result, many children and families need help and support long after permanence has been obtained, including when children reach different milestones and experience transitions. In a longitudinal study of adopted children, Rosenthal found difficulties several years after adoption,

particularly in adolescence: “The study’s core finding — one that those in the special-needs adoption field know from their everyday practice experience — is that ‘problems’ in special needs adoption do not dissipate in a steady, predictable fashion. Instead, children and families continue to present complex challenges throughout the adoption. In particular, behavioral problems are quite persistent and may even intensify.”

The challenges for young people who leave care without permanency are even more significant since they don’t always have supportive, caring adults in their lives. Youth who leave foster care due to age continue to experience poor health outcomes into adulthood, including high rates of drug and alcohol use, unplanned pregnancies, and poor mental health outcomes. More than half of those who aged out of foster care report being uninsured. More than one-fifth report unmet needs for medical care—research findings from Chapin Hall at the University of Chicago highlight additional troubling statistics. One-third of youth aging out reported two or more emergency room visits in the past year, 22 percent were hospitalized at least once, three-quarters of young women had been pregnant, and 19 percent received mental or behavioral healthcare in the past year.

At this time, there is no single access point for children, youth, and parents dealing with serious mental health and substance abuse issues to access services, treatments, and support. Foster care, juvenile justice, and education appear to be the primary points of access for the child welfare community, frequently exacerbating or creating much more significant issues such as specific populations being disproportionately overrepresented. In contrast, others may be denied services and experience discrimination. This fragmented model of mental health care provides no room for accountability. Instead of addressing the failure to provide services, blame is often pushed to systems not designed to provide these services, like the three above. In the end, that accountability has to be placed on a mental health system whose responsibility it is to ensure access, quality, and oversight are provided.

Regardless of which agency has the responsibility to provide access and ensure treatment effectiveness, no child or family involved with the child welfare system, especially those taken into foster care and promised our government’s protections, should experience any form of abuse or neglect, including discrimination based on race, religion, sexual orientation, gender identity, or gender expression. The wellbeing of our children, especially the wellbeing of their mental and behavioral health, demand that we improve access and provide children and families with trauma-informed, evidence-based, mental and behavioral health systems with a single point of entry—creating a mental health system that can be held accountable for failures in treatment, but also responsible for ensuring that all services providers and treatment options promote racial equity, strive to block discrimination, and dismantle system racism - ensure that mental health of those impacted by the System is preserved and nurtured and reduce trauma rather than inflict it.

Given the body of scientific evidence regarding the long-term effects of trauma on child development, child welfare, and behavioral health, systems must ensure they offer children and families a robust array of mental health and other post-permanency support and services.

VFA is pleased to provide recommendations to the Senate Finance Committee and welcomes opportunities to meet with committee members to discuss our requests further.

Fund Post-Permanency Support Services

- **Congress should require and fund a core set of support services for children and families exiting foster care to a permanent family, with such services to include trauma-informed and permanency-competent mental and behavioral health services.**

As noted above, research on the short- and long-term impact of trauma has revealed that many children and families need support long after legal adoption or guardianship has been obtained, including when children reach different milestones and experience transitions. As a result, child welfare systems must make a comprehensive array of services available to adoptive and guardianship families, including critical mental health services. These services must be available when needed and without waiting times and responsive to the needs of each family; a "one size fits all" approach is not acceptable. Importantly, professionals must deliver them with the expertise and training to meet adoptive and guardianship families' unique needs. Delay of services and inadequately trained mental health providers can exacerbate family problems and ultimately disrupt a child's adoption or guardianship placement.

State, local, and tribal child welfare systems need to have federal guidance and funding so they can fully develop and maintain comprehensive and responsive post-permanency services. Several states, including Tennessee, Alabama, and Illinois, provide a model of providing comprehensive, in-home mental health services to adoptive or guardian families.

Improving Access for Children and Young People

- **Congress should maintain access to Medicaid for youth who age out of foster care up until age 26 and assure this coverage extends across state lines when a young person moves to a new state. This requirement should take effect immediately rather than in 2023 as currently written.**

- **Congress should protect this Medicaid benefit in every state by precluding work requirements for youth who have experienced foster care.**

- **Congress should extend access to Medicaid to children who leave foster care to adoption and guardianship, just as it extends the benefit to those who emancipate from care.**

More than 20,000 youth age out of the foster care system every year. Statistics about their uncertain futures are dire, and the lifetime societal costs are astronomical. The Affordable Care Act (ACA) is a critical lifeline for these youth. As a result of the ACA, young people who aged out of care without a permanent family can remain on Medicaid until age 26, just as other young people can stay on their parent's health care plans. The Congressional Research Service reported that in 2015, 70 percent of 21-year-olds who had aged out of care were on Medicaid, showing how necessary this provision is to this population.

For those who age out of care or who exit to adoption or guardianship, access to Medicaid is a critically important way to meet the lifelong, significant mental health, substance use, and behavioral health care needs of young people who have experienced abuse and neglect and the challenges of separation from their birth parents. Losing coverage at age 18, when so many other transitions and changes are happening, is particularly risky for this population with a much higher rate of mental and behavioral health challenges.

Strengthening Workforce

Congress should:

- **Support the expansion of adoption-competency training for mental health providers and caseworkers and encourage their participation by providing ongoing funding to the National Adoption Competency Mental Health Training Initiative and other similar adoption-competency programs.**

- **Provide federal incentives to recruit and train more master's-level clinicians. There is a shortage of well-trained mental health specialists who can meet the complex and unique needs of the child welfare and adoption community.**

- **Provide funding for targeted recruitment and retention initiatives to recruit, train, and support BIPOC and LGBTQ+ clinicians to address the unique needs of BIPOC and LGBTQ+ children and families in foster care and adoption.**

Although funding is critically important to ensure access to post-placement support services, it is equally essential that services be permanency and adoption competent—reflecting the impact of trauma, grief, loss, and other critical issues in adoption and permanency. Children, youth, and families must have workers and other service providers who understand and respond to these issues and build their skills to serve children with their specific experiences. Families must have professionals who understand adoption and provide mental health services designed to respond to clinical issues and build parenting skills for families parenting children who have experienced trauma and broken attachments.

But more than training is needed. We have an urgent need to recruit additional highly skilled, diverse providers into the field. BIPOC and LGBTQ+ children and youth are over-represented in the foster care population. Having a workforce and service providers who reflect their background and understand their experiences will improve outcomes for children.

Services provided by highly trained staff who reflect the population of children and families in adoption and guardianship will be more effective at ensuring that families thrive and remain together, preventing foster care re-entry.

Increasing Access to Care

- **Congress should increase Medicaid rates to align with private insurance.**

The vast majority of children in and exiting foster care have Medicaid as their insurance provider. But these children and their families face significant obstacles accessing services due to low reimbursement rates and too few providers who accept Medicaid (often due to low rates), particularly in non-urban communities. Clinicians must be reimbursed at fair rates through Medicaid, which authorizes just a fraction of the rates clinicians get privately or through some other insurance providers. Reasonable reimbursement rates will ensure that skilled clinicians are willing to see our children and families.

- **Congress should ensure that Medicaid includes coverage for family therapy, not just services to individuals, as well as nontraditional treatments that effectively help those affected by trauma.**

Too often, Medicaid (and other insurance policies) covers only services to the insured individual, when the issues facing those in adoption, guardianship, and foster care are often related to the family system. Medicaid should explicitly cover therapeutic services provided to the entire family of children, including the children, their siblings, and birth, foster, and adoptive parents and guardians.

Youth and families must also have access to Medicaid coverage for nontraditional forms of therapy (such as neurofeedback, mind-body-sensory trauma interventions, and other alternative innovations).

- **Congress should support the development and advancement of services sensitive to racial and cultural and other needs of LGBTQ+ and BIPOC individuals, including ensuring that Medicaid and other insurers cover them.**

In addition to recruiting and retaining diverse providers as recommended above, we must do more to ensure that the various children and families served by the child welfare system have access to mental health and behavioral health services designed to address their unique needs, including the impact of racism, homophobia, transphobia, and other discrimination. Funding should support ongoing development and research on new or adapted interventions sensitive to the racial, cultural, and different needs of LGBTQ+ and BIPOC children and families. In addition, Congress should ensure that these services are supported by Medicaid and other insurers and are accessible to those who need them.

- **Congress should require Medicaid and other insurers to cover the subspecialty of therapists to include competence in child welfare and adoption.**

There currently is no recognized "subspecialty" of adoption/permanency competence despite the wide recognition of the unique needs of children in adoption and other permanent families. Congress should support and incentivize the creation of such a subspecialty whereby therapists complete either accredited adoption competency training or trainings that have an evidence base to show a positive change in practice and child and family outcomes. This is consistent with

Medicaid managed-care companies' needs to ensure they spend their capped dollars on effective treatments specific to the audience.

- **Congress should amend the Dosha Joi Immediate Coverage for Former Foster Youth Act (S. 712) and the Expanded Coverage for Former Foster Youth Act (S. 709) to include explicit language stating that Medicaid covers individual therapy and telehealth therapy services for young people who are or were in foster care.**

Currently, young people who have Medicaid coverage may not have access to a full range of services that they need to meet their well-documented needs. Congress should ensure that those covered by Medicaid can access the type of services they specifically need, including individual therapy rather than simply group care and telehealth services.

- **Congress should also support expanded telehealth options, including allowing reimbursement to providers in other states, maintaining equal reimbursement rates for telehealth and in-person visits, and setting national standards for telehealth services.**

Expanding telehealth services is vital to supporting many children, youth, and families, including, but not limited to, those residing in more remote locations. These individuals have limited access to providers and a reduced selection of treatment options. This may prevent access to services at all or, at a minimum, result in delays in access. Such limitations can cause additional problems as untreated mental and behavioral health problems worsen untreated.

By lifting geographic barriers to telehealth, children and families would have access to services from providers who can best meet their needs, with reduced wait times and choices for more adoption- or permanency-competent providers.

National standards for telehealth services would ensure that the provided services are of high quality and are most likely to serve each client effectively.

- **Congress should increase the Federal Match Assistance Percentage (FMAP) rate for all children's mental health and supportive services provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitlement, covering all children under the age of 21 in all states and territories. In addition, Congress should expand access to these services for children and youth in foster care and who have exited care to adoption and guardianship while ensuring that such services are adoption/permanency-competent for this population.**

Increasing the FMAP would encourage states to use this vital, underused resource for children covered by Medicaid. According to MACPAC, more than 40 million children were eligible for EPSDT services in 2014, but less than 60 percent of children who should have received at least one screening received one. Such screenings are essential concerning psychiatric care, which typically requires a determination of the medical necessity for future coverage. As noted above, children in and exiting foster care to permanency have significantly higher mental and behavioral health needs rates. They would particularly benefit from such screenings and the coverage that the screening results may make available to them. But for the screening and services to be

effective for this population, they must consider specific issues common in foster care, including the impact of trauma, grief and loss, and broken attachments.

- **Congress should refine language in the Timely Mental Health for Foster Youth Act (S. 3625) to mandate all jurisdictions to participate and require an additional mental health screening by trauma-informed professionals conducted 60 days before youth exit care to permanency or due to emancipation. Ensure that professionals work with families or young people to arrange for services to address any needs identified.**

In many cases, children receive mental health assessments soon after entering foster care to determine their needs and identify services to be provided. Because needs change over time, such screening must also be done before children exit the system—and thus lose access to some services and supports—so that their current state of health is determined. The assessment process must include identifying and connecting to access services that address the child or youth's identified needs.

- **Congress should mandate that the National Youth in Transition Database (NYTD) measure outcomes for healing and trauma through a qualitative question that addresses how to best support youth with their mental health and healing needs.**

The NYTD current data collection falls short of identifying the needs of youth who have exited care and what is helping them heal. Additional questions, developed with the input of young people who have been in care, will help assess needs and identify which services and supports are successfully meeting those needs. The reported data would also hold states accountable for assisting young people in their healing process.

Ensuring Parity

- **Congress should ensure that all health insurance provides true parity for mental and behavioral health services in all health insurance plans. Congress should hold more hearings, issue state report cards, and direct HHS to craft model state laws to reach parity.**

In 2020, the *Psychiatric Times* noted that we had not achieved mental health parity despite previous legislation and other action. Citing a report card based on 2017 data, the Times reported on "continued and increased disparities between behavioral health care and physical health care coverage, indicating possible evidence of non-compliant insurance practices." Data showed more out-of-network visits and higher co-pays for behavioral health than physical health in many states. Many of these disparities can be attributed to managed care rules.

There should not be limits on the number of visits and other mental and behavioral health services if such limits are not put on physical health needs. Services should be provided based on the individual's needs and the professional opinion of the service provider.

The mental health needs of children and young people who have been in foster care are significant. Their experiences and their families as they struggle to access appropriate services show us how fractured this country's mental health system is. We need a robust, comprehensive mental and behavioral health system that serves all Americans while also providing targeted investments and support for those children for whom the government accepted responsibility when it removed the children from their families and placed them in foster care.