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Written Testimony of

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INTRODUCTION

Good morning! I am Twila Costigan, Program Manager for the Intermountain Adoption & Family Support Program located in Helena, MT. I have worked in the Child Welfare System in Montana for almost 27 years as a group home substitute parent, a counselor in a group home for Seriously Emotionally Disturbed (SED) children, a Child Protective Services Social Worker, an Adoption Approval and Foster Care Licensing Social Worker, and for the past 10 years a Program Manager at Intermountain. Intermountain's Relational Developmental Treatment Model is now 25 years old and continues to provide successful outcomes for SED children and their families.

Our vision at Intermountain is to secure emotional health and a loving, permanent family for each child. Our Adoption & Family Support Program was developed to facilitate permanency for Seriously Emotionally Disturbed children by recruiting, training, matching and supporting therapeutic families to provide permanent homes for children in the custody of the State of Montana due to abuse and neglect and termination of parental rights. We have expanded our program to serve birth, kinship, pre-adoptive and post-adoptive families. In my current position I am responsible for the provision of effective therapeutic wrap- around services for SED children and their parents.

My husband and I have never had birth children. We have been licensed foster parents and co-parented 4 children involved in the Child Welfare System, one of whom we adopted. We have 5 grandchildren aging from 16 months to 19 years.

I have been involved in the Montana State Foster/Adoptive Parent Association for the past 19 years serving in the offices of Secretary, Vice President, President and currently Past President. I am also the Treasurer of our local Foster/Adoptive Parent Association.

On behalf of Intermountain, the children and families of Montana, and the Child Welfare League of America, thank you for this opportunity to testify before you.

MEDICAID AND THE CHILD WELFARE SYSTEM

As a nation we believe that children deserve to have their physical, emotional, intellectual and spiritual needs met in their family of origin. We believe that children deserve to be safe, secure and loved so they can develop into productive citizens of our great country. Unfortunately it is a sad fact that not all children have their needs met by their birth parents. Some of these children come to the attention of teachers, doctors and law enforcement agencies. Some of these children find their way into our Child Welfare System because of the actions of their caregivers. Some of these children witness domestic violence, are physically and/or sexually abused, and most have been severely emotionally if not physically neglected. It is not my intention to speak disparagingly about the caregivers of these children, for in my experience, they often did not

have safe and secure childhoods themselves. These caregivers love their children as best they can, and certainly do not wake up in the morning and plan to abuse their child that day.

Children in our Child Welfare System come to the attention of Child Protective Services due to *severe* trauma, abuse and/or neglect. Child Protective Services workers recognize that removing a child from their primary caregiver causes harm to children and the decision to remove a child and place them in foster care is only made when the worker believes the child is in danger of further trauma, abuse and/or neglect.

The good news is that, at least in Montana, many of these children are not removed from their birth families, or if they must be placed in temporary protective services substitute care (usually a foster home or shelter) most of them are reunified with their caregiver or placed with another parent or birth family member. According to the Child and Family Services Division in testimony to the 2007 Montana Legislature: 42% of these children return home, 35% are placed with the other parent or another relative (77% placed with birth family members). Some of these children cannot be safely reunified with their parents and are adopted (13%), placed with a guardian (4%), age out or are Emancipated (6%).

The AFCARS (Adoption and Foster Care Analysis and Reporting System) Report by the Administration for children and Families, Administration on Children, Youth and Families, Children's Bureau states that there were 513,000 children in foster care on September 30, 2005 and 114,000 (22%) have been waiting an average of 41.6 months to be adopted. It is estimated in the AFCARS Report as of September 2006 that 60% of the children adopted nationally are adopted by their foster parents. Other children are not adopted by their foster parents and States cannot find permanent homes for them. These children are the most damaged children in our society (due to severe abuse and neglect and multiple placements) and have some of the worst profiles in regards to mental health and well being when they reach adulthood. These children have the government as a parent and are the focus of our discussion today. They have no primary caregiver or birth family member that can provide them a permanent, safe, secure and loving home in which to grow up. As you know, a positive relationship with a nurturing adult that lasts a lifetime is crucial to the growth and development of all children.

The Child Welfare League of America (CWLA) estimates that more than 80% of the children in foster care system have mental health issues, compared with about 10% of all U.S. children. The U.S. Department of Health and Human Services reports that 75 to 80 percent of all children requiring mental health services do not receive them. Children placed by our Child Welfare System may be found to have emotional, behavioral or psychological reactions including: depression, anxiety, anger, conduct problems, learning impairments, attachment and developmental disturbances, dissociation, and posttraumatic stress symptoms. It is not surprising that these children have more mental health needs. They have experienced trauma, abuse, neglect and abandonment from their family of origin. They have been removed from their caregivers due to these safety issues and placed in a home or other setting, thus losing their families,

communities, friends, pets, sense of belonging and sometimes their school and teachers. They have lost everything that a child needs to grow and develop normally. Some of these children are able to attach to new care givers and utilize these relationships to meet their needs for love, security and belonging. Some of these children have been so traumatized that they are unable to connect to adults in healthy ways because they are unable to trust that an adult will protect them or meet their needs.

While I was employed by the State of Montana as a Child Protective Services Social Worker, very little emphasis was placed on the mental health needs of these children. Tragically, in my experience, this has not changed. The agencies responsible for the protection of abused and neglected, children (Child Protective Services) and the agencies responsible for the mental health needs of children in the custody of the State (Medicaid Bureaus) do not work together to meet the physical, emotional, intellectual, spiritual and psychological needs of the children for whom they are responsible.

For youth who age out of the system (turn 18 years of age and are discharged from foster care) the future is bleak. According to the Pew Commission on Children and Foster Care:

"Studies have found significantly lower levels of education, higher rates of unemployment, and higher rates of homelessness for adults who spent time in foster care as children.[51] For example, a study by Westat, Inc. reported that only 54 percent of young adults who grew up in foster care had completed high school, 40 percent continued to rely on public support in some way (were receiving public assistance, incarcerated, or receiving Medicaid) and 25 percent had been homeless for some period.[52] Other studies indicate that a significant percentage of the homeless population in many cities were adults who once had been foster children."

The Child Welfare League of America (CWLA) has identified other barriers to appropriate Mental Health Services for children in foster care. These barriers include:

- A lack of providers trained in the issues that face children in foster care. Many providers are dissuaded from serving such children because of low reimbursement rates from Medicaid;
- Decreased funding has in some cases limited the number of children who may access services to those who are diagnosed with a serious emotional disturbance or those who are overtly acting out (verbal and physical aggression towards self, others, property). The types of services that are covered may be decreased, and children who are only "moderately unstable" may not receive coverage;
- A lack of continuity as children are moved between placements;
- Foster parents express frustration in finding medical and mental health providers, especially those that will accept cases involving children in the foster care system and those that will accept Medicaid;

- Rural areas have issues with access to mental health services as most service providers are clustered in urban areas;
- High Child Protective Services (CPS) caseloads limit the amount of time that a caseworker can spend on a particular case and high turnover limits effectiveness of services provided. Staff need better training to understand children's foster care and mental health needs. High turnover exacerbates this problem. Many studies cite the need for more training of CPS staff in order to help them identify mental health needs and to understand the treatment options. Better trained staff can also provide counsel and support to foster and adoptive parents attempting to manage and moderate children's problematic behaviors;
- Children in kinship care are less likely than those in non-kin care to have mental health problems; however, studies show that there are many barriers for those that do have mental health issues including; lack of mental health assessments, visits to mental health professionals, as well as receiving only part of the Medicaid benefits for which they are eligible.

THERAPEUTIC FOSTER AND GROUP HOME CARE

There is good news in the Child Welfare System. For the past 15 years the Federal Government has been promoting a children's "system of care" through SAMHSA (see www.mentalhealth.samhsa.gov). The focus has been to provide services to Seriously Emotionally Disturbed children (a diagnosable disorder that severely disrupts social, academic, and emotional functioning. About 7-9 percent of all children ages 9 to 17 have SED per DHHS, 1999) and their families in the least restrictive, most appropriate setting in a community. The principles and vision of systems of care are best practices for working with SED children and their families. Many of the professionals working with abused and neglected children in the temporary or permanent legal custody of the State, work together to meet the needs of these children and families. The services of Therapeutic Foster Care (TFC) and Therapeutic Group Home Care were developed to meet the physical, emotional, intellectual, spiritual and psychological needs of these children in the least restrictive and most appropriate setting. In a continuum of care Therapeutic Foster and Group Home services fall in between regular foster or pre-adoptive care and Residential Treatment Centers. Providers of regular foster care are reimbursed around $18 per day by the Child Protection Agencies and Residential Treatment Centers are reimbursed around $300 per day. Reimbursement for Therapeutic Foster and Group Home Care is between these two levels of service.

With regard to **Therapeutic Foster Care**, a report by the Former Surgeon General, David Satcher, M.D., Ph.D. Chapter 3 titled Children and Mental Health states:

"Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders. Care is delivered in private homes with specially trained foster parents. The combination of family-based care with specialized treatment interventions creates "a therapeutic environment in the context of a nurturant family home" (Stroul & Friedman, 1988). These programs, which are often funded jointly by child welfare and

mental health agencies, are responsible for arranging for foster parent training and oversight. Although the research base is modest compared with other widely used interventions, some studies have reported positive outcomes, mostly related to behavioral improvements and movement to even less restrictive living environments, such as traditional foster care or in-home placement...

There have been four efficacy studies, each with randomized, controlled designs. In the first study, 20 youths who had been previously hospitalized were assigned to either therapeutic foster care or other out-of-hospital settings, such as residential treatment centers or homes of relatives. The youths in therapeutic foster care showed more improvements in behavior and lower rates of reinstitutionalization, and the costs were lower than those in other settings (Chamberlain & Reid, 1991). In another study, which concentrated on youths with histories of chronic delinquency, those in therapeutic foster care were incarcerated less frequently and for fewer days per episode than youths in other residential placements. Thus, at 2-year followup, 44 percent fewer children in therapeutic foster care were incarcerated (Chamberlain & Weinrott, 1990). In a third study, outcomes for children in therapeutic foster care were compared with those of children in standard foster care. Children in therapeutic foster care were less likely during a 2-year study to run away or to be incarcerated and showed greater emotional and behavioral adjustment (Clark et al., 1994). In the most recent study, therapeutic foster care was compared with group care: children receiving the former showed significantly fewer criminal referrals, returned to live with relatives more often, ran away less often, and were confined to detention or training schools less often (Chamberlain & Reid, 1998).

All four studies of treatment effectiveness showed that youths in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior. In addition, gains were sustained for some time after leaving the therapeutic foster home (Bogart, 1988; Hawkins et al., 1989; Chamberlain & Reid, 1991)."

With regard to **Therapeutic Group Home** care the same Surgeon General Report states:

"For adolescents with serious emotional disturbances the therapeutic group home provides an environment conducive to learning social and psychological skills. This intervention is provided by specially trained staff in homes located in the community, where local schools can be attended. Each home typically serves 5 to 10 clients and provides an array of therapeutic interventions. Although the types and combinations of treatment vary, individual psychotherapy, group therapy, and behavior modification are usually included...

There is a dearth of research on the effectiveness of therapeutic group home programs targeted toward emotionally disturbed adolescents. These homes have been developed primarily for children under the care of juvenile justice or social welfare. A dissertation (Roose, 1987) studied the outcomes of 20 adolescents treated in a group home. Adolescents with severe character pathology or major psychiatric disorders were not admitted. Twenty group home adolescents were compared with 20 untreated adolescents. At an 18-month followup, 90 percent of the treated group had fair or good functioning, defined by improved relationships with parents, peers, and fellow workers. Only 45 percent of the untreated group achieved similar functioning.

The treated group experienced a significant decrease in psychopathology, while the untreated group did not.

Therapeutic group homes were compared with therapeutic foster care in two studies. The first study found equivalent gains for youth in the two interventions, but group home placement was twice as costly as therapeutic foster care (Rubenstein et al., 1978). A second study, a randomized clinical trial, compared the outcomes for 79 males with histories of juvenile delinquency placed in either group homes or therapeutic foster homes (Chamberlain & Reid, 1998). The boys treated in therapeutic foster homes had significantly fewer criminal referrals and returned more often to live with relatives, suggesting this to be a more effective intervention. The implication of these studies is that if therapeutic foster care is available, and if the foster parents are willing to take youth with serious behavioral problems, therapeutic foster care may be a better treatment choice for youth who previously would have been placed in group homes.

Existing research suggests that therapeutic group home programs produce positive gains in adolescents while they are in the home, but the limited research available reveals that these changes are seldom maintained after discharge (Kirigin et al., 1982). The conclusion may be similar to that for residential treatment center placement: long-term outcomes appear to be related to the extent of services and support after discharge. Adolescents who have been placed in therapeutic group homes because of mental disorders frequently have histories of multiple prior placements (particularly in foster homes), a situation that is associated with a poor prognosis. Thus, future programs would benefit from assessing alternative strategies for treatment after discharge from group homes."

USE OF MEDICAID REHABILITATION SERVICES TO MEET THESE CHILDREN'S NEEDS

The use of Medicaid Rehabilitative Services is crucial to the provision of Therapeutic Foster and Group Home care for Seriously Emotionally Disturbed children. As reported by the Surgeon General above, these levels of care allow the child to stay in the community, get on a different Mental Health trajectory and avoid higher levels of care and crisis services. In our Adoption & Family Support Program, rehabilitative services are used to allow program staff to go into therapeutic foster homes to model and teach effective interventions to parents and children. Staff also work with the child to help them develop personal skills to allow them to identify and communicate their feelings to the adults in their lives—rather than acting out these feelings of rage, sadness, fear, humiliation, jealousy and anxiousness in destructive ways. Rehabilitative Aides also work with children in community settings such as daycare or group activities to help children gain skills that allow them to feel and act more "normal" thus reducing the effects of their emotional disturbances. In follow-up Studies conducted by Intermountain, children state that Rehabilitation Aides "help me every time when I can't talk to anyone else…they listen and never give up on me…they have done wonders for my social life". In reference to Rehabilitative Aides parents state, "they never give up on us…they give us hope."

The use of flexible Medicaid Rehabilitative funding allows Therapeutic Providers to maintain and develop innovative programs that meet the needs of Seriously Emotionally Disturbed (SED) children and their families. For example, SED children of any age typically do not have the

ability to stay safely at home alone for any length of time. Summer and out-of-school days present major problems for the therapeutic parents. Many SED children cannot be safely served in regular day care settings, and most day care settings are not appropriate for 12-16 year old youth. The Adoption & Family Support Program Summer Program successfully serves SED children ages 3-17 with structured therapeutic interventions funded with the current Medicaid Rehabilitative Services. In the Summer Program, the children participate in social skills building involving education and activities led by Rehabilitation Aides. This begins with a weekly group session based on good character traits with topics such as trustworthiness, responsibility, respect, good citizenship, peer skills and caring/compassion for others. Throughout the week the daily activities are then focused on the character building or social skill of the week. The children have the opportunity, some for the first time, to realize that there are other children like themselves that are struggling with emotional and behavioral issues and to feel acceptance by other children and adults instead of their usual experience of being ostracized because of their disruptive behaviors.

It is my understanding that the State of Montana Children's Mental Health Division has been verbally notified by the Center for Medicare and Medicaid Services (CMS) of the Federal Government that Montana must "unbundle" payment for the services provided to Seriously Emotionally Disturbed children and their families. What is "unbundling"? To answer that question we must first answer the question "what is a bundled rate"? Currently, Therapeutic Foster and Group Home providers receive a daily payment from the Montana Children's Mental Health Division for these services to be provided to children, youth and parents. A bundled rate wraps the costs for all aspects of treatment into a single payment. From the day a child is admitted to Therapeutic Foster or Group Home care the day discharged, providers are paid a daily rate for their services to SED children and families. The bundled daily rate includes active treatment interventions, qualified treatment parents, specialized behavior management techniques, a treatment team, treatment planning, adequate clinical, direct care (such as Rehabilitative Aides) and administrative staff, weekly face to face contact with therapeutic parents, individual treatment meetings with the child or youth two times per month, clinical supervision meetings, treatment plan reports, and 24 hour per day/7 days per week crisis response. Bundling of the rate allows program staff to develop treatment plans with the input of all involved in the child's life (including parents, therapists and school staff if possible), and to ensure that the treatment plan goals, and strategies are been implemented across as many environments as possible (home, school, therapy, community). Program staff can spend the needed amount of time with a particular child and their family working on a particular treatment goal at any time. An "unbundled" rate requires that providers draw from a variety of funded services. Rehabilitation services would be at the core of the provision of Therapeutic Foster or Group Home care because most of the interventions are provided by highly trained and clinically supervised treatment parents and Bachelors level program staff. In the Medical Medicaid model therapeutic providers could be reimbursed for individual, group and family therapy by a licensed therapist and Rehabilitation services. Providers would be required to relegate all activities into face to face specified time-limited block with the possibility of accompanying arbitrary limits on the number of service units that can be provided. The idea of a "program" to serve SED children and their families that included sound clinical direction and seamless treatment, recruitment and training of treatment parents would be fiscally unrealistic without Medicaid Rehabilitation Services funding.

The Montana Children's Mental Health Division worked with Montana providers to create a proposed financial plan for the unbundling of Therapeutic Group Homes Services. Central to this new plan for unbundling are individual, group and family therapy and Rehabilitation Services.

CONCLUSION:

Flexible Federal funding such as Medicaid Rehabilitative services that are used to serve Seriously Emotionally Disturbed children and their families in the community is crucial to the success of the Federal Government's Systems of Care as well as Therapeutic Foster and Group Home care. Medicaid Rehabilitative services are congruent with the President's Freedom Commission on Mental Health which states, "The 'mental health maze' is more complex and more inadequate for children...The most seriously affected children are defined, under Federal regulations, as having serious emotional disturbance".

The loss of the Medicaid Rehabilitative services has the likely consequence of eliminating Therapeutic Foster and Group Home care for the Severely Emotionally Disturbed children in Montana. Montana children who cannot be maintained safely in regular foster care the next level of care will inevitably be the more restrictive and more expensive Residential Treatment Center option.