

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***



**Testimony of**

**Bryan Samuels, Commissioner**

**Administration on Children, Youth and Families**

**Administration for Children and Families**

**U.S. Department of Health and Human Services**

**Before the**

**Subcommittee on Human Resources**

**Committee on Ways and Means**

**U.S. House of Representatives**

**June 16, 2011**

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

Chairman Davis, Ranking Member Doggett, and members of the Subcommittee, I appreciate the opportunity to testify before you today as you consider the reauthorization of title IV-B – subpart 1: the Child Welfare Services Program and subpart 2: the Promoting Safe and Stable Families Program (PSSF). These programs in the Social Security Act are essential as they are the primary source of dedicated Federal child welfare funding to help State and local child welfare agencies support the critical services needed by children who are at-risk of or have been abused and neglected and their families.

Before I speak to the specifics of those two subparts and our proposal for reauthorizing title IV-B following the principles for child welfare reform set forth in the President’s FY 2012 Budget request, I want to acknowledge and applaud how this Subcommittee, and Congress as a whole have operated in a bipartisan manner when it comes to issues impacting child abuse and neglect. It demonstrates a clear recognition that vulnerable children and families deserve our best collective efforts to improve their chances for success. We especially appreciate your work to extend State child welfare waiver authority. These waivers will serve as a complementary tool to the Administration’s child welfare proposal to spur innovation and develop more robust evidence-based practices.

**Title IV-B, subpart 1 – Stephanie Tubbs Jones Child Welfare Services Program**

The Stephanie Tubbs Jones Child Welfare Services Program helps State and Tribal child welfare agencies develop and expand their child and family services programs by: (1) protecting and promoting the welfare of all children; (2) preventing the neglect, abuse or exploitation of

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

children; (3) supporting at-risk families through services that allow children, where appropriate, to remain safely with their families or return to their families in a timely manner; (4) promoting the safety, permanence and well-being of children in foster care and adoptive families; and (5) providing training, professional development and support to ensure a well-qualified child welfare workforce.

Services are available to children and their families without regard to income. Funds are distributed to States and Tribes as formula grants, based on the population of children under age 21. The non-Federal match requirement is 25 percent. Funding for the program in FY 2011 is \$281,181,000.

**Title IV-B, subpart 2 – Promoting Safe and Stable Families**

The primary goals of the Promoting Safe and Stable Families (PSSF) program are to prevent the unnecessary separation of children from their families; improve the quality of care and services to children and their families; and ensure permanency for children by reuniting them with their parents, placing them with an adoptive family or in another permanent living arrangement.

States and eligible Tribes (funded out of a three percent set-aside) are to spend most of the funding for services that address four service categories: family support, family preservation, time-limited family reunification and adoption promotion and support. PSSF is funded by both mandatory and discretionary funding streams. Funding for PSSF in FY 2011 is \$428,184,378 (\$365,000,000 in mandatory funds; \$63,184,378 in discretionary funds).

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

In addition to providing PSSF formula grants to States and Tribes, this program also sets aside funding for evaluation, research, training and technical assistance projects (\$6 million mandatory, 3.3 percent of discretionary). Funds also are set-aside for State Court Improvement Programs (\$30 million mandatory, 3.3 percent discretionary); and \$40 million in mandatory funds split between State formula grants to improve the quality and quantity of caseworker visits with children in foster care and competitive discretionary regional partnership grants to work with children and families impacted by a parent's or caretaker's methamphetamine or other substance abuse.

*The Four Categories of PSSF*

The four categories of PSSF are family preservation services; family support services; time-limited reunification services; and adoption promotion and support services.

The following are examples of the work States are doing within these categories:

- **Family Preservation Services** – Kentucky uses its PSSF funding to focus on two areas – preventing at-risk children from being removed from their homes and assisting children to reunify safely and successfully with their families. To these ends, Kentucky provides intensive assistance including using “Families and Children Together Safely” (FACTS) for at-risk families with children who may be in the home or returning from out-of-home care by providing in-home therapy and community-based prevention/intervention services.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

- **Family Support Services** - In North Dakota, Nurturing Parent Programs are evidenced-based group programs in which both parents and their children participate. This program helps parents learn nurturing behaviors, communicate in non-threatening ways and use alternatives to physical discipline. Nurturing Parent programs offer two modules – one for families with children under age five and one for families with children age 5-12.
  
- **Time-limited Reunification Services** - The Nebraska State child welfare agency contracted with five family-serving organizations to provide one-on-one mentoring and support services to families whose children are in foster care, parents who are involved with the child welfare agency and parents whose children have been diagnosed with a serious emotional disturbance and substance dependence disorders. Services include one-on-one mentoring and coaching of parents, advocacy, support groups for parents and youth, and community referrals.
  
- **Adoption Promotion and Support Services** - The Tennessee child welfare agency has utilized funds to provide specialized pre-adoptive counseling services to help children grieve loss and prepare them to accept a new family.

*State Caseworker Visit Grants*

The 2006 reauthorization of PSSF sought to ensure that all States would visit at least 90 percent of children in foster care on a monthly basis by FY 2011. Quality caseworker visits are essential

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

to ensuring the safety of children in foster care. States have chosen a variety of ways to increase caseworker visits and improve their quality. California and Maryland offer good examples of how funds are being used to further progress toward the 90 percent goal.

In FY 2010, California allocated funds to all 58 counties to perform activities designed to support more monthly caseworker visits to children in foster care; to improve caseworker retention, recruitment and training; and to improve the ability of caseworkers to access the benefits of technology.

Maryland utilizes additional funds to support monthly casework visits with children in foster care by funding travel for caseworkers to visit foster children in out-of-State placements, and allocating funds for supplies, books, toys, and tools for caseworkers to enhance the content and quality of visits.

*Grants for Children Affected by Methamphetamine and Other Substance Abuse*

The impact of methamphetamines has been a concern in the child welfare community since the drug emerged in the 1990s. Given this trend, Congress chose to target funds in PSSF during the last reauthorization to build effective approaches over a five year period to combat the effects of methamphetamine on child welfare. Congress created a targeted grant program to regional partnerships for the purpose of improving permanency outcomes for children affected by methamphetamine or other substance abuse. In October 2007, 53 Regional Partnership

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

Grants (RPGs) were awarded to applicants across the country. The three- and five- year grant awards ranged from \$500,000 to \$1,000,000 per year.

The grants address a variety of common systemic and practice challenges that are barriers to optimal family outcomes including: recruitment, engagement, and retention of parents in substance abuse treatment; conflicting time frames across the systems to achieve outcomes; and chronic service shortages in both child welfare services and substance abuse treatment systems. Program strategies to address these barriers include the creation or expansion of family treatment drug courts, expanded and timely access to comprehensive family-centered treatment, in-home services, case management and case conferencing, the use of evidence-based practice approaches such as motivational enhancement therapy and parenting programs, parent partners, mental health and trauma informed services, and strengthening of cross-system collaboration.

Based on information we received from grantees, the Federal investment has served to establish and advance cross-systems collaboration and service integration, as the legislation intended. Additionally, various State, regional and local governmental and community partners are contributing their own financial and human resources to help sustain these collaborative activities and services beyond the grant period, also as envisioned by the legislation. Approximately one-third of RPG services strategies are currently supported primarily by other community resources. Through the RPG program efforts, child welfare systems now have additional tools to use to continue to address the impacts of methamphetamine and other substances.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

The use of methamphetamine has declined in this decade. According to the 2009 National Survey on Drug Use and Health<sup>[1]</sup>, the number of past-month methamphetamine users decreased between 2006 and 2009. The numbers were 731,000 (0.3 percent) in 2006 and 502,000 (0.2 percent in 2009).

As reauthorization of these funds is considered in light of the current landscape of child welfare, we would suggest that there may be a diminished need for meth-specific programming providing an opportunity to target some funds towards driving innovation in other areas.

*Court Improvement Program*

Statutory language sets aside both mandatory and discretionary funds to support three State Court Improvement Program (CIP) formula grants. The Basic grant is funded at approximately \$12 million annually (\$10 million mandatory funds; 3.3 percent of discretionary funds); the Data and Training grants each receive \$10 million in mandatory funds annually. All 50 States, Puerto Rico and the District of Columbia receive CIP funds.

Courts play a critical role in the child welfare system. However, historically few courts and judges have possessed specialized child welfare knowledge. The CIP has begun changing this by helping courts become more effective partners in promoting the safety, permanence and well-being of children involved in dependency cases and building their capacity to do so.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

Since the CIP was created, judges and attorneys have become better trained, more aware of the needs of families and children and far more engaged in all aspects of child abuse and neglect cases. Judges and attorneys have emerged as leaders in the child welfare field and agencies and courts are working together to implement innovative data-sharing systems and evidence-based practices. CIP funding has been and continues to be a catalyst for promoting improved outcomes for children and families involved in child welfare. For this reason, we strongly urge you to reauthorize the CIP grant program.

*Evaluation, Research, and TA Funds*

Since its inception in 1993, the PSSF program has reserved funds to be used by HHS for evaluation, research, and technical assistance in the amounts of \$6 million in mandatory funds and 3.3 percent of discretionary funding.

The bulk of these reserved funds are used to provide technical assistance to States in response to findings from the Child and Family Service Reviews (CFSRs). When weaknesses are identified in a program through the CFSR, the State is offered technical assistance to help them address that weakness from a national network of training and technical assistance providers including the Children's Bureau's National Resource Centers (NRCs), several national clearinghouses, and selected grants to local entities. For example, if a State is found to be in nonconformity with child safety, the National Resource Center for Child Protective Services can be deployed to help the State implement safety decision making. Research activities supported by PSSF funds are intended to support the development of an evidence base to guide program implementation at the

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

national, State, and local levels. These activities are regularly carried out in partnership with HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as through other partnerships within HHS, such as the National Institute on Alcohol Abuse and Alcoholism, and other Departments, such as the Department of Justice, to support studies addressing areas of mutual interest. Projects supported in FY 2010 examined such issues as collaborations between child welfare and TANF, the intersection of domestic violence and child maltreatment, and early childhood-child welfare partnerships.

### **Today's Child Welfare Landscape**

From 1982 to 1995, the number of children in foster care increased by 63.2 percent. During this same period, Federal expenditures grew from \$309 million to \$3.05 billion. Congress recognized these unsustainable trends and began a concerted effort that led to more than two decades of reforms in the child welfare field beginning with the passage of the bipartisan Adoption and Safe Families Act (ASFA) in 1997 (P.L. 105-89). The guiding principles of ASFA were:

- The safety of children is the paramount concern that must guide all child welfare services.
- Foster care is a temporary setting and not a place for children to grow up.
- Permanency planning efforts should begin as soon as a child enters the child welfare system.
- The child welfare system must focus on results and accountability.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

- Innovative approaches are needed to achieve the goals of safety, permanency, and well-being.

Congress recently spurred another wave of child welfare reforms with the passage of the bipartisan Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). This legislation provided a focus on promoting permanency and improving outcomes for children in foster care by supporting permanent family connections through guardianship assistance; increasing educational stability; encouraging health care oversight and coordination; extending supports for older youth beyond age 18; providing incentives and assistance for adoption; and providing new authority for Tribes to directly manage title IV-E funds. With the changes these and other laws have supported over the past 14 years, the child welfare system has made tremendous progress:

- Since 1998, the number of all children in foster care has decreased by 25 percent, due both to improved permanency outcomes for children in foster care and increased support for at-risk families preventing entry into foster care in the first place.
- Thirty-two out of 52 States (including DC and Puerto Rico) had a reduction in the number of children entering care between 2002 and 2009.
- Nationally, child welfare systems brought 14.5 percent fewer children into foster care in 2009 than in 2002; during the same time period, 12 percent more children exited foster care to permanency.
- The number of children adopted from foster care has been increasing steadily from year-to-year. In 1998, 37,000 children were adopted from foster care while in 2008, 57,500

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

children were adopted from foster care. This represents a clear sign that the message Congress has sent about adoption promotion is being heard in the field.

The goals of safety, permanency and well-being have been foundational to the work of child welfare. The progress made has primarily been in the areas of safety and permanency.

Sustaining and furthering this progress will be a critical consideration in the revisions that the Administration is planning for the CFSTRs, which are anticipated by the end of 2012. While further progress in safety and permanency is possible and important, the reauthorization of title IV-B provides an opportunity to focus on improving well-being in children who have experienced child maltreatment.

### **Opportunities in Reauthorization to Move the Child Welfare Field Forward**

Well-being is a complex and multifaceted construct. As such, there are many aspects that can be considered when determining where to target limited resources. The research suggests that a focus on the social-emotional well-being of children who have been maltreated would have a significant impact as it would address both the fundamental reason that children come to the attention of the child welfare system and the potential to positively impact adult outcomes.

The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

When I was in Illinois, my response to this problem was to institute a universal assessment using the Child Behavior Checklist for all children entering care and then determine which interventions would be most likely to improve the functioning of the largest number of children. It became apparent that these children were deeply affected by the trauma they had experienced and many presented with a complex array of needs. We acknowledged that the complex nature of maltreatment required a multi-faceted approach and we took steps to build a system equipped to meet the constellation of children's social-emotional needs. There are many opportunities for taking a similar approach to build a Federal response to the social and emotional needs of children and their families.

Once abuse or neglect is substantiated and it has been determined that a child can either safely receive in-home services or that he/she should come into foster care, the focus shifts primarily to ensuring stability (in-home cases) or achieving permanency (out-of-home). This is and should remain an essential function of the child welfare system. However, this imperative often glosses over the responsibility we have to provide effective and timely services that lead to healing and recovery for children and families whose lives have been deeply impacted by the abuse or neglect they have experienced. The data show that the act of achieving permanency – whether it be through in-home services, reunification, guardianship or adoption does not by itself lead to improved life outcomes for children who have often experienced chronic and complex trauma due to the abuse or neglect that has occurred.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

The research on the impacts of maltreatment on the social-emotional, behavioral, and mental health needs of children has grown over the years and informs the Administration's FY 2012 child welfare proposals. I would cite several key examples:

- Studies consistently find that a maltreated child is more likely than not to have psychological difficulties of sufficient scale or severity to require mental health services, regardless of their placement history.<sup>1</sup>
- Maltreated children endure poorer physical health, higher prevalence of learning and language difficulties, and poorer educational outcomes than other children.<sup>2</sup>
- Although children adopted from care enjoy greater placement stability than those who remain in care, studies suggest as many as 60 percent of children manifest mental health difficulties six years after being adopted from care.<sup>3 4</sup>
- While specialized mental health services for child welfare populations have been developed, we have not developed an integrated model of clinical practice that adequately addresses their complex psychopathology, which is often characterized by attachment difficulties, relationship insecurity, problematic sexual behavior, trauma-related anxiety, inattention/hyperactivity, and conduct problems and defiance.<sup>5</sup>
- A pattern of spiraling deterioration in mental health and social functioning, serial placement breakdowns and increasingly unstable living arrangements is more commonly observed among children who arrive in care in middle childhood or later, following chronic exposure to abuse and emotional deprivation. Fewer of these youth are adopted from care.<sup>6</sup>

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

- The systems in place today are largely piecemeal. The most visible shortcoming in the provision of effective mental health services for children in care, as well as those adopted from care, is insufficient capacity.<sup>7</sup>
- Moreover, the current system services are poorly matched to the service needs of a child population presenting with complex attachment- and trauma-related symptoms, and unstable living arrangements. These children require greater continuity and certainty of care than typical acute care services are designed to provide.<sup>8</sup>
- Generic treatment interventions are also mostly designed for discrete disorders rather than complex bio-psycho-social phenomena. Children in care are more likely to present with complex and co-occurring disorders that are less likely to respond to psychological treatments developed for discrete disorders.<sup>9 10</sup>

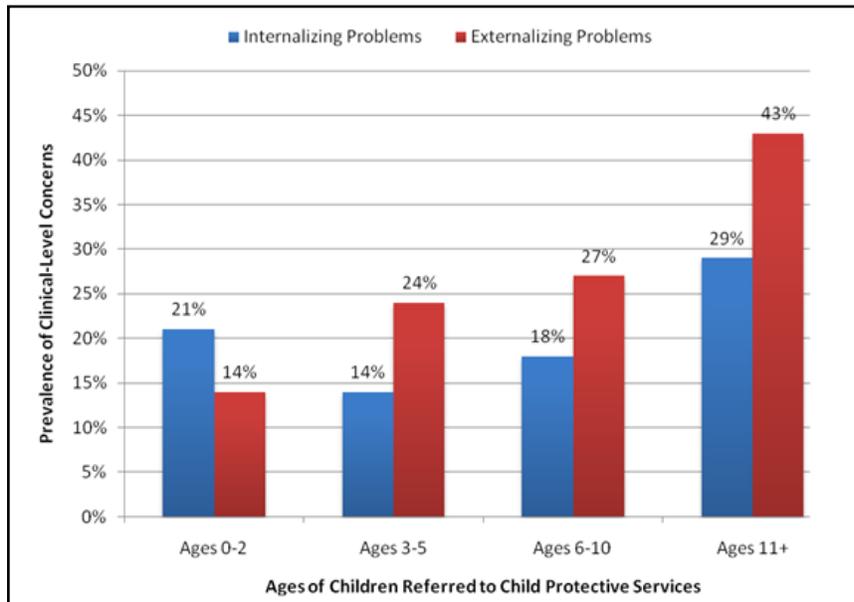
Children known to the child welfare system have often experienced multiple traumas related to child abuse and neglect, domestic violence, and community violence. The research on trauma and child abuse and neglect is clear in demonstrating that these co-occurring adverse childhood experiences have a compounding and corrosive effect on the developmental, social and emotional trajectories of these children. Trauma can manifest itself in many ways including disturbed attachment patterns, aggressive behavior towards others, loss of regulation in the areas of sleep, food and self-care, self-hatred and chronic feelings of ineffectiveness.<sup>11</sup>

Figures 1 and 2 below provide data on the mental health and behavioral health experiences of children known to child welfare. Figure 1 shows the percentage of children known to child welfare by age who exhibit either externalizing behaviors such as aggression, defiance, etc. or

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

internalizing behaviors such as somatic complaints, self-esteem problems, thought problems and relationships difficulties, etc. Figure 2 shows the percentage of children (at age 17) who have a mental health diagnosis at any point in their lives, before they enter foster care, and/or during the past year; age of onset is also provided, which ranges from age 4.85 to age 12.17 and is far younger than typically understood by the general population. The data are remarkable also insofar as at least a third and up to over a half of children in the foster care system had a diagnosable mental health need prior to entry into foster care.

Figure 1: Social and Emotional Needs of Children Known to Child Welfare<sup>12</sup>



**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

Figure 2: Onset and Prevalence of Major Psychiatric Disorders for the Past Year, Lifetime, and Before Entrance Into the Foster Care System<sup>13</sup>

Psychiatric Disorder	Lifetime			Met Diagnostic Criteria in Past Year
	Ever Met Diagnostic Criteria	Met Diagnostic Criteria Before Foster Care Entry	Age at Onset	
Mania	6%	33%	12.17	6%
Posttraumatic Stress Disorder	14%	42%	10.48	8%
Attention Deficit Hyperactivity Disorder	20%	75%	4.85	10%
Major Depression	27%	35%	11.82	18%
Conduct Disorder/Oppositional Defiant Disorder	47%	57%	9.65	17%

The table and graph above show the significant extent of both diagnosable mental health needs and the clinical-level social and emotional needs of children who do not meet the criteria or threshold for a diagnosis. Their functioning has been impaired due to their life circumstances, and we know there are effective ways to intervene. These data also help us understand that these needs span the full age range and increase as children get older.

*Building a System that Meets the Needs of Maltreated Children*

These mental health, behavioral health and social and emotional needs are the core challenge before us. If we are to put children who have been maltreated and exposed to trauma on a positive life trajectory, we must build a child welfare system that responds effectively to these compelling and complex needs.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

A sophisticated, multifaceted clinical and behavioral approach is needed to meet their needs as the traditional mental health strategy is inadequate to address the complexity common to this population. If we are to improve the life outcomes of children known to child welfare - not just in the short term but into and throughout adulthood - we must take an approach that is supported by clinical research and has been shown to be effective. Our policies, programs and funding must be aligned with the reality these children face every day.

The child welfare system in partnership with the mental health system responds primarily to children with diagnosed mental health disorders and to those children who exhibit externalizing behaviors. The traditional array of services used, however, does not fully address their unique needs given the trauma and maltreatment they have experienced. Additionally, children who do not meet the criteria for a mental health diagnosis and exhibit *internalizing* behaviors are often underserved or receive services that are inappropriately matched to their clinical needs. These systemic gaps result in children struggling unnecessarily with social and emotional needs. Intervening in their lives to improve their overall functioning is an imperative we cannot overlook.

For those children who do have a mental health diagnosis, there is a high rate of use of psychotropic medications – substantially higher than in the general population - reflecting the clinical complexity of these children. One study focusing on the use of psychotropic medication in Texas found that the prevalence of any psychotropic medication for Medicaid-enrolled youth in foster care was 34.7 percent. Of the children in foster care receiving psychotropic medications, 17 percent were receiving two psychotropic drug combinations and 60 percent

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

receiving five or more concomitant psychotropic drug classes.<sup>14</sup> There are significant variations across States in the rate of psychotropic medication use among children in foster care, suggesting that far more work needs to be done to identify best practice in the use of these medications with this population. Recent studies have found that older age and clinical need, as measured by the Child Behavior Checklist, were associated with higher rates of psychotropic medication use, findings similar to those previously reported in the literature.<sup>15</sup>

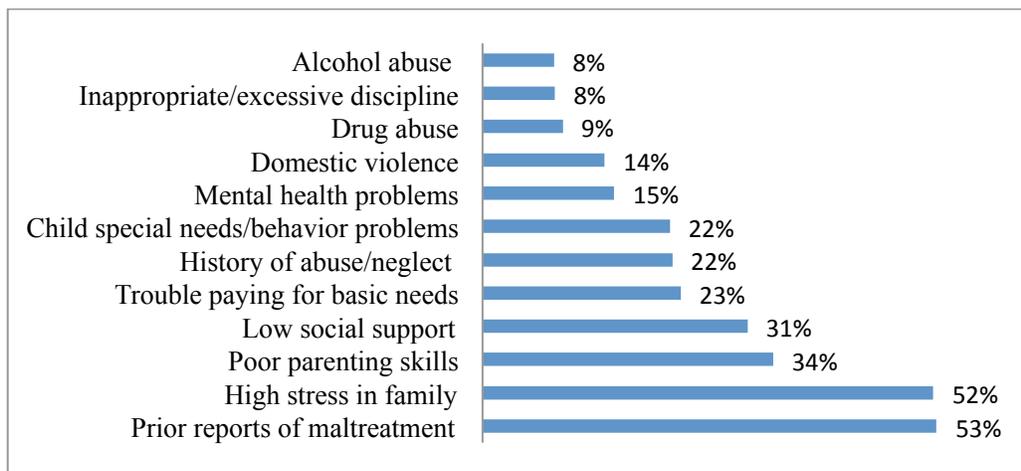
There is emerging consensus and research evidence that a more responsive service array for this population should include non-medication based interventions such as cognitive behavioral therapy, behavior management, and family skills training – sometimes in addition to psychotropic medications, which can provide significant help for some children. However, these non-medication, evidence-based interventions that are known to be effective are underutilized for this population due to a number of variables including lack of adequate assessment of needs, lack of practitioners, and lack of consistent funding streams. Many of these interventions include the involvement of families (i.e. Parent-Child Interaction Therapy), which is clearly supported through the PSSF goals of family preservation and family support.

As PSSF acknowledges the importance of parents and families in the lives of children, attention must be paid to the array of needs that are specific to caregivers as well. Data in Figure 3 below clearly demonstrate the high prevalence of issues that impact caregivers' ability to provide safe, stable home environments for children: use of inappropriate or excessive discipline, low levels of social support, mental health problems and caregivers' own history of experiencing abuse or neglect. Given the child welfare system's emphasis on preventing removal when possible and

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

reunifying children in foster care with their parents when it is safe and appropriate, the constellation of physical, mental, social, and concrete needs that their caregivers encounter must be addressed.

Figure 3: Risk Factors in Parents Involved with Child Welfare



### **The President's FY 2012 Proposal**

The recognition of the risk factors in parents and the mental health, behavioral health and social and emotional needs of children provides a real opportunity to develop a critical area of focus during the reauthorization of both subparts of title IV-B by strengthening the child welfare system's ability to identify, develop, train, and implement interventions that meet these needs and support effective strategies that improve outcomes for children.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

*Title IV-B, Subpart 1 (Child Welfare Services Program)*

The Administration supports the reauthorization of the title IV-B Child Welfare Services Program for five years with total funding set at the same level, as specified in the President's Budget proposal. This continued support will allow States and Tribes to fund child welfare services and build on the progress made relating to caseworker visits with children in foster care. Under subpart 1, all States are required to visit at least 90 percent of children in foster care on a monthly basis by FY 2011. The provision of the law relating to submission of caseworker visit data has prompted improved State performance in the frequency of caseworker visits and the proportion of visits conducted in the home of the child. The law has also lead to improvements in the accuracy of State data in this area. The baseline data submitted by States indicated that initial State performance ranged from a low of two percent to a high of 94 percent, with a mean of 42 percent in FY 2007. Most States have made improvements, and preliminary figures indicate that the national average rose to 50 percent in FY 2008 and 73 percent in FY 2010. We expect that improvements will continue and we will continue to monitor this through the Child and Family Services Reviews.

We would also recommend clarifying that implementation and/or expansion of effective clinical, trauma-focused treatments for both children and families are an allowable expenditure under this subpart.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

*Court Improvement Program*

The Administration's proposal requests that the State Court Improvement Program (CIP) grants be reauthorized for five years.

CIP has provided an opportunity to invest in improved data collection and collaboration between courts and child welfare agencies, the infrastructure built through these funds now allows for a return on investment that can help to focus on the following key areas:

- *Raising the visibility for concurrent planning.* Only four percent of children who were in foster care in FY 2009 were placed in a pre-adoptive home. The Adoption and Safe Families Act (ASFA) requires child welfare agencies to begin concurrent planning upon entry into foster care. The statute should be revised to support strategies that allow courts to support the increased use of placements that facilitate concurrent planning.
- *Reducing the time to adoption after parental rights have been terminated.* ASFA appropriately focused on reducing the time to a determination of the termination of parental rights. However, only 14 percent of children who were awaiting adoption (meaning their parental rights had been terminated) in FY 2009 were placed in a pre-adoptive home. This could be accomplished by further revising the statute to support the development of strategies that allow courts to help with the reduction of the time to adoption after the termination of parental rights.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

- *Broadening policies that provide for more opportunities for youth to participate in child welfare hearings.* Youth have much to contribute to the placement, treatment and other decisions that significantly impact their lives and we believe the statute should support development of policies that provide for more opportunities for youth to participate in child welfare hearings.
- *Improving the understanding of the impacts of trauma:* Children who are served by dependency courts have experienced complex trauma and we believe the statute should support training judges and other legal personnel on the effects of trauma due to maltreatment.

*Tribal CIP*

The Administration also proposes the creation of a Tribal Court Improvement Program to be used to support Tribal court improvement efforts as Tribes begin to operate their own title IV-E programs as was authorized under the Fostering Connections Act. The Fostering Connections to Success and Increasing Adoptions Act of 2008 allows Tribes, for the first time, to apply for title IV-E funds to support their child welfare activities. It is a priority of the Administration to reach out and engage the Tribes to support them in achieving better outcomes. Currently, 11 Tribes are receiving support to plan and prepare to operate their own title IV-E program.

*Title IV-B, Subpart 2 (Promoting Safe and Stable Families)*

The Administration supports the reauthorization of the title IV-B Promoting Safe and Stable Families Program for five years with total funding set at the same level, as specified in the

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

President's FY 2012 Budget proposal. We would also recommend repurposing the \$40 million in mandatory funds that previously supported discretionary regional partnership grants focused on methamphetamine and other substance use and formula grants to States to improve caseworker visits with children in foster care. We suggest that instead these funds could better be used as an initial step to support incentivizing State improvement in a range of key outcomes that would address the most pressing child welfare issues including mental health, behavioral health and social and emotional needs of children as outlined in my testimony. These funds should be available for interventions that work in improving the help provided to children who have been abused and neglected and suffer from the fingerprint such trauma leaves as well as training to support a clinically competent workforce.

This concept is derived from the principles outlined in the President's FY 2012 budget to: create financial incentives to improve child welfare in key areas; improve the well-being of children and youth in the foster care system; reduce costly and unnecessary administrative requirements; use the best research currently available on child welfare policies and interventions; and expand our knowledge base by allowing States to test innovative strategies that improve outcomes for children and reward States for efficient use of Federal and State resources. The President's Budget proposed \$250 million in additional mandatory funds for these purposes.

Fiscal incentives would be provided to States that demonstrate real and measurable improvements in permanency, safety and service delivery for children known to the child welfare system and those in foster care. This proposal seeks to create financial incentives to improve

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

child outcomes in key areas, by reducing the length of stay in foster care, increasing permanency through reunification, adoption, and guardianship, decreasing rates of maltreatment recurrence and any maltreatment while in foster care, and reducing rates of re-entry into foster care.

The purpose of this incentive fund, which States would have to earn based on their performance, is to expand the reach of Federal support and build additional infrastructure and capacity within States. A methodology that incorporates the goals of accuracy, transparency, continued quality improvement and fairness would be used to determine how States would earn the funds.

Eligibility for incentive funds would be based on the number of measures for which States have demonstrated improvement on both a core set of outcome measures and a core set of quality measures.

States would be able to use the funds to focus on three areas of importance to the Administration: post-permanency services designed to improve the success rate of permanent placements; services that address the social, emotional, and mental health needs of children that can foster better permanency outcomes; and services designed to reduce the number of children who age out of foster care.

Child welfare systems serve some of America's most vulnerable children. The Federal Government should be helping States to help those children achieve safety, permanency, and success in life. Current law, however, can discourage investment and innovation that would serve children's best interests. The Administration looks forward to working with Congress on this effort, including incorporating a complementary incentive structure in Promoting Safe and

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

Stable Families to align with the direction the President's broader FY 2012 proposal would take us in moving toward meaningful reform in child welfare.

## **Conclusion**

The title IV-B funding streams are a crucial component of the child welfare system charged with supporting the safety, permanency, and well-being of maltreated children. The flexibility of these funds allows for the support of the services that can lead to the much-needed healing and recovery of children and families who have experience with child abuse and neglect. Given data that demonstrate the significant impact of a focus on meeting the social-emotional, behavioral and mental health needs of children on the child welfare system as a whole, this reauthorization provides an opportunity to strategically target funds to begin incorporating and further building a more clinically sophisticated child welfare system that is responsive to the complex needs of children who have been maltreated.

Thank you and I look forward to working with the Subcommittee on these proposals. I am happy to take any questions.

---

### ENDNOTES:

<sup>[1]</sup> Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

<sup>1</sup> Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21(4), 345-349.

**\*\*\* THIS TESTIMONY IS EMBARGOED \*\*\***  
**\*\*\* UNTIL TUESDAY, JUNE 16, 2011 AT 9:00 A.M. \*\*\***

---

- <sup>2</sup> Crawford, L., & Tindal, G. (2006). Policy and Practice: Knowledge and Beliefs of Education Professionals Related to the Inclusion of Students with Disabilities in a State Assessment. *Remedial and Special Education*, 27(4), 208-217.
- <sup>3</sup> Rushton, J.L., Fant, K.E., & Clark, S.J. (2004). Use of Practice Guidelines in the Primary Care of Children With Attention-Deficit/Hyperactivity Disorder. *Pediatrics*, 114(1), e23-8.
- <sup>4</sup> Selwyn, J., Sturgess, W., Quinton, D., Baxter, C. (2007). Costs and Outcomes of Non-Infant Adoptions. *British Journal of Social Work*, 37 (6): 1120-1122.
- <sup>5</sup> Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21(4), 345-349.
- <sup>6</sup> Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21(4), 345-349.
- <sup>7</sup> Sturgess, W., & Selwyn, J. (2007). Supporting the placements of children adopted out of care. *Clinical Child Psychology and Psychiatry*, 12(1): 13-28.
- <sup>8</sup> Leslie, LK, Hurlburt, MS, Landsverk, J, Rolls, JA, & et al. (2003). Comprehensive assessments for children entering foster care: A national perspective. *Pediatrics*, 112(1), 134-42.
- <sup>9</sup> Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21(4), 345-349.
- <sup>10</sup> National Institute for Clinical Excellence (NICE). (2008). Cognitive behavioural therapy for the treatment of common mental health problems: Commissioning Guide.
- <sup>11</sup> van der Kolk et al. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*. 18(5). 389-399.
- <sup>12</sup> National Survey of Child and Adolescent Well-Being, USDHHS. Analysis courtesy of C. Simmel, Rutgers University School of Social Work. Sample: 5,501 children and youth referred to child protective services.
- <sup>13</sup> McMillan, C.J; et al. (2005). The prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*. 44:88. Sample: 373 17-year-old youth in foster care in one Midwestern State. Percentages indicate lifetime prevalence.
- <sup>14</sup> Zito, JM et al. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*. 121(1).
- <sup>15</sup> L.K. Leslie et al. 2011; Breland-Noble et al., 2004; Raghavan et al., 2005; Zima et al., 1999