Custody Relinquishment to Obtain Children's Behavioral Health Services: Current Findings and Strategies to Address the Practice

Beth A. Stroul, M.Ed., President, Management & Training Innovations and Partner, Technical Assistance Network for Children’s Behavioral Health

Elizabeth Manley, MSW, Clinical Instructor for Health and Behavioral Health Policy, The Institute for Innovation and Implementation, University of Maryland School of Social Work

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

31st Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health
Tampa, Florida March 5, 2018
Content for this presentation comes from resources developed by the National TA Network for Children’s Behavioral Health, operated by and coordinated through the University of Maryland.

Resources were prepared by the National Technical Assistance Network for Children’s Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201500007C.

The views expressed in this presentation and by speakers and moderators do not necessarily represent the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Custody Relinquishment for Behavioral Health Services

- “Tragic” – Bazelon Center for Mental Health Law
- “Heart wrenching” – National Alliance on Mental Illness (NAMI)
- “Inhumane” – Mental Health America
- “An act of desperation” – Family Organizations

“The idea of being forced to decide between the custody of a child and accessing critically needed services for a child with severe mental illness is unspeakable, but a stark reality for too many families. As a result, many families are forced to do the unthinkable – relinquish custody of their child to the state to access services to treat the child’s mental illness. (NAMI Ohio, 2005)
Definition

- Situations in which parents transfer legal and physical custody to the state in order to access services they would otherwise be ineligible for or unable to obtain.
- No maltreatment (abuse or neglect) involved – parents agree to “trade custody for care,” most often residential treatment.
- Majority of cases child welfare assumes custody, may be juvenile justice if behavior is aggressive or “delinquent” and courts may order services.
- Neither child welfare nor juvenile justice systems are designed to serve children solely because of behavioral health treatment needs.
• Some families so desperate and see no viable options that they refuse to allow children to come home from psychiatric hospitals, hoping state will take custody and their child will receive needed treatment ("psychiatric lockouts")

• Even knowing they may be treated as abusive or neglectful

• Some children are becoming “stuck” in hospital emergency rooms for extensive periods of time awaiting placement when families do not feel they can safely take them home

• Both create risk for custody relinquishment
Custody Relinquishment Revisited

- Previous analyses (e.g., Bazelon Center for Mental Health Law in 2000 and U.S. Government Accountability Office in 2003), but little current information about custody relinquishment for behavioral health services nationwide
- SAMHSA project to revisit problem and provide up-to-date information across states, progress, strategies to address the practice, inform efforts to eliminate it
- Conducted by the TA Network for Children’s Behavioral Health led by University of Maryland, School of Social Work
- Companion analysis of custody relinquishment in tribes conducted by the National Indian Child Welfare Association (NICWA)
- Report in process
Methodology

- Review of literature and state-specific documents
- Informational scan to collect current information across states on the extent, reasons, how states are trying to address
  - Sent to state child welfare directors, state behavioral health directors, and family-run organizations (FROs)
  - Responses obtained from behavioral health and/or child welfare agencies in all 50 states, 3 territories, and 18 FROs
- Informal discussions with leaders in the behavioral health and child welfare systems in selected states reporting different frequency of relinquishment, and leaders of FROs to obtain more in-depth descriptions of effective strategies and lessons learned
- Tribal scan
  - Discussions with tribal child welfare and children’s mental health agencies in South Dakota and Oregon
Previous Analyses

- Portland State University 1989 – Found 25% of approximately 1,000 families received suggestions that they give up custody to obtain care
- NAMI 1999 – Found 23% of families were told they had to relinquish custody to access services
- Commonwealth Institutes for Child and Family Studies 1991 – Found at least one agency in 62% states used custody relinquishment as a method to access and finance mental health services (Cohen, et al)
- Bazelon Center 2000 – Found practice to be common in at least half of states, even those with statutes and other policies to prevent this
- U.S. General Accounting Office (GAO) 2003 – Found practice widespread, at least 12,700 instances in FY 2001 (understated because surveyed agencies in only 19 states and 30 counties), no data collected by states
- George Washington University 2005 – Found direct connection between lack of access to behavioral health treatment and entry into juvenile justice (Koppelman)
Maryland 2002 – Maryland Coalition of Families for Children’s Mental Health found 27% families surveyed were advised to relinquish and/or refuse to bring children home from hospitals by social services staff, therapists, hospital staff, advocates, friends, relatives

Virginia 2005 – Legislature found it occurred primarily to obtain residential or longer-term services that couldn’t be financed by insurance or other vehicles

Utah 2007 – Disability Law Center found families could not pay significant costs and relinquishment was seen as only way to qualify child for Medicaid and access array of services in Medicaid benefit

Texas 2014 – Legislature found cost was primary reason and parents who relinquished were placed on the state’s child abuse registry with implications for their future employment (Faulkner, et al)
Consequences

Families
- Feel they have failed as parents, abandoned their children
- Lose authority to make or participate in decisions about child’s life (medical and behavioral health treatment, education, etc.)
- Must go through child welfare investigation and court proceedings that are intimidating and stigmatizing
- Subject to determination of abuse or neglect, refusal to accept parental responsibility, abandonment
- Placement on child abuse registries

Children
- Trauma, feel abandoned, unwanted, displaced, betrayed (especially adopted children)
- Lose contact with families, family bonds weakened
- May be arrested and placed in juvenile correctional facilities, feel punished for behavioral health needs
- May have multiple placements in residential treatment, group homes, etc.

Service Systems
- Expense for treatment, supervision, legal proceedings, placement, room and board
- Questionable outcomes from costly residential treatment
Availability of Data

State Data Collection on Custody Relinquishment to Obtain Behavioral Health Services

- Lack of systematic data collection cited as a problem in previous analyses
- Findings on extent have been estimates
- Continues to be a problem with about 2/3 states not collecting data specifically on relinquishment for behavioral health treatment
- Some improvement found since over 1/3 now collect some data
How Often it Occurs – Frequency

- Relinquishment for treatment is occurring less frequently than in the past
- States – Most reported it now occurs rarely, none extensively, 6% (13 states) never
- FROs – Most reported sometimes
Positive movement in reducing relinquishment for treatment since Bazelon report in 2000
- States mean rating – 7.4 Substantial
- FROs mean rating – 3.4 Some
When and Why it Occurs

• Severity and complexity of child’s behavioral health condition:
  – So severe that children or adolescents are judged to be a danger to themselves or others
  – May have caused harm or threatened parents, siblings, peers, teachers
  – “Extreme” behaviors, sometime with co-occurring disorders, e.g., developmental disabilities
  – Need for high levels of supervision make it difficult for parents to meet their needs – feel exhausted, hopeless, fearful for safety

• Parents and providers may believe that treatment in a secure setting, e.g., a residential treatment center (RTC), is the best (or only) option for ensuring safety of child, family, and community
Three Primary Reasons: HCB Services, Payment, Courts

1. Causes related to HCB services
   - Lack of availability and/or accessibility
   - Not successful in keeping child in the home and community safely

2. Causes related to payment mechanisms for high-cost services (both HCB services and residential)
   - Private insurance
   - Public insurance (Medicaid and State Children’s Health Insurance Program - CHIP)
   - Individuals with Disabilities Education Act (IDEA)

3. Causes related to juvenile courts
   - Judges commit children into custody for residential services
Reasons: Issues with HCB Services

- Ranked second as a reason
- States – Between somewhat common and not common
- FROs – Somewhat common
- Could be lack of investment, lack of leveraging available federal and state financing streams, budget cuts
- Could be insufficient capacity, wait lists, uneven availability across state (e.g., gaps in rural, frontier areas), shortages of professionals, stringent eligibility requirements, etc.
- Without HCB services for treatment and safety, residential treatment may be seen as only option with risk of relinquishment
Reasons: Payment Issues Private Insurance

- Seen as most problematic by states and FROs
- Intensive HCB services and residential treatment are either not covered or coverage is inadequate (67% states, 88% FROs)
- May exhaust insurance benefits (less common than inadequate coverage)
- Even with parity legislation requiring equal coverage for health and behavioral health (Mental Heath Parity and Addiction Act of 2008)
- May give up custody to qualify for typically richer benefit package in public insurance (Medicaid) or state agency funds
- Middle class families may be more at risk with poor coverage and high deductibles and co-pays
Reasons: Payment Issues Public Insurance

- Ranked lowest as a cause, especially by states (68% reported not common)
- Medicaid tends to have more robust benefits than private insurance plans, but coverage of intensive HCB services varies across states, and managed care approaches may create barriers to accessing Medicaid or CHIP-financed services by limiting scope or duration
Reasons: Payment Issues IDEA

- Ranked third as a cause
- Supposed to provide a free public education and special education and “related services” to children with disabilities
- Varying definitions of what services and supports constitute related services
- SED is reportedly under-identified
- School districts reported to be reluctant to pay for costly intensive HCB services or residential treatment
- Plans under Section 504 of Rehabilitation Act do not entitle children to HCB services, only school accommodations

States
FROs

Children with SED are Not Identified
Inadequate Funding for Behavioral Health Services through IDEA
Reasons: Courts Judges Commit Children to Residential Treatment

- Ranked fourth out of the five reasons
- Reported by most states to be not common or somewhat common
- After an arrest, parents or providers may request behavioral health services as part of a disposition, and the court may then order behavioral health services
- Most frequently residential treatment
- May be done without input from behavioral health professionals
- May be done without knowledge of available HCB services or pathway to access them
# Mean Rating of Reasons for Custody Relinquishment

<table>
<thead>
<tr>
<th>Causes</th>
<th>FROs</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>2.1</td>
<td>1.25</td>
</tr>
<tr>
<td>Availability and Accessibility of HCB Services</td>
<td>2.45</td>
<td>1.8</td>
</tr>
<tr>
<td>Identification of Needs, and Provision of Services Under IDEA</td>
<td>2.45</td>
<td>1.95</td>
</tr>
<tr>
<td>Judges Commit Children into Custody for Services</td>
<td>2.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Public Insurance – Medicaid and CHIP</td>
<td>2.7</td>
<td>2.03</td>
</tr>
</tbody>
</table>

- FROs rate all causes as more common than states
- However, same rank order for causes as states

1 = Very Common
2 = Somewhat Common
3 = Not Common
Strategies to Eliminate Custody Relinquishment

1. Strategies to directly address custody relinquishment

2. Strategies to expand HCB services

NEED BOTH

“Just banning the practice closes one door without opening another.” (Stine, 2005)
State Strategies to Directly Address Custody Relinquishment

Three Categories:

1. Mandates or Requirements
   - Statutes/Legislation
   - Rules and Regulations
   - Monitoring and Enforcement

2. Policies and Guidance
   - Written Policies or Guidelines
   - Voluntary Placement Agreements
   - Training and Technical Assistance

3. Diversion
   - Differential/Alternative Response
   - Review Processes
Overall, nearly 90% states reported using at least one strategy.
Mandates
• GAO found 13 states with statutes, now 26 states
• 8 more states with regulations
• Total of 67% with one or both
• Least common strategies

Policies
• Voluntary Placement Agreements (VPAs) used as option in 41% states
  - Parents retain degree of control and rights
  - Considered preferable since legal ties are not severed
  - Still require entry into child welfare system that is designed for abuse and neglect with court reviews, etc.
• Executive orders, policy manuals, guidelines with specific procedures
Diversion

• Most common strategies
• Procedures and protocols, e.g., multi-agency review teams and specific programs for diversion from custody
• Differential, alternative, multitrack, dual track response, allows tailored services whether or not maltreatment is substantiated without custody relinquishment
State Strategies to Expand and Finance HCB Services

Four Categories:

1. System of Care (SOC) Strategies
2. Medicaid Strategies
3. Cross-System Strategies
   - Mental Health and Substance Abuse Block Grants states
   - Child welfare strategies
   - Juvenile justice strategies
   - Education strategies
   - Other behavioral health and state agency strategies
4. Local Strategies
State Strategies to Expand HCB Services (cont.)

- SOC and Medicaid strategies are the most frequently used.
- Mental Health and Substance Abuse Block Grants and child welfare are the next most common strategies reported.
- Initiatives and funds from other child-serving agencies are used less frequently.
- Local initiatives and funds were reported by half of the states.
System of Care Strategies

- SOCs provide a comprehensive array of HCB services and supports
- SAMHSA invested in building SOCs in states and communities to provide comprehensive array of HCB services and supports
- Started with 6-year SOC development grants
- Documented positive outcomes and return on investment
- Led to SOC expansion grants, currently 4-year grants to expand and sustain SOCs
- 94% states reported SOC strategies
- More than half have state SOC-related policies, some have statutes

*5 States Tribal Expansion Grants Only
• 90% use Medicaid to finance/increase availability of HCB services and supports
• EPSDT entitlement is most common, although have been problems with weak behavioral health screening and referral (Requires periodic screening and provision of all needed services, even if they are not included in the state’s Medicaid plan.)
Cross-Agency Strategies

- Most common Mental Health and Substance Use Block Grant
- Previous analysis found Block Grant is used mainly for services not covered by Medicaid or other sources (e.g., peer support, flex funds)
- State mental health and substance use agency funds (general revenue)
- Child welfare IV-E waivers also common
**Effective Strategies**

### Custody Strategies in States with No vs. Frequent Occurrence

- Compared strategies used in states with no occurrence vs. frequent occurrence.
- States reporting that custody relinquishment occurs frequently have no mandates (statutes, regulations, or policies), majority of states with no relinquishment have mandates in place.
- Suggests that some type of requirement and/or explicit, formalized policy can have an impact.
- Somewhat less training related to this practice occurs in states with frequent relinquishment.
- The two states reporting frequent relinquishment both have VPAs, while only one state of the six states with no relinquishment uses VPAs. VPAs may not be as significant in eliminating the practice.

![Bar chart showing percentages of different strategies in states with no vs. frequent occurrence](chart.png)

- **Mandates**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)

- **Policies**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)

- **Training**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)

- **VPAs**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)

- **Diversion**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)

- **Monitoring**
  - Never Occurs (N=6)
  - Occurs Frequently (N=2)
Strategies used by both groups to build HCB service are fairly consistent.

- SOCs, Medicaid, Block Grant, and state behavioral health and other state efforts and funding are the strategies used most frequently.

- Child welfare strategies are used in half of states with no occurrence and not at all in states with frequent occurrence.

- Juvenile justice, education, and local efforts/funding are used less frequently in both groups.

### HCB Strategies in States with No vs. Frequent Occurrence

<table>
<thead>
<tr>
<th>System of Care</th>
<th>Medicaid</th>
<th>Block Grant</th>
<th>BH/Other State</th>
<th>Child Welfare</th>
<th>Education</th>
<th>Local</th>
<th>Juvenile Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Occurs (N=6)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Occurs Frequently (N=2)</td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>33%</td>
<td>33%</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Bar Chart:**
- The chart shows the percentage of states using various strategies for HCB service.
- The strategies include Medicaid, Block Grant, BH/Other State, Child Welfare, Education, Local, and Juvenile Justice.
- The chart compares states with no occurrence (N=6) and states with frequent occurrence (N=2).
• Child welfare agency, behavioral health agency, and FRO interviewees all emphasized that an effective approach requires multiple strategies in each of these areas.

• New Jersey example documents how a statewide system of care with an array of HCB services and supports, and residential options as needed are all available, financed, and provided as needed to any child and family.
## Federal Strategies to Expand and Finance HCB Services

<table>
<thead>
<tr>
<th>System</th>
<th>Financing Strategy</th>
</tr>
</thead>
</table>
| Child Welfare                             | • Title IV-E Waiver Demonstration  
• Title IV-B  
• Social Services Block Grant           |
| Medicaid                                  | • 1915(c) Home and Community Based Services Waiver  
• EPSDT  
• Tax Equity and Fiscal Responsibility Act (TEFRA) (Katie Becket Option)  
• Health Homes  
• 1915(i) State Plan Amendment  
• Medicaid Eligibility Expansion  
• Money Follows the Person (MFP) Rebalancing Demonstration Grant  
• 1115 Research and Demonstration Waiver  
• Psychiatric Residential Treatment Facility (PRTF) Demonstration  
• Rehabilitation Option  
• Targeted Case Management               |
| State Children’s Health Insurance Program (CHIP) | • CHIP Benefits Expansion                                                |
| Behavioral Health Grants                  | • SOC Development Grants (Children’s Mental Health Initiative)  
• SOC Care Expansion Grants (Children’s Mental Health Initiative)  
• Mental Health and Substance Abuse Block Grants  
• Now is the Time Healthy Transitions (HT) Grants |
| Education                                 | • Individuals with Disabilities Act (IDEA)  
• Safe Schools/Healthy Students Grants |
| Juvenile Justice/Courts                   | • Office of Juvenile Justice and Delinquency Prevention (OJJDP) Formula Grants |
| Legislation                               | • Mental Health Parity and Addiction Equity Act  
• Patient Protection and Affordable Care Act  
• 21st Century Health Cures Act          |
Recommendations to Directly Address Custody Relinquishment

• **Implement Mandates** – Prohibit custody relinquishment solely to obtain behavioral health services through statutes, rules/regulations coupled with monitoring and enforcement.

• **Implement Diversion Strategies** – Implement protocols for responding to situations with a risk of custody relinquishment for behavioral health services to identify alternatives and remove barriers to care.

• **Provide Training** – Train key constituencies (agencies, courts, etc.) on requirements, policies, and protocols that address custody relinquishment for behavioral health services and options for obtaining treatment without relinquishment. Train families and FROs on their rights and options.

• **Use VPAs** – Create a VPA mechanism that allows the state to provide and finance services temporarily without transfer of legal custody.

• **Prevent Penalties for Families** – When it occurs, ensure that parents are not charged with abandonment, placed on child abuse and neglect registries in the absence of maltreatment, or are subject to any other types of penalties.
Recommendations to Directly Address Custody Relinquishment (cont.)

- **Collect Data on Custody Relinquishment** – Track frequency of custody relinquishment for behavioral health services (and other non-maltreatment reasons), why it occurred, and what strategies or services could have prevented it. Use data to better understand the extent to which the practice is being used, for what reasons, and potential solutions.

- **Work with Psychiatric Hospitals** – Implement procedures to work with inpatient psychiatric hospitals to connect them with SOCs offering intensive HCB treatment services and supports post discharge to reduce referrals for residential treatment and reduce psychiatric lockouts.

- **Involve Family Members and Youth in Problem Solving** – Involve family and youth organizations and leaders in identifying the circumstances that lead to custody relinquishment and what measures and strategies they recommend to eliminate the practice.
Recommendations to Increase Availability, Access, and Financing of Intensive HCB Services

- **Implement Comprehensive SOCs** – Provide resources to implement SOCs broadly across states, communities, tribes, and territories.
  - Provide intensive HCB services and supports, such as intensive care coordination using the Wraparound process, intensive in-home services, mobile response and stabilization, family and youth peer support, respite, etc.
  - Ensure that residential treatment is available to children who meet the clinical criteria for this service, that it is used to achieve specific short-term treatment goals, and that it is linked to intensive HCB services in SOCs for ongoing treatment.

- **Use Existing Entitlements** – Maximize the use of existing entitlements to ensure access and payment for behavioral health services.
  - Strengthen the use of the Medicaid EPSDT entitlement to screen for behavioral health conditions and to then provide all needed behavioral health services.
  - Strengthen enforcement of IDEA requirements to identify and meet the service needs of children with behavioral health conditions.
Recommendations to Increase Availability, Access, and Financing of Intensive HCB Services (cont.)

- **Identify Payment Sources for Services** – Ensure that payment sources are available to cover the costs of intensive HCB services and residential treatment when indicated, so that children and families receive services based on clinical need. May include:
  - Ensuring that these services are covered under Medicaid through state plans, waivers, state plan amendments, and other authorities
  - Ensuring that medical necessity criteria do not inappropriately restrict payment for intensive behavioral health services
  - Allocating state agency funds to pay for services not in the benefit packages of Medicaid or commercial insurance or to serve children who do not qualify for Medicaid
  - Redirecting resources currently being spent by child-serving systems on high-cost, out-of-home services to lower-cost HCB services and identifying new resources to expand SOCs
  - Providing data on the effectiveness and return on investment in intensive HCB services across child-serving agencies to support the allocation of funds
• **Work with Commercial Insurers** – Reach out to encourage coverage for intensive HCB under private insurance plans. Provide data on the effectiveness and return on investment in intensive HCB services and supports.

• **Involve Family Members and Youth** – Involve family and youth organizations and leaders in planning, implementing, and financing HCB services and supports to determine their needs; barriers to accessing and financing care; and the effectiveness of strategies to increase availability, access, and payment for services.
<table>
<thead>
<tr>
<th>State/ Territory</th>
<th>Mandates or Requirements</th>
<th>Policies and Guidance</th>
<th>Diversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>American Samoa</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arizona</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>California</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Colorado</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Connecticut</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Delaware</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Florida</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Georgia</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hawaii</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Idaho</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Illinois</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Indiana</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Iowa</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kansas</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kentucky</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Louisiana</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maryland</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Michigan</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Minnesota</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mississippi</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>State/Territory</td>
<td>Mandates or Requirements</td>
<td>Policies and Guidance</td>
<td>Diversion</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Missouri</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nebraska</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Jersey</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Mexico</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>North Carolina</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ohio</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>South Carolina</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Texas</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Utah</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Virginia</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Washington</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
References


Disability Law Center (2007). Between a Rock and a Hard Place. An investigation of custody relinquishment as a method for accessing essential mental health services for children in Utah. A report to the community from the Disability Law Center. Salt Lake City, UT: Author


The Children’s Initiative concept operates on the following abiding principles:

- The system for delivering care to children must be restructured and expanded.
- There should be a single point of entry and a common screening tool for all troubled children.
- Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible.
- Families must play a more active role in planning for their children.
- Non-risk-based care and utilization management methodologies must be used to coordinate financing and delivery of services.
• Increase access and availability of in home services and supports
• Outlined a path to move away from overreliance on both child welfare and juvenile justice systems as the front door of the behavioral health system
• Increase and simplify access to both urgent and emergent services and supports
• Created a single point of access to care and supported utilization management to address clinical necessary services
Structural Changes

- Moved the front door to access, responsibility and resources from child welfare and juvenile justice to the behavioral health system (which has grown to the system of care)
- The role of Medicaid and sustainable funding
- Created a Medicaid alike number
- Focused on Clinical Necessity not ability to pay
- Created strategies around both braided and blended funding
- Supported Family Support and Youth Partnerships
- Created both local and statewide feedback loops
Overuse of Deep-End Services

- Low Intensity Services
- Out of Home

Out of Home

- Intensive In-Community
  - Wraparound – CMO
  - Behavioral Assistance
  - Intensive In-Community

- Lower Intensity Services
  - Outpatient
  - Partial Care
  - After School Programs
  - Therapeutic Nursery
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Welfare</td>
<td>• Required Child Welfare involvement</td>
</tr>
<tr>
<td></td>
<td>• Required the signing over custody and/or voluntary placement agreements</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>• Family Crisis Units and Family Crisis Petitions</td>
</tr>
<tr>
<td></td>
<td>• Formal charges and detention/probation engagement and court orders for</td>
</tr>
<tr>
<td></td>
<td>treatment</td>
</tr>
<tr>
<td>Acute Care</td>
<td>• Inpatient connection to child welfare for payment of residential</td>
</tr>
<tr>
<td></td>
<td>• Long length of stay in hospitals</td>
</tr>
</tbody>
</table>
New Jersey Children’s System of Care

- Access through single point of access – 24 hour access
- Clinical necessity established through 3 mechanisms
  - Independent Needs Assessment
  - Mobil Response and Stabilization
  - Needs assessment by engaged mental health provider
- Payment for any services are blind to the parent/youth and young adult
  - Medicaid for youth who meet fiscal or clinical criteria
  - New Jersey Behavioral Health Carve Out
The New Jersey Children’s System of Care serves:

- Behavioral health: Youth with moderate and complex needs, entire New Jersey population
- Behavioral Health Home
- Child welfare: Youth with child welfare involvement and a treatment need
- Developmental/Intellectual Disabilities: Youth eligible for services based on regulatory definition of functional impairment
- Substance use: Youth who have Medicaid or are underinsured and have a treatment need
Department of Children and Families
Division of Children’s System of Care (CSOC)

Policy Development
Manages and Approves Provider Network
Funder; contracts directly with agencies
BH Carve Out; Providers bill on fee for service basis

Contracted System Administrator (ASO+)
Single Point of Entry and Access to Care 24/7
Triage, Utilization Management
Care Coordination
Authorizes Services
Non risk based
Hosts CSOC’s MIS (EHR and Data)

Mobile Response & Stabilization Services
Crisis response and planning; 24/7/365 within 1 hour

Children’s Interagency Coordinating Council (CIACC)-One per county (21)-local planning bodies

Family Support Organizations
Family-led peer support and advocacy for parents/caregivers and youth group

Care Management Organization
Utilizes wraparound model to serve youth and families with moderate and complex needs; designated health home entity

Child Family Teams

Physical Health Integration

CANS ASSESSMENT TOOL
Utilized in Triage, for Treatment Planning and Outcomes Tracking

Other Authorized Services includes but is not limited to:
• Biopsychosocial Assessments
• In home Clinical/Therapeutic
• Out of Home Care (OOH)
• Partial Hospitalization
• Substance Use Services
• In home Behavioral for I/DD youth
• Family Support Services for I/DD Youth
• Non Medical Transportation
• Interpreter Services
• Outpatient
• Assistive Technology

Populations Served are youth (and their families) with:
• Behavioral health challenges
• Substance use challenges
• Intellectual/developmental disabilities
• Autism
**Youth with multisystem involvement:
child welfare and/or juvenile justice

1115 Waiver-Children’s Supports Waiver, I/DD and SED
State Plan Amendments
Targeted Case Management-CMO
Psych under 21 Benefit-OOH Programs
Rehabilitative Option-MRSS, IIC/BA, Out of Home
State Option to Provide Health Homes
Flex Funds

State and Federal Appropriations
Title XIX and Title XXI

Rutgers UBHC Training and Technical Assistance- Trains All System Partners, Families

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

Dept. of Human Services
Division of Mental Health and Addiction Services

Dept. of Human Services
Division of Developmental Disabilities

Dept. of Human Services
Division of Children’s System of Care (CSOC)
New Jersey Children’s System of Care Utilization Information

![Utilization Information Chart](chart.png)
For More Information on New Jersey

New Jersey’s Children’s System of Care

www.state.nj.us/dcf

PerformCare

www.performcarenj.org
Thank You.

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

Beth A. Stroul, M.Ed. – bstroul@mtiworld.com
Manley, MSW – elizabeth.manley@ssw.umaryland.edu

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)