SOMETIMES "FOREVER FAMILIES" NEED A LITTLE HELP: A WHITE PAPER ON POST ADOPTION SERVICES FROM PARSONS CHILD AND FAMILY CENTER

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Introduction

Parsons Child and Family Center has committed itself to the establishment and maintenance of services that will support families and children following the legalization of adoption. Although the great majority of adoptions successfully join children and families for the whole of their lives, problems develop for some. If unaddressed, these problems may damage the entire family and even lead to the disruption* or dissolution** of the adoption. The pain of such an ending is indescribable for everyone involved.

As the facilitating party in countless adoptions, Parsons feels that its responsibility extends through the course of the family's life, not merely until a legal process is finalized. We believe that specialized services can make professionals aware of possible adoption complications, can reduce significantly the impact of attachment disorders, and can give families hope and direction during times of crisis.

> *Disruption refers to the termination of an adoptive placement prior to finalization of the adoption. this occurs between placement and the finalization before the child legally gains new parents.
> **Dissolution refers to an adoption which is legally dissolved. This occurs after finalization of the adoption.
> Placement of a child outside of the home after finalization would be considered a placement and does not indicate either a disruption or a dissolution.

Background

About 2% of the children in the United States have been adopted—about 1.8 M individuals (*Adoption USA*, 1). About 38% of these were united with families through private, domestic adoption, 37% were adopted out of foster care, and the remaining 25% were adopted internationally. In fiscal year 2006, 51,000 children (average age 6.6 years old) with public service involvement were adopted nationally; 129,000 children remained in foster care awaiting permanent families (U.S. Dept of Health and Human Services, 2008).

The overwhelming majority of American adoptions work very well: a 2009 study by USDHHS (*Adoption USA*) found that 87 % of adopting families would adopt the same child again, and that parents believed 90% of their adopted children viewed the adoptions positively. From the age of 6 on, 88% of all adopted children exhibit positive social behaviors. Interestingly, adopted children are far more likely to be read to as young children than are biological children (68% to 48%)

Much emphasis has been placed on foster care adoptions in the last 15 years, with very positive effect. The federal Adoption and Safe Families Act was enacted in 1997 and offered financial incentives to states exceeding benchmarks. President Clinton initiated the "Adoption 2002" program, which aimed to double the number of foster care adoptions in five years. New York's efforts were supported by Judge Judith Kaye's "Adoption Now" initiative in 2003; from 2000-2005, 24 526 New York State children were discharged from foster care to adoptive families. New York State won fiscal incentive awards from the federal government in 2004 and in 2005.

Evidence in Professional Literature Supporting the Need for Post Adoption Services

Despite the general efficacy of all forms of adoption, this road to family development is self-evidently different than the biological path. The children and adults involved in adoption engage in a process that, while offering very special rewards, also presents risks that are quite unique and different than those encountered within biological families.

Because of conditions and afflictions faced by some foster care youth—compromised physical health, CPS involvement, disorders of attachment, trauma and mental health problems—the integrity of adoptive families and the functioning of their children may be at risk following adoption. Groze (1996) found in a longitudinal study that 8% of children receiving adoption subsidies in Iowa had been placed out of the home after four years. Of note is that none of these families dissolved their adoption and all remained active in the lives of their children. Goege, et al. (1996) conducted a longitudinal study from 1976 through1994 that included both public and voluntary agencies in Illinois. They found that disruption and dissolution in adoption over those 8 years was 12%. Festinger (2002) found that 3.3% of children adopted in New York City from public or voluntary agencies had been in foster care during the next four years. McDonald, Propp, and Murphy (2001) similarly found that 3% of adopted children were not living with their adoptive parents 24 months after the adoption. Festinger (2004) reviewed more than 25 reports on disruption rates in the mid 1980s. These documented a 9%-15% rate of disruption for all adoptions. Among older child adoptions, the rate reached 25%.

Festinger (2002) reported that families who adopt children with special needs from foster care undergo enormous struggles and face serious barriers to obtaining services. Greatest barriers reported were lack of information as to where to go for services and the cost of services. Smith and Howard (1991) identified the following factors as significant for risk in disrupted adoption in comparison to successful adoptions: history of sexual abuse, strong attachment to birth Mother, and behavior problems before and after placement.

Dance and Rushton (2005) conducted a longitudinal study of children, 5-11 years old, placed from the foster care system in England. Poor ratings for maternal attachment and maternal sensitivity at the end of the first year strongly predicted negative outcomes for adoptions, as did the number of moves and returns home that had occurred prior to the adoption.

The *Adoption USA* report notes that foster care children come to adoption with particular challenges: 38% are identified with ADD or ADHD, as opposed to 19% of those adopted domestically, and 17% of international children; 21% of foster adoptees suffer from attachment disorders, compared to only 6% of domestic children and 8% of international children. Foster adoptees also seem to have more social-emotional problems, and do not do quite as well in school as their domestic and internationally adopted peers.

Local Evidence

Our agency experience leads us to believe that there may be a disproportionate representation of adopted children in New York State high-level treatment services such as B2H, residential treatment centers, mental health clinics, etc. For purposes of comparison with numbers below, we note that 2.5 % of all children under age 18 in the United States are adopted, according to the 2000 U.S. census.

In the last ten years, Parsons has participated in the adoptions of 178 children who were adopted through the foster care system. Anecdotally we know that 2 of these children have been re-surrendered back to the foster care system. Ten or more of them are in other living arrangements because of difficulties within the family for which the parents could not find help. This means that 6.7% of our foster care adoptions may have subsequently resulted in separation of the adopted child from the family—a percentage very similar to those reported by Groze (1996) and Festinger (2004).

The following percentages of children enrolled in Parsons' programs have a history of adoption, meaning that they have been in an adoptive home at some time in their lives:

Number and Percentage of Adopted Children in Parsons Programs, 2007-2009

	FY 07-08	Percent	FY 08-09	Percent
Residential Treatment Facility	3	10 %	5	22%
Residential treatment centers	3	6%	6	11%
Miriam House	36	51%	6	25%
Healy House	17	16%	17	13%
Child Guidance	43	9%	41	9%
Foster Board Home programs	7	4.8%	5	3.7%
Home and Community Based Waiver	15	7.7%	24	13%
B2H	NA	NA	4	7.8%

It must be noted here that while many of these children were adopted out of foster care, others come from domestic and international adoptions. In all cases, it is crystal clear that every adoption is a special situation that evolves continuously over many years.

In addition to data, we submit as well direct reports from families who have participated in our Post Adoption Resource Center (PARC).

"I adopted my child at 9 months. Who would have ever guessed that the alcohol exposure would impact my bright smiling child so much? But his impulsivity was high, and he was always so aggressive. It was only later that I learned about the need for "hard touch." It was not aggression but sensory seeking. And only as he grew did I really come to understand that fetal alcohol damage was permanent. It would not get better, although perhaps could be managed. My child was bright, so when he came home telling me how much he hated school and that he didn't do the work, I was not prepared to accept his teacher's comments that he was just lazy. They looked at what I was doing wrong at home, and blamed me for my poor parenting. They did not understand how afraid he was at school. Home was terrible because he let out all his anxiety there. At times it became down right dangerous as he would feel hurt and threatened by statements of other children that seemed innocuous to me. I got numerous phone calls at work because of school behavior, or a babysitter having problems with him and we went through repeated babysitters. My job was jeopardized and the stress began to take a toll on my health. I could not longer work full time, and once a more than adequate income, we needed to look at safety net programs. His mental health needs increased. I finally conceded, something I had fought for years, I could no longer parent him in my home. I needed out of home treatment."

"We adopted our child overseas. We got no service afterward. Now that we know what the needs are, we would be afraid to adopt again. Until we found PARC we received no services. I think people who adopt should be fearful about what they will do afterwards to meet not only the needs of their child but the needs of the whole family."

"My child would not be living with us without PARC. If funders really knew the truth we would take 3 more children if we could get the support that these kids need."

"I'd like to see the school get training to understand the needs of these children and our needs for their support. At least at PARC I can be with a group of people who understand. The school blames me for the problem, and I can't work on it without their support. I feel so judged and then there is no energy to do the work I need to do for my child."

Consequences

1. <u>Disruption and Instability</u>
   Adopted children may suffer a repetition of their initial parental loss. Parents, and any other siblings in the home, have their own sense of stability challenged. Children again are at risk of placement in expensive out-of-home care—often institutional rather than family-based foster care.

Adoptive families report that when they faced problems with their children, friends, family members, and even well-meaning professionals often encouraged them to "give the child up." They found such advice inconsiderate of the relationship that already existed with their adopted child, and they derived little hope for the future. Negative professional advice in particular may erode, rather than strengthen adoptive family relationships.

2. Damage to Adopted Child

There is evidence accruing in the National Childhood Traumatic Stress Network (sponsored by the United States Substance Abuse and Mental Health Administration) that the removal of children from families may constitute a traumatic event for many children, followed by predictable symptoms and functional deterioration. As a child's behavior and functional ability deteriorate with successive placements, the prospects for lasting attachment diminish, needs exacerbate, and the level of intervention increases.

3. New Costs

Residential care can be expected to cost $80,000 per year or more. If just three placements are averted a year, a post adoption program can serve over 100 families. The importance of preserving enduring relationships is priceless and the most important reason to fund post adoption services. There is cost savings to the taxpayer of preserving these relationships.

Family Needs

In July 2009 Parsons PARC conducted a needs survey among adoptive and pre-adoptive parents throughout PARC's catchment area. Six local DSS units sent the survey to all pre-adoptive parents, and to all adoptive parents receiving subsidies. A total of 650 surveys went out; 17% were returned. The survey asked the families to rate which service they thought they needed most, and which service they would use if it were offered.

1. Services Rated by Families as "Most Needed"

Service	Percent of Respondents Rating Service "Most Needed"
Respite	47%
School Vacation Day Camp	36%
Individual Counseling	34%
Child Background Information	32%
After School Programming	29%
Services Information and Referral	29%
Peer Support Groups	23%

2. <u>Services That Would Be Used if Available</u>

Service	Percent of Respondents
Services Information and Referral	58%
School Vacation Day Camp	54%
Educational Advocacy	50%
Respite	48%
Peer Support Groups	47%
Children Support Groups	46%
Crisis Intervention	44%
Parent Education	43%
After School Programming	42%
Subsidy Information	42%

The following are examples of children and service needs actually addressed through Parsons' PARC.:

- A twelve-year-old boy was placed soon after birth with an adoptive parent. Although there is no history of drug exposure in utero, he was fed very poorly and was failure to thrive when placed at one month of age. Now at age 12, he is physically aggressive within the family setting. He receives the following services:

  Special education with an IEP
  Support group: family regularly attends—2 parents, 2 children
  Respite: 12 hours a month
  After School Program: 3 days a week
  Advocacy with CSE
  Consultation for their school

  The family uses professional services as well as the support of other families experiencing the same type of stressors. They have had two crisis residence placements and one hospitalization in the last year. They stated that the support they received from PARC enabled them to keep their son at home rather than pursue residential placement.

- A 14-year-old girl was placed at four years of age from Eastern Europe. She came with a history of trauma and abuse. She was placed with a sibling. She has struggled a bit academically in school but has always managed to pass with supports. Peer relationships with girls have been difficult. She initially struggled a great deal with her relationships within the family, and has a history of depression. PARC was able to help the family access appropriate counseling within the community, adoption-sensitive psychiatry for medication management, advocacy within the school, and support groups for the parents and the children.

Current services:

IEP with mainstreamed programming
Support group—family attends regularly with one or both the children. Peer groups, especially teen group, is useful.
School advocacy

There have been no hospitalizations and no crisis placements. The parents have felt that PARC has made the difference for their daughter because they can access support of people who

> *understand and don't judge us--something that has been hard for our own immediate and extended families to do as they watch us hurt for our children. Their solution to end our pain is 'just give them up.' We would never do that. People don't understand they are our children even if they were not born to us. They are ours.*

- A single woman adopted a toddler who was diagnosed as a special needs child with cerebral palsy and asthma. As a nurse, she felt she could meet his needs. This child was from the foster care system in an adjoining state. She adopted with a subsidy for special needs.

By the time the boy was four years old, the cerebral palsy and asthma were relatively mild needs. The Attention Deficit Hyperactivity Disorder (ADHD) was now pronounced. The son was expelled from several day care centers. The mother was exhausted from doing the supervision in her home and was having difficulty in her job because of the frequent absences responding to the inability of school programs to meet her son's needs.

Mother asked the county for respite and support, but the county had none. She did receive help in a crisis intervention program because his dangerous and impulsive behavior was not abating nor being helped by medication. When it was time to leave this program, mother went to her county and asked to do a voluntary placement. The county offered to take a voluntary permanent surrender. Take him home or surrender were the only two choices offered by her county. Mother's lawyer advised her to go into court and ask for a placement as she could not meet his needs without help of an afterschool program or some form of respite. The judge denied the request and took the surrender. The child was five years old at the time. After mother returned subsidy payments, her county of residence assessed her 17% of her income, toward the cost of the child's placement.

Seven years later, the boy was still in residential treatment without a family.
We believe the lesson of this anecdote is not that practitioners are incompetent, insensitive, or unintelligent, but that the system as currently designed offers an incomplete array of support for a special circumstance—the high risk adoption.

- Jerry had been in foster care since 2 years old, with several returns home to his birth family. Despite efforts to help the birth parents and their love of Jerry, his mother and father were struggling with a drug addiction and were not able to gain control over it and maintain control of their sobriety. When Jerry was 5 ½ years old his birth parents surrendered, and by age 6, he was adopted.

  By age 13 Jerry was struggling. His parents could not understand why he guarded himself from connecting with them, or why he had become so aggressive. They were advised that this is normal teenage behavior. To the parents it just felt too intense. They felt like no one really understood and they were ready to give up and surrender Jerry back to the system.

  One provider suggested they call the post adoption program. Jerry was able to meet with other teens who were adopted, and the parents were able to meet with other parents. This gave them emotional energy to keep going. That didn't mean that all was smooth. One night, in a very destructive rage, he blurted out that he had been sexually abused by a babysitter while living with the birth family. He didn't want anyone near him, and he didn't want all the things he saw going on with his peers. His parents called the post adoption resource center, and got some understanding support from the parent advocate and social worker. The pieces were beginning to fit together.

Programs in Other States

Forty-eight states and the District of Columbia, including New York State, indicate that they provide, directly or indirectly, post adoption services. There are no specific post adoption services available in North Dakota or Washington State.

The services offered vary in terms of eligibility, services, and how they are provided. Most states fund and/or provide post adoption services to families who have adopted out of the state foster care system and/or are eligible for adoption financial assistance. There are only a few states that provide services to any family who has adopted, and at least one state that provides services to all members of the adoption constellation. Services in most states are state funded and provided by private agencies and/or parent organizations and are overseen by the state. Services delivered or supported by public child welfare agencies are of at least four types:

1. Those funded as part of the workload of the typical adoption worker.
2. Those funded as part of a special unit of service providers.
3. External contracts involving multidisciplinary collaboration and training.
4. Network of family resource centers.

According to the Child Welfare Information Gateway, Adoption Assistance by State, states offer:

Support groups – 48 states
Information and Referral – 43 states
Respite – 40 states (includes 3 states that provide child care/child care reimbursement)
Counseling – 31 states
Search/Adoption Reunion Registry – 26 states (includes 1 state that provides medical and family history)
Advocacy including Educational Advocacy – 16 states
Resource Library – 13 states
Case Management – 12
Crisis Intervention – 11 states
Mentoring/Buddy System/ Family Liaison – 7 states
Residential Care, including cost share agreement with family – 6 states
Newsletter – 5 states
Family Preservation – 4 states
Diagnostic Assessments and Evaluations – 4 states
Waiver of Higher Education Tuition and Fees – 4 states
Recreation and Retreat – 4 states
Internet Chat Room – 2 states
Developmental Disabilities Services – 1 state
Legal Resource Information – 1 state
Tutoring – 1 state
24-Hour Crisis Hotline – 1 state
Walk-in Center – 1 state

Highlights by State

Alabama is one of only three states (others are Alaska and Massachusetts) that provides post adoption services to any family that has adopted, regardless of income or source of adoption. The program, known as the Alabama Post Adoption Connections (APAC) program, is funded through a contract with the State Department of Human Resources and is provided through five offices located throughout the state. The money is actually 75%-80% federal funding that the state matches for adoption services. The state solicits Requests for Proposals and various agencies bid for a contract.

Massachusetts also provides post adoption services to any family that has adopted, regardless of income or source of adoption, and to families who have permanent guardianship. The program known as Adoption Journeys in Massachusetts, formerly known as Adoption Crossroads, is 100% funded through the Department of Children and Family Services. Services are provided at five offices throughout the state. The program is consumer driven, which means that families are self-referred to the program.

Services:

Information and Referral (24 hour)
Parent liaison
Support groups for parents, teens and children, which are ongoing
Respite through monthly activities, financial assistance or direct provider
Training of respite providers
Adoption competency training – adoption sensitive training for therapists and schools
Regional Response Team: 2-person team (social worker and master level worker) go out to the home to work with families for a short-term period of time (3 months) to stabilize situation and make referrals, if necessary, to longer term counseling resources.

Massachusetts also provides a tuition waiver for Massachusetts's state colleges, universities and community colleges to children up to 25 years of age who were adopted from DSS by residents of Massachusetts.

The program was initiated in 1998. The state contract is for three years with a renewal process. The School of Social Work at Bridgewater State College is beginning to review data submitted by the program to determine effectiveness. They are looking at levels of family stress and risk of out-of-home placement. The preliminary, unofficial findings are that post adoption services are effective.

Tennessee requires the Department of Human Services to offer post adoption services "in order to reduce the risk of adoption dissolution and to support the goal of permanency in adoption" to families who have adopted children from foster care, and to birth families of children adopted through the department. Services include:

crisis intervention, including the provision of immediate assessment and time-limited treatment in volatile situations and connecting families to long-term adoption-sensitive treatment providers;
family and individual mental health counseling provided in the home;
support groups for families and children;
respite through respite financial assistance;
information and referral;
case management;
and networking between families and community service providers.

State funding supports programs provided by three partner agencies throughout the state through annual grants. Services are provided to families on a fee-for-service basis who request them but who do not meet the criteria of the state programs. The fees were described as "nominal." The in-home treatment and counseling to children and families was described as the most highly utilized service, which can extend until the youngster is 19 years of age. The Adoption Support and Preservation (ASAP) program also provides training to professionals in the community on attachment and bonding. The state has recently extended services to pre-adoptive families.

In Oregon, post adoption services are administered by the Department of Human Services (DHS), State Office for Service to Children and Families (SOSCF) through yearly contract with Northwest Resource Associates, a private not-for-profit provider. Services provided to eligible adoptive families by ORPAR include:

Information and Referral including needs assessment and referral to parent run programs, agencies or individuals providing services such as support groups, respite, counseling or residential treatment. Information also dispensed through quarterly newsletters and website
Educational programs for parents and professionals
Educational materials through a lending library
Advocacy
Mediation/search services – Cooperative Adoption Mediation Program (CAMP) to encourage mediation and assist in search and reunification efforts.

Oregon also has a voluntary Adoption Registry, and all parties to adoption are informed of its availability. Services are available to Oregon residents who are parents of children who have been adopted through the public child welfare system in Oregon or in any other state. Parents request services in person, by telephone, or in writing. Provision of services is based on the needs of the child and family, and the availability of DHS and community resources.

Funding is 75% federal and 25% state, administered through the State DHS. During the current financial crisis in Oregon, their state funds have recently been cut by 30% which, in turn, has impacted the federal funds. The federal funds were part of Title IVB part 2B, Adoption Preservation and Support.

Utah has provided post adoption services administered through DCFS. It coordinates and local post adoption resources in each area of the state and informs adoptive parents of the availability of these resources. Services focus on information and referral, education and training, family support and respite care, and treatment and crisis intervention.

Results of a post adoption survey published in 2008 indicated that the adoptive families' levels of awareness of post adoption supports and their ability to access these services had increased. The use of services had remained stable, but the satisfaction had increased over studies completed in 2002 and 2003 when the state had an Adoption Opportunities Grant. Education, mental health, information about the child's special needs, respite care, and DCFS post adoption services were ranked as those areas of the greatest needs for families. The goal that the state has set for these services is to keep adoptive children and their families safe and thriving. A summary of policy recommendations made to Utah from this study include:

1. Continue use of a state wide newsletter and resource booklet.
2. Keep information in these vehicles current.
3. Educate community partners about post adoption services.
4. Advocate for and facilitate adoption competent education and mental health service provision for children and families.

5. Continue to promote unencumbered accessibility to an array of post adoption services to meet needs for information and referral, education and training, family supports and respite care, and treatment and crisis intervention needs.
6. Recognize that DCFS will always remain a point of contact for these families.

Programs in New York State

There are currently 13 post adoption programs supported by TANF grants within New York State. These are the post adoption programs currently being offered. These include information and support, respite programs, training programs, crisis intervention, counseling, support groups, children's groups training for professionals and training for parents. Most of these programs are primarily TANF funded. Some programs have small grants which supplement their TANF Funds. One agency had a federal grant. Unfortunately the bulk of these programs were principally funded with government grants which made their stability highly vulnerable.

Four Common Objections to the Establishment of Post Adoption Services

Misconception and insufficient information have contributed to our inability so far to raise the profile of post adoption services in degree commensurate with their importance. Four of the most common objections are presented and discussed below.

1. **"This family chose to adopt, and therefore it should be responsible for managing the consequences of adoption without obligation on the part of the government."**

There are two considerations here—commonsense and morality. We know for a fact that most adoptions are successful, and that the great majority of adopting families do not need and would not use services. We also understand that an increased risk attends the formation of family through adoption. Should these risks overwhelm the unsupported adopting family, very expensive consequences are visited upon the state in the form of foster care and treatment services. It makes sense to take relatively inexpensive steps to preclude the small but significant risk that is part of every adoption.

When a family adopts a child from the foster care system, that family relieves the state of a profound legal and financial burden. The state—the unquestionable beneficiary of the adopting family's actions--does have a moral obligation (in addition to the commonsense obligation described above) to be with that family in the event of future difficulty. When it stands by families that have come forward to adopt foster children, the state encourages others by assuring them that they will not be left alone. When it abandons families that have taken kids out of foster, the state frightens and discourages others who might have been willing to do the same.

2. **"We should not deprive children and families the opportunity to enjoy normalized family lives free from unwanted services."**

We agree completely: families have complete discretion to use or not use services as they see fit. Adoptive families must be indistinguishable from every other sort of family with respect to their right of self-determination. But for all the reasons given in this paper, if an adoptive family asks for help, then help should be there—specialized help expressly designed and directly tested for the particular circumstances that surround adoption. We do not use firemen everyday, but when we need them they should come quickly, and they must know what they are doing when they arrive.

3. **"B2H will provide all the help families need. We do not require specialized services for adoptive parents."**

B2H is an enormous step forward, but a child must be in foster care in order to be eligible. Some adopted children are; most are not. Over 2/3 of adopted children are adopted privately and domestically or internationally; only about 1/3 are adopted from foster care. Many of that 1/3 leave foster care for adoption without B2H and do not develop a need for service until later, when they are no longer eligible for B2H.

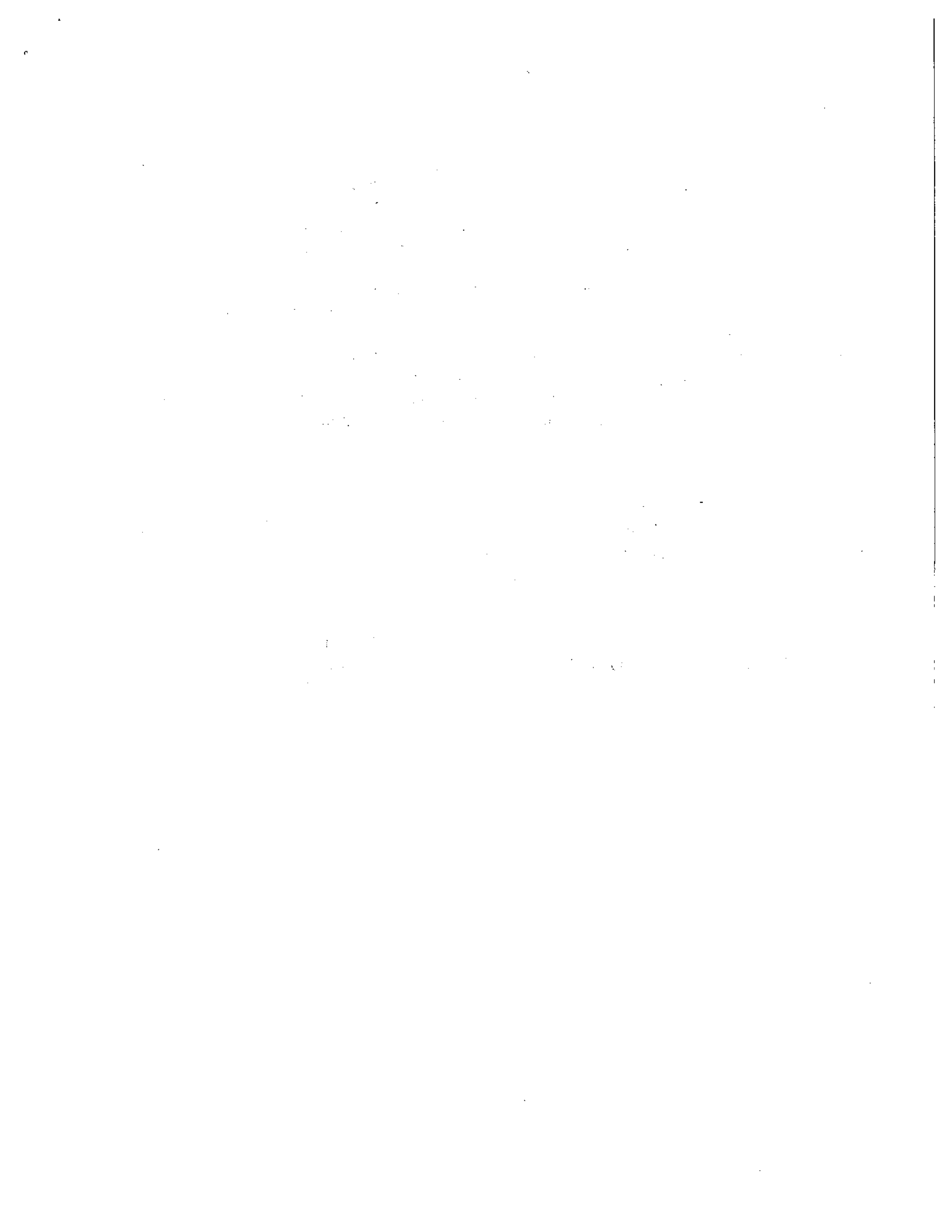
4. **"The families already receive generous long-term subsidies. They should use these to purchase whatever help they need."**

Families cannot purchase what does not exist, or what they do not know they need. The complexities of attachment and attachment failure, confusion about sources of inexplicable behavior, self-doubt and guilt, and unexpected reaction to overwhelming emotion are all hallmarks of those adoptions that become problematic. Children and families suffering from these things need specialized assistance. They are unlikely to find it without access to post adoption centers that can refer them to trained therapists and bring them into contact with peers who are in identical situations. All the money in the world is useless to people who are isolated.

The subsidies are indeed generous, but they are often not enough to spare adopting families financial stress. How can an $18 000 annual subsidy not be enough? Consider that in the year prior to the adoption of a foster child, state and county were paying a minimum of $50 000 for a foster family placement, and between $80 000-$100 000 for congregate care. The effects of a successful adoption can seem miraculous, but the details that support it are not magical.

Parsons' Recommendations

1. Given the unique aspects of adoption as a path to the creation of families, and the special risks that attend adoption, we believe NYS should establish permanent post adoption services.
2. Post adoption services should be available to all adoptive families, irrespective of whether the child is adopted privately and domestically, internationally, or from state foster care.
3. Because of their greater risk, and because of the state's direct responsibility in them, NYS should place special emphasis on foster care adoptions. In addition to the services recommended above, we believe NYS should upgrade its monitoring of post adoption outcomes so that it can continually adjust support to adopting families.
4. Post adoption services should be available at any time following adoption, and should include at least:
    - Adoption information
    - Peer support
    - Parent education
    - Adoption-informed family counseling
    - Adoption-informed individual counseling
    - Crisis intervention
    - Respite
    - Continuing adoption services training for professionals
5. Fees for services should only be considered above an income threshold, irrespective of the type of adoption (i.e., private domestic, foster care, or international).



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February 5, 2010

Senator Carl Kruger
Chair – Senate Finance Committee
913 Legislative Office Building
Albany, New York 12247

Chairperson Kruger:

Attached you will find Local 372, New York City Board of Education Employees testimony for the February 3, 2010 Mental Health and Hygiene Budget Hearing. I would like to submit my testimony for the record.

If you have any questions, please feel free to contact me at (212) 815-1372.

Thank you

Veronica Montgomery-Costa
President – Local 372, District Council 37 and
International VP of AFSCME

LOCAL 372

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FEBRUARY 3, 2010

TESTIMONY SUBMITTED BY

VERONICA MONTGOMERY-COSTA

PRESIDENT - LOCAL 372 AND DC 37, AFSCME, AFL-CIO

VICE PRESIDENT - AFSCME

February 5, 2010

Don't give the Mayor the flexibility to double-dip our SAPIS allotment.

Although the 2010 Executive Budget does not further reduce the number of SAPIS, the Mayor and Chancellor have found a way.

The Mayor and Chancellor are asking the legislature for more flexibility in spending, suggesting the consolidation of funding categories.

They publicly proclaim that since personnel takes up the largest portion of their budget, the best means of saving money are layoffs.

Here's how the Mayor double-dips the State allotment.

First, they take the State SAPIS allotment, then lay off enough vetted, experienced and qualified SAPIS to pay for an outside contract providing uncertified, unknown, less qualified prevention counselors. Now that contract is paid by the State.

Then, the SAPIS, funded by the state and laid off by the City cost the State in Unemployment, Welfare, Food Stamps and Medicaid. The City loses nothing and the State pays twice, as well as losing income tax revenues.

The SAPIS allotment must be earmarked for SAPIS only.

Local 372 SAPIS are the best qualified for their work.

Local 372 SAPIS received training in science-based counseling methods by the State — through OASAS. The majority of our SAPIS have 20 years of experience and are fingerprinted, vetted and have completed job-related college requirements. In fact, the State has, since 1971, evaluated the New York City prevention programs and rated them among the best in New York State.

Outside contractors from organizations, even those with boards of directors listing corporate stars from Wall Street — Good Shepherd, for example — may not do adequate background checks and may employ counselors with far less suitable qualifications

Local 372 SAPIS are worth their weight in gold.

Local 372 SAPIS (Substance Abuse Prevention/Intervention Specialists) are established active members of their school community. They are your constituents. The majority of SAPIS live, vote and pay taxes in their school community and are parents/grandparents/guardians of children in their neighborhood schools. SAPIS spend their wages supporting school community businesses.

Cutting SAPIS vital services diminishes the quality of school life and has consequences in the family life of the children, who are their life's work.

SAPIS layoffs by the City seriously compromise our schools' first line of defense against alcohol, tobacco and substance abuse, intolerance, drug related violence, dropping out, teen pregnancy and HIV/AIDS. Particularly, in hard economic times such as these, cutting vital school life support services also has consequences for New York City families. Loss of these services puts our students' families at greater risk of child abuse, poverty, homelessness and dependence on the State.

In Conclusion:

Local 372 asks our State elected officials to insure that the Mayor cannot double-dip the SAPIS allotment and have the State pay for his addiction to outside contracting.

We urge that you take action to prevent SAPIS layoffs by the City for the benefit of your community and the children who depend upon us to do the right thing. We must work together to insure our children a safe, healthful and rewarding future.

Testimony before Joint Legislative Committees

Topic: SFY 2010-2011 Executive Budget Proposal

Mental Hygiene Hearing
February 3, 2010

Presented by Lauri Cole, Executive Director
New York State Council for Community Behavioral Healthcare
(518) 461-8200

Good morning.

My name is Lauri Cole. I am the Executive Director of the NYS Council for Community Behavioral Healthcare. The NYS Council is a statewide, nonprofit membership association representing the interests of mental health and substance abuse / chemical dependency agencies. The Council is a unique organization in that we represent the needs of freestanding treatment and rehabilitation providers, the behavioral healthcare divisions of general hospitals, and the mental hygiene departments of local government units.

I am here today to discuss aspects of the Governor's Executive Budget proposal as they relate to the State Office of Mental Health and the Office of Alcohol and Substance Abuse Services.

Summary:
The members of the New York State Council for Community Behavioral Healthcare are grateful to Governor Paterson, Commissioner Hogan, and Commissioner Carpenter-Palumbo for their efforts to protect core Programs and Services in their budget proposals. Our members recognize the extraordinary fiscal circumstances facing New York at this moment and we are working hard to ensure New York gets its' fair share from Washington. It is for these reasons that the NYS Council supports with few exceptions the Executive Budget proposals put forward by the Office of Alcohol and Substance Abuse Services, and the State Office of Mental Health.

Response to OASAS Executive Budget Proposal

Investments in Residential Treatment Beds and Outpatient Services

The OASAS Budget proposal continues New York's investments in substance abuse and chemical dependence residential and outpatient services. In doing so, the State is honoring its' commitment to develop capacity, and to make treatment options available to clients being impacted by recent Drug Law Reform. The New York State Council strongly supports these investments in community-based treatment and recovery services. We believe recovery is possible.

OASAS APG Reform

The ongoing effort to restructure the reimbursement methodology and rates associated with OASAS Outpatient Clinics including Methadone Clinics and hospital-based outpatient services presents a significant challenge to the service delivery system. It also presents opportunities for improvement to the range of services provided in these settings. It is our hope that as the OASAS APG initiative moves toward implementation, an evaluation process will be initiated that monitors for unintended gaps in care that may exist as result of this reform. It is also our expectation that the state will invest in providers and make resources for training and technical assistance opportunities available to them. We also think it will be necessary for the state to invest in the success of this conversion by making concrete assistance available to providers, to assist them with infrastructure changes that will be required to bring APGs online.

Response to SOMH Executive Budget Proposal

Outpatient Clinic Reform

As you know, the Ambulatory Care reform projects underway across the health and behavioral health continuum of care are numerous. While no more or less significant than any other reform, the SOMH Outpatient Clinic restructuring project has the potential to alter the mental health service system in very profound ways.

The New York State Council has been at the forefront of efforts to prepare our members for the implementation of Clinic Reform. We see this change as inevitable. We agree with state leaders that the funding model for clinics must change due to a variety of factors including federal Upper Payment Limit Rules, and the existence of a subsidy that must come out of the current funding formula. We support the Department of Health in its continuing efforts to build an ambulatory system where rate structures are transparent, payers can quickly identify what they are purchasing, and most important, where clients get more of what they need in the way of evidence-based care.

We believe that the SOMH clinic reform model includes several new opportunities for providers to begin offering services that will result in better care for clients. ***However, we need to alert you to a potentially adverse outcome associated with Clinic Reform. Unfortunately, the Executive Budget proposal is silent on this matter.***

As providers have continued to prepare for implementation of Clinic Reform, we have asked them to evaluate what impact the removal of the COPS subsidy will have on their continued ability to serve the variety of clients who seek their assistance. This includes clients who are Medicaid Managed Care beneficiaries as

well as those individuals and families with commercial insurance. It also includes New Yorkers who are uninsured or under insured and as such, are often unable to afford the co-pays associated with care.

When clinic operators run the numbers, many find they will be unable to serve Medicaid Managed Care and commercially insured clients due to insufficient rates paid by these insurers. About one-third of our members have already cancelled one or more contracts with Medicaid Managed Care vendors that will not agree to pay rates approximating the Medicaid Fee for Service rate paid by the State. Another third of our members are contemplating discontinuing services to Medicaid Managed Care and commercial clients as they try to re-contract with insurers who are attempting to lower their reimbursement rates. Many insurers cite the economy as their primary rationale for a decrease in rates.

Many NYS Council agencies provide children's clinic services. A significant number of them anticipate being unable to offer high quality care under Clinic Reform due to insufficient rates currently paid by Child Health Plus and Family Health Plus. Others of them are opting out of insurance provider networks entirely. When they do this, they are required to collect fees from commercially insured clients on an out of pocket basis. This leaves the family or individual in a position where they must choose between necessities. Ultimately, they are often unable to lay out the fee for services.

For the past forty years, New York State has made an investment in the development of a statewide network of public mental health clinics that provide critical services to New York's most vulnerable children and adults. Our clinics are the safety net provider community members turn to when they are unable to find a private practitioner who will treat a serious condition/s due to the complicated nature of the illness or the considerable amount of time that would be required to manage the case.

Finally, if rates do not permit clinics to continue to serve clients as they do presently, workers employed in these settings, many of whom are your constituents, will no longer remain employed on a full time basis with health insurance and other benefits, as they will be too costly for providers to maintain.

The New York State Council supports SOMH and DOH in their efforts to require MMC plans to pay the same as or close to the Medicaid Fee for Service rates. **We expect a proposal with language to address this issue may reach the Governor's desk during the current 21-day budget amendment process. We ask your support for any proposal that seeks to remedy what is a dire problem facing mental consumers and providers.**

Finally, while the NYS Council applauds the planned development of an indigent care pool to reimburse behavioral health providers, the compensation for services will also fall significantly short of the new Medicaid fee for service rate. We would like the State to make sure that reimbursement from the indigent care pool are at levels equal to Medicaid Fee for Service rates.

Other SOMH Executive Budget Proposal We Support

The New York State Council strongly supports a proposal in the state operations portion of the OMH Budget proposal that authorizes up to 250 adult inpatient beds be reduced or replaced via conversion of these beds to the Transitional Placement Program (TPP). TPPs provide support to transition individuals to community care.

We support the proposal of a new initiative to implement in-home assessments of adult home residents in order to build and enhance services for these vulnerable individuals.

We support the proposed allocation of $1.75 million for two ongoing Managed Care initiatives (one in NYC; one in Western NY).

We support continued funding ($500,000) for initiatives designed to enhance services for individuals with co-occurring disorders.

We support the proposal to close eight psychiatric center wards at various state facilities, thus reducing state-operated inpatient capacity by approximately 5% *on the condition that savings are reinvested in less costly and more appropriate community care options for seriously ill New Yorkers.*

Executive Proposal to Extend the Exemption for the Social Work and Mental Health Practitioner Licensing Requirements for an additional 4 years

In 2002, New York State enacted laws to restrict the practice of psychotherapy to individuals licensed in Clinical Social Work by the Education Department. This statutory change affected the licensure and practice of psychology, social work, and the mental health professions not only in private practice, but also at thousands of nonprofit agencies and in state-operated facilities. As a result of amendments made to the Licensing law in 2004, a range of unintended consequences have been identified by mental health professionals, licensed master social workers, state and local officials, and nonprofit administrators.

Leaders of the New York State Council continue to work alongside our colleagues from across the human services delivery system as part of an Alliance of agencies working to identify solutions to the primary licensing issues facing our field at this time. Given our belief that an extension to the current exemption is necessary to permit the members of our Alliance to work with the Education Department, the Higher Education Committee and the multitude of stakeholders involved impacted by this issue we unconditionally support the Executive proposal to extend the exemption for four years. The current exemption is scheduled to sunset on June 30, 2010. If this is allowed to happen, a significant number of workforce problems emerge, placing even more pressure on a system that is already deprived of resources.

We also request that you please support the 21-day budget amendment letter submitted by Manatt, Phelps and Phillips, LLP on behalf of our coalition to extend the exemption to the following state agencies:

1. The Department of Corrections
2. The State Office for the Aging, and
3. The Department of Health

Executive Proposal Increasing OMIG Recovery Targets

Governor Paterson's budget includes a proposal to increase the fraud and abuse recovery targets for the Office during the coming budget year. The Executive Budget proposes to increase the target by $300 million for a total of $1.7 billion (if enacted) (state share only).

The NYS Council rejects in the strongest possible terms the current practice of this Administration to increase OMIG targets as the state's fiscal circumstance changes.

The members of the New York State Council for Community Behavioral Healthcare support appropriate actions on the part of the Office of the Medicaid Inspector General to identify and punish those providers who knowingly commit fraud and/or abuse. There is no question in our minds that providers who defraud the Medicaid Program should receive a punishment commensurate with the crime. What we do not condone are targets placed on the backs of providers who are delivering services as directed and according to regulation, who come under attack by auditors who are under increased pressure to identify artificial monetary targets assigned to them.

In last year's Deficit Reduction Plan, OMIG fraud and abuse targets were increased by some $150 million.

We ask your support for an immediate moratorium on any/all proposals to raise OMIG recovery targets beyond their current levels until there has been a public discussion of this matter.

We urge you to reject the Governor's proposed increase of recovery targets for the OMIG until the Governor's Office makes public their formula for calculating and setting these targets. We would also request a public comment period where stakeholders are able to comment on the methodology used to determine OMIG recovery targets.

New York State Council positions on Executive Budget revenue proposals, taxes, and/or fees:

- Although not proposed as part of the Executive Budget proposal **the New York State Council will strongly support legislation sponsored by Assemblyman Felix Ortiz (A06738) to raise taxes collected on the purchase of alcoholic beverages** with revenues returned to OASAS for purposes of expansion and enhancement of OASAS Programs and Services.
- We support the implementation of a tax on the purchase of beverage syrup and soft drinks with revenues directed to healthcare.
- We support an increase of the cigarette excise tax by $1.00/pack.
- We oppose allowing the sale of wine in grocery stores.
- We oppose extending VLT Hours of Operation.

Supplemental Funding for Behavioral Health Infrastructure Improvements

The NYS Council would like the Legislature to consider supporting the **maintenance of the behavioral health system by authorizing a supplemental infrastructure investment pool of dollars that will cover increases in costs of mandated computer technology requirements.**

In many instances, the community-based behavioral health system has been left behind when funding is available for infrastructure improvements. For example, when the Federal stimulus bill authorized new funding for Health Information Technology (HIT) investments, money has been made available to primary care providers, hospitals, nursing homes, etc. Unfortunately, community based organizations were not eligible to access stimulus money for IT improvements, even though we are accountable to the same financial standards, as well as IT requirements, like the development of electronic health records.

Thank you for your time.

Written Testimony of

Audrae Erickson

Corn Refiners Association

Submitted to the

New York State Legislature

Senate Finance Committee

Assembly Ways and Means Committee

For the Joint Hearing on

2010-2011 Executive Budget Proposal

February 1, 2010

The Corn Refiners Association thanks the Senate Finance Committee and the Assembly Ways and Means Committee for the opportunity to submit written testimony regarding the 2010-2011 Executive Budget Proposal. One aspect of this budget proposal includes a tax on "sugared beverages". We offer the information in our testimony as evidence for the Committees that sugared beverages should not be taxed.

The Corn Refiners Association (CRA) is the national trade association representing the corn refining (wet milling) industry of the United States. CRA and its predecessors have served this important segment of American agribusiness since 1913. Corn refiners manufacture sweeteners, ethanol, starch, bioproducts, corn oil, and feed products from corn components such as starch, oil, protein, and fiber.

Singling out certain foods or beverages for government penalization, whether through nutrition or tax policies, will only serve to further confuse consumers and will not lead to meaningful results in assisting Americans to adopt healthier lifestyles. We therefore urge that this specific tax on sugared beverages be rejected.

According to James M. Rippe, M.D., cardiologist and biomedical sciences professor at the University of Central Florida, "We are eating too much of everything, not just sugar. Over the last three decades, the average American has increased their calorie consumption by 24% and physical activity has declined. People are singling out sugar as the one smoking gun in the obesity epidemic when there are guns everywhere." (Boyles S. "Fresh Take on Fructose vs. Glucose." WebMD Health News. April 21, 2009)

A peer-reviewed study published in the August 2007 issue of *Food and Chemical Toxicology* found that those who frequently consume sweetened soft drinks do not have a higher obesity rate than those who rarely drink them. The study found higher obesity rates correlated with several other factors, such as the amount of time in front of the computer or TV, or the consumption of high amounts of dietary fat.

The authors noted, "Obesity is a multi-factorial problem which is rooted in a positive balance between energy intake and expenditure. Lifestyle, behavior, and environment appear to have a more dominant role in obesity prevalence than do individual foods." (Sun SZ, Empie MW. 2007. Lack of findings for the association between obesity risk and usual sugar-sweetened beverage consumption in adults - A primary analysis of

databases of CSFII-1989-1991, CSFII-1994-1998, NHANES III, and combined NHANES 1999-2002. *Food Chem Toxicol* 45(8):1523-1536.)

It is especially important to understand that Americans are consuming more calories from all types of foods today than what was consumed 30 years ago, and we expend less energy to burn the extra calories. Consider the numbers reported in the February 2009 Loss-Adjusted Food Availability Data by the U.S. Department of Agriculture. Total caloric intake on a per capita basis for Americans increased from 2,172 calories per day in 1970 to 2,775 calories per day in 2007 – an additional 603 calories.

Major contributors to this 603-calorie increase include 299 calories from added fats and 194 calories from flour and cereal products. Added sugars account for only 57 calories of the daily increase. (U.S. Department of Agriculture, Economic Research Service. 2009. Calories: average daily per capita calories from the U.S. food supply, adjusted for spoilage and other waste. Loss-Adjusted Food Availability Data.)

Many sugared beverages are made with high fructose corn syrup, a safe and natural ingredient that is handled the same as sugar by the body. There has been a lot of confusion about high fructose corn syrup. We would like the following statements from the American Medical Association and American Dietetic Association included on the record.

The American Medical Association stated that, "Because the composition of high fructose corn syrup and sucrose are so similar, particularly on absorption by the body, it appears unlikely that high fructose corn syrup contributes more to obesity or other conditions than sucrose." (Report 3 of the Council on Science and Public Health A-08, June 2008.)

According to the American Dietetic Association (ADA), "high fructose corn syrup…is nutritionally equivalent to sucrose. Once absorbed into the blood stream, the two sweeteners are indistinguishable." The ADA also noted that "Both sweeteners contain the same number of calories (4 per gram) and consist of about equal parts of fructose and glucose." (Hot Topics, "High Fructose Corn Syrup." December 2008.)

For the reasons set forth in this written testimony, the Corn Refiners Association urges the Senate Finance Committee and the Assembly House and Ways Committee to oppose a tax on sugared beverages. Thank you for considering our concerns.

Respectfully submitted,

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Rippe Lifestyle Institute

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Written Statement of
James M. Rippe, M.D.
Founder and Director
Rippe Lifestyle Institute
Professor of Biomedical Sciences
University of Central Florida
Submitted to the New York State Legislature
Senate Finance Committee
Assembly Ways and Means Committee
Joint Hearing
February 1, 2010

The purpose of this written statement is to express concern regarding the proposed measure to tax sugared beverages as part of the 2010-2011 Executive Budget being considered at the joint hearing of the New York State Senate Finance Committee and the Assembly Ways and Means Committee.

As a board certified cardiologist and Professor of Biomedical Sciences, my background in this area comes from extensive research over the last 25 years in cardiovascular disease, metabolism, obesity, and diabetes. My research laboratory has been a leading source of information on nutritive sweeteners over the past decade. My research team has published extensively in the metabolic effect of nutritive sweeteners, and I have testified in front of the American Medical Association and elsewhere concerning these issues.

The issue of obesity is a complicated one. There are multiple causative agents that impact on obesity. The simple fact is that we are eating more from all sources than we were 25 years ago and are exercising less. In fact, as a percentage of calories the calories from all nutritive sweeteners combined have actually declined over the last 25 years. In our diet we consume 3-1/2 times as many calories as fat than we do from all nutritive sweeteners combined. Historically, every effort to combat obesity by singling out one component of the diet has resulted in abysmal failure. There is significant risk in targeting any one segment of the diet as a causative agent of obesity. Such efforts are doomed to failure and when this latest attempt fails, the public will once again be left with less trust in our government when it comes to the important public health issue of obesity.

The argument that taxing or banning certain substances in the food supply will result in decreasing their consumption may be true, but it will not have any measureable impact on the overall calorie consumption or prevalence of obesity in our country.

Sincerely,

James M. Rippe, M.D.
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THE GEORGE WASHINGTON UNIVERSITY
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Written Statement of
Arthur Frank, M.D., Medical Director
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Submitted to the New York State Legislature
Senate Finance Committee
Assembly Ways and Means Committee
Joint Hearing
February 1, 2010

I am writing to express concern regarding the proposed taxation of sugared beverages as part of the 2010-2011 Executive Budget being considered at the joint hearing of the New York State Senate Finance Committee and the Assembly Ways and Means Committee.

Part of my perspective on the issues of diabetes and obesity derives from my professional activities for the past 33 years in research and in the clinical management of obese patients as the Medical Director of the George Washington University Weight Management Program. With this background I have served also as a member of the scientific advisory committee of the Corn Refiners Association.

There is no single culprit in the puzzle of obesity. There is no single process that causes the disease. Eating is regulated by complex neurochemical signals, and food selection *alone* is not likely to be a significant cause of the problem. A substantial body of epidemiological and metabolic evidence establishes that obesity is not caused only by misguided food selection. Focusing the blame on a single food or beverage will be simplistic and potentially misleading. It will create a target for directing the public's concern on one component of the food supply which happens to be an incidental part of the problem. There is a risk that this focus on this one component of our complex food supply will do more harm than good.

Taxing or banning certain components of the food supply will result in decreasing the consumption of these food components but, unless we modify the complex neurochemical system that regulates the control of eating and calorie balance, we will have the risk that total calorie consumption and body weight problems will remain unchanged.

Sincerely,

Arthur Frank, M.D.
Medical Director
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