REPORT OF THE
STATE EXECUTIVE COUNCIL WORKGROUP ON

The Relinquishment of Custody for the Purpose of Accessing Behavioral Health Treatment

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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A. INTRODUCTION

The issue of parents being faced with the choice of giving up custody of their child with severe emotional disturbances solely to obtain behavioral health treatment is a serious and significant problem in Virginia and the nation. A publication of the Bazelon Center for Mental Health Law calls this problem "the tragic result of failure to meet children's mental health needs." The President's New Freedom Commission on Mental Health recommends the "elimination of conditions under which parents must forfeit parental rights so that their children with serious emotional disturbances can receive adequate mental health treatment." Based on widespread concerns within the Commonwealth regarding this issue, the 2004 Session of the Virginia General Assembly directed that:

> "The State Executive Council for the Comprehensive Services Act shall investigate the reasons leading to the practice of parents relinquishing custody of their children solely to obtain necessary and appropriate mental health services. The State Executive Council shall recommend policy options, including legislative action if appropriate, for abolishing this practice while continuing to make the services available and accessible to children, and report to the Chairmen of the House Appropriations and Senate Finance Committees, and to the Chairman of the Joint Commission on Health Care, by November 1, 2004." (Item 299 F)

As chair of the State Executive Council, The Honorable Jane H. Woods, Secretary of Health and Human Resources, established a widely representative task force to complete this study. This task force consisted of 32 members and was chaired by Raymond R. Ratke, chief deputy commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. The task force held a total of seven meetings including an extended session to hear from six families who faced this impossible decision and experienced the heart wrenching and destructive consequences.

The task force initially focused on three primary areas of inquiry:

1. The extent to which custody relinquishment for the purpose of obtaining behavioral health treatment occurs and the related impacts on children, families and communities.
2. The causes, factors, policies, procedures and practices relating to custody relinquishment.
3. The existing or available best practices or model programs that offer access to services without requiring custody relinquishment (except where necessary and appropriate).

While given the extreme complexity and breadth of the issues relating to this problem, this group has not fully reached conclusion regarding these three areas. The efforts of the task force have resulted in ten primary "findings" and 18 comprehensive recommendations.

The essential and most important conclusion of the work of this task force is that this problem is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents.

B. FINDINGS

1. For a significant number of families, the only way to access resources for behavioral health treatment services for their children is to relinquish custody.

2. Relinquishing custody under these circumstances has myriad negative consequences, sometimes severe and devastating, for families and their children, and communities.

3. Relinquishing custody solely for this purpose uses Virginia's child serving systems in unintended, inappropriate, and inefficient ways.

4. Virginia laws, policies, and practices that govern custody relinquishment are primarily designed for purposes other than addressing children's treatment needs and, as such, can be experienced as adversarial by parents.

5. Limited availability, lack of funding, or inadequate insurance coverage for behavioral health treatment service are primary reasons families relinquish custody in order to obtain these services.

6. Virginia's child serving system, comprised of multiple state and local agencies, is fragmented both programmatically and in its funding streams. This complex fragmentation poses significant challenges for families and the professionals who serve them.

7. Extreme variability exists across localities in the Commonwealth and within localities themselves regarding the consistent application of policies and practices, service availability and resources.

8. Virginia lacks a strong, organized family advocacy network. Such networks have proven in other states to be effective resources in helping families of children with serious emotional disturbances navigate the complex public and private systems of children's services. These networks have also successfully advocated for system improvement.

9. In the short-term, changes in code, regulation, policy, and practice to Virginia's *current* system of care for children will improve access to behavioral health services and reduce some the negative effects of custody relinquishment for *some* families.

10. In the long term, *Transforming* and adequately funding Virginia's system of care for children and families, building on the CSA and based on nationally recognized and evidence-based solutions, will significantly improve access to behavioral health services and eliminate the need for relinquishment of custody.

C. RECOMMENDATIONS

The State Executive Council (SEC) shall be responsible for implementing and monitoring all recommendations contained in this report. To this end, the SEC should analyze and ensure that correct infrastructure and commitment is in place at the state level to ensure, support, and provide continued enhancement of the Comprehensive Services Act for At-Risk Youth and Families (CSA) as measured against Systems of Care guidelines and principles.

Given the complexity of this issue and the need for oversight and monitoring of progress, the workgroup recommends that this study continue for one additional year with a final report from the SEC to the Joint Commission on Health Care by November 1, 2005. The next task of this workgroup is the development of an implementation plan with specific target dates for the completion of these recommendations. Finally, to further enhance the coordination and monitoring of the implementation of these recommendations, these recommendations should be incorporated, where appropriate, into the SEC strategic planning process.

Recommendations for System Reform

1. Develop the mechanism to coordinate with other affected Secretariats all state level children's services in the Commonwealth. This coordination should include, but not be limited to, the current efforts underway related to the state's Program Improvement Plan (PIP) developed in response to the federal Child and Family Services Review (CFSR) to improve access to mental health services for youth, and the expansion and enhancement of access to child and adolescent mental health services.

2. Examine the State Corporation Commission (SCC), Bureau of Insurance's role in exploring mental health parity for at-risk youth and the inclusion of a full service continuum in private sector insurance. Specifically, explore the use of private insurance funds for home-based, day treatment, and crisis stabilization in order to prevent more expensive hospitalization. Further, consider "hold-harmless" in which funding for hospitalization could be redirected without exceeding existing financial risk.

3. The Department of Social Services shall collaborate with other child serving agencies to develop, by July 1, 2005, a method for tracking the incidence of custody relinquishment for the sole purpose of obtaining behavioral health treatment services.

4. Review and analyze alternative models of child serving systems that reduce or eliminate categorical funding, decrease fragmentation, and support cost containment strategies.

5. Support development of an appropriate, accessible, and outcomes based continuum of behavioral health and substance abuse treatment services for Virginia youth that at a minimum includes:

- assessment and diagnosis
- behavioral aide services
- case management services
- crisis residential services
- crisis services
- day treatment/partial hospitalization services
- early intervention and prevention
- family support/education
- home-based services
- wraparound services
- inpatient hospital services
- medical management
- mental health consultation
- outpatient psychotherapy
- respite services
- school-based services
- therapeutic foster care, therapeutic group home
- residential treatment centers
- transportation

Recommendations for Funding Expansion and The Efficient use of Existing Resources

6. Explore differential matches for CSA funding, specifically related to incentives for localities to use CSA non-mandated funds and request necessary policy and code changes that would reduce the local match requirement for localities using their non-mandated CSA allocation.

7. Analyze the financial implications of increasing the CSA targeted non-mandated levels of funding.

8. Review, analyze and develop specific recommendations for development and funding of community based services infrastructure and program start-up.

9. Expand funding for behavioral health services for youth.

10. Explore funding options allowable under the Medicaid and State Children's Health Insurance Programs including those implemented in other states.

Recommendations for Changes in Policy/Code

11. Direct each child serving agency to initiate an immediate review of all policies, procedures and practices and to bring forward specific recommendations for changes that would enhance parental collaboration and involvement, enhance and expand access to appropriate mental health treatment, and reduce the variability in the implementation of services.

12. The Department of Social Services shall, in collaboration with other state and local partners, revise, disseminate and train localities on clearly defined policies and procedures regarding the use of voluntary placement agreements that will encourage the appropriate use of these options. Areas to be addressed include but are not limited to: collection of child support; access to treatment foster care; and non-custodial foster care case management practices.

13. The Department of Social Services shall put forth revisions to the Code of Virginia, Departmental policy, and if necessary, will promulgate emergency regulations to ensure consistency between public and private child welfare agencies in all areas that effect parental access to the full range of placement services as allowed by the Code of Virginia.

14. Encourage prevention, early intervention and the use of least restrictive, community-based services with differential CSA match rates for localities for these services. Specifically, the SEC shall review and analyze a differential match rate on mandated foster care prevention funding used to purchase community-based, non-residential services.

15. Advocate for changes in federal laws, regulations, and funding to reduce or eliminate the need for families to relinquish custody for the sole purpose of accessing behavioral health treatment services. Specifically, the SEC should advocate for passage of the Family Opportunity Act (S. 622, H.R. 1811) and the Keeping Families Together Act (S. 1704 and H.R. 3243).

Recommendations for Service Improvements and Program Development

16. Continue process to review and identify Virginia and national best practices that demonstrate results in improving access to behavioral health treatment and the reduction of custody relinquishment.

17. Direct all agencies represented on the State Executive Council to develop and implement technical assistance and training for localities focusing on the dissemination of best practices in the areas of access to mental health, parent collaboration, early intervention and development of a system of care model. This can best be achieved by working with the well-established, nationally recognized associations and organizations readily available to state and local jurisdictions.

These resources include:

- National Resource Centers supported by the Children's Bureau of the federal Health and Human Services (available at no cost to Virginia)
- Bazelon Center for Mental Health Law
- Child Welfare League of America
- National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center
- SAMSHA Center for Mental Health Services – Systems of Care information
- Federation of Families for Children's Mental Health

18. Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to lead a collaborative effort with other child serving departments, parents, and advocacy organizations to develop and implement a statewide parent/family resource and advocacy program that is coordinated with existing programs and affiliated with the Federation of Families for Children's Mental Health.

D. ISSUE DISCUSSION, BACKGROUND, AND DATA

1. Quantitative Data

The families that are the subject of this study are those in which parents are committed to the continuing care and custody of their child with an emotional or functional impairment, but are lacking financial resources sufficient to secure appropriate mental health services. In order to gain access to publicly-funded mental health services, many of these families are forced into the child welfare/foster care system and, by virtue of existing policy and law, are forced to choose between relinquishing custody of their child to a child welfare agency in order to access funding, or relinquish hope for the child's treatment. (The term "relinquishing custody" is not the same as terminating parental rights and can have several different meanings that will be defined later).

In Virginia, there were 8,702 children in foster care as of June 1, 2004[1]. Using a conservative approach to the analysis (See Table 1), conditions of removal identified 2,008 children (23 percent) who appear to be in custody to obtain treatment, and an additional 328 children (4 percent) whose conditions of removal offered no indication of abuse, neglect, or parental problems that would have otherwise explained the child's being in social services custody. Thus, it appears that between 23 percent and 27 percent of the children under the Department of Social Services (DSS) supervision are primarily in custody in order to obtain needed treatment. Based on national surveys, the proportion of children in Virginia's foster care system primarily to address treatment needs would be expected to fall in this range.

It is important to note that this information is derived from OASIS, the Virginia Department of Social Services (VDSS) database, which does not specifically identify which children have been placed in custody for the *sole* purpose of obtaining treatment services. Thus, this report has estimated the extent of this practice by inferring the reasons for placement in foster care from the best data currently available.

The problem of relinquishing custody has been a growing concern at the national level as well as in Virginia. There have been an increasing number of reports in local and national media outlets including *Time, Newsweek,* ABC PrimeTime, the *Richmond Times-Dispatch*, and others, which document the extent to which this process has affected children and their families. National surveys by the Bazelon Center for Mental Health Law (1999), the National Alliance for the Mentally Ill, the Federation of Families for Children's Mental Health, and Maryland's Coalition of Families for Children's Mental Health report that between 23 percent and 27 percent of families who have children with Serious Emotional Disturbance (SED) report being encouraged to relinquish custody in order to obtain needed services for their children. Approximately 20 percent of those who have children with SED actually do relinquish custody. This situation has also been identified as a significant issue by the President's New Freedom Commission on Mental

[1] OASIS (Foster care SACWIS system) Data as of June 1, 2004.

Health, which recommends eliminating the practice of "Trading Custody for Care" and encourages the development of more family-friendly practices.

<table>
<tr><td colspan="2"><u>Table 1: Conditions of Removal</u>
The foster care data was carefully evaluated to assess the scope of the problem. For every child in foster care one or more of the following Conditions of Removal are listed. In order to provide the most conservative estimate regarding the number of children in foster care for treatment purposes, every child whose Conditions of Removal noted any indication of parental problems were ruled out (6,366 children, see Rule-Out Conditions). Of the remaining children, only those whose with a condition suggestive of the need for treatment were considered as being likely to be in foster care for treatment purposes. The remaining children were not possible to rule-out or rule-in.</td></tr>
<tr><td><u>Rule-Out:</u> Conditions of Removal which ruled out the child as being likely to have been placed in foster care for treatment purposes</td><td><u>Rule-In</u>: Conditions of Removal (absent Rule-Out Conditions) suggesting the child may have been placed in foster care for treatment purposes.</td></tr>
<tr><td>1. Abandonment
2. Alcohol Abuse (Parent)
3. Death of Parent(s)
4. Drug Abuse (Parent)
5. Inadequate Housing
6. Incarceration of Parent(s)
7. Neglect (Alleged/Reported)
8. Physical Abuse (Alleged/Reported)
9. Sexual Abuse (Alleged/Reported)</td><td>1. Alcohol Abuse (Child)
2. Child In Need of Services (CHINS)
3. Child's Behavior Problem
4. Child's Disability
5. Delinquency
6. Drug Abuse (Child)
7. Relinquishment (Request Relief)</td></tr>
<tr><td colspan="2"><u>Neutral:</u> Conditions of Removal which gave no indication of the placement in foster care being related to a child's mental health needs</td></tr>
<tr><td colspan="2">1. Caretaker ILL/ Unable to Cope
2. Entrustment Agreement
3. Voluntary</td></tr>
</table>

2. Qualitative Data

Six families who have children with SED presented their experiences around seeking services to the workgroup. These families reported that they experienced the following challenges and barriers in accessing services for their children. These experiences are not necessarily representative of the experiences of all families, but are accurate representations of their own attempts to access services:

a. Private insurance provides limited coverage for mental health services, and it does not cover many services. The services needed by these families exceeded the caps set by their private insurance. Medicaid covers many of these services, although the majority of children in the families speaking to us were not eligible for Medicaid while living with their parents because of the families' incomes.

   - Services not covered by private insurance include: respite, home-based therapy, mentoring, crisis stabilization, day treatment, and residential treatment.

"Families are exhausted from dealing with the behavior of their mentally ill child and most lack the energy, time, and/or knowledge to battle a complicated system to obtain services."
- Virginia Parent

b. Services these families needed were unavailable or non-existent, or inaccessible (unfunded or insufficient capacity) and often involved multi-month delays before they could be initiated.

> "In cases where a child with mental health issues is in the system, parents are still seen as the ones to blame."
> -Virginia Parent

- Families could not get home-based services in some instances in which funding was approved due to the lack of capacity by providers.
- Families found that agency staff (both private and public) were often inexperienced, underpaid, and inadequately prepared to serve children with more challenging needs.
- Families experienced frequent turnover of case managers and provider staff, which reduced the effectiveness of services. Case manager and staff were not always reliably available due to their workloads.
- Families had no access to crisis stabilization, "cool-off" centers, or respite care. These services might have delayed or prevented the need for residential treatment (and potential custody relinquishment).

> "Information regarding available community mental health services was not provided by either the schools or by mental health professionals."
> - Virginia Parent

In the experiences of these families, the system often made negative assumptions that families were the cause of the children's mental health problems. This is somewhat due to the nature of the foster care and juvenile justice systems, which are designed to deal with child abuse and neglect situations. These systems include processes and procedures that often seem, or are, adversarial. When these systems are used to address the mental health needs of children with cooperative and caring families, there can be a disconnect between the system's role and the child and family's needs.

c. Medicaid and private health insurance criteria for covering mental health treatment is based on medical necessity. Children's behavioral health needs, however, may go beyond medical necessity criteria. This means that funding sources do not always pay for continuation of treatment at the same level of care, even when the family and providers think the child needs to continue that treatment. One family reported that after a one-month "honeymoon" period in residential treatment, Medicaid denied continued funding despite professional judgments recommending the need for continued residential services. In this instance, Medicaid later overturned the denial.

d. Parent representatives or advocates on the Family Assessment and Planning Team (FAPT) teams were not very active in several of the cases cited.

e. The difficulty families experienced accessing services had many negative effects on them, which included:

- Incurring large debts from paying substantial sums for services not covered by insurance (e.g., intensive in-home therapy, respite), and for co-payment of covered services (out-patient therapies, hospitalization).

- Receiving inconsistent advice about the level of child support ordered, and the calculation of this amount not taking into consideration the debt previously incurred in caring for their children with disabilities. Garnishment of wages for child support jeopardized some parents' jobs.

- Feeling at risk for substantial out-of-pocket costs when discharge planning for Medicaid-funded residential services was complicated by denials and appeal processes.

- Facing financial crises aggravated by the loss of jobs or income resulting from: a) parental involvement in attending court, meetings or treatment sessions during work hours; b) parents needing to stay home to supervise their children with disabilities when they could not find other care; or c) employers not accepting garnishments being imposed by the Division of Child Support Enforcement (DCSE).

- Receiving different options from different localities in the foster care system, some localities offered non-custodial foster care agreements and others did not. In one jurisdiction, a family could no longer care for their child in their own home and residential expenses were overwhelming. The family reported that it was only offered the option of fully relinquishing custody of their child to social services, including terminating parental rights, rather than being offered other less permanent options such as temporary relief of custody or a non-custodial foster care agreement. Other jurisdictions might have handled the case differently, allowing the child to remain in foster care with the parents retaining some parental rights even though the child did not live with them, was in the legal custody of a child placing agency, and was not expected to ever return home.

- Feeling as though they were losing control over, and had no choice about their children's treatment, even when they did not give up their parental rights.

- Enduring the emotional impact of trying to keep their child with SED at home, including a fear of being harmed in their own home, the loss of social life, the negative impact on siblings, a loss of self-esteem, a sense of having failed, and feelings of losing control over their own and their children's lives. These families also found themselves isolated from their community due to their children's behaviors.

- Feeling a sense of isolation while going through the process of obtaining services. There is no organized process for learning about available treatment options, service providers, obtaining support or advocacy, sharing struggles and learning ideas from other families. Parents said that additional supports would be very appropriate given the complexity of navigating multiple child-serving systems.

- A perception that the system is crisis-oriented, in that they had trouble accessing services unless their children were in crisis.

- Experiencing service quality that was quite variable. One family described an instance where a teacher tied their child to a chair, and in one residential placement a child was placed in isolation for up to 10 hours at a time.

> "Relinquishment of custody takes away the child's support system if the child still has a family who cares about him."
> -Virginia Parent

3. Background

Relinquishment of custody is one specific consequence of a broad-based problem of lack of access to appropriate mental health services in a timely manner. The following factors contribute to this lack of access.

a. Financial Barriers to Services

1.) **PRIVATE INSURANCE** does not pay for most community-based services and has caps on the services it does cover, usually a certain number of outpatient counseling sessions and a limited number of days of inpatient hospitalization. Children with intensive treatment needs can easily exhaust their annual or lifetime limits in private insurance and be left with no coverage for mental health services. Most private insurance does not cover essential community-based services such as intensive in-home services, therapeutic day treatment, or behavioral aides. For families with private insurance but still limited financial means, these services are simply inaccessible. Recent insurance parity laws, designed to equalize mental and physical health benefits, still do not cover these community-based services. Also, large companies that self-insure are exempt from parity laws, leaving many families without even these protections. Additionally, local staff and providers report that some private insurance plans reimburse providers at such a low rate that providers are unwilling to participate; leaving families without services even though they technically are covered by their insurance policies. Additionally, some health insurance plans do not provide mental health benefits. These are both reported to especially be a problem in rural areas.

2.) **MEDICAID RESTRICTIONS:**

• ***ELIGIBILITY:*** Medicaid eligibility for children is primarily determined by income. Children whose countable income falls below 133 percent of the federal poverty level are eligible for Medicaid; those whose countable income falls between 133 percent and 200 percent of the federal poverty level are eligible for FAMIS. One exception to this income-based eligibility is that children whose families' income exceeds Medicaid income requirements may become Medicaid-eligible after being out of the home for 30 days. After 30 days, eligibility is based on the child's income only. A recent clarification of a DMAS policy reiterated that, for children who become eligible after being out of the home for 30 days, the date of Medicaid eligibility is the first day of the month in which the thirtieth day out of

home occurred. That means that once the child enters an out-of-home placement, Medicaid may not cover services from the first day of placement. This will depend on the day of the month the child was placed. The child's Medicaid eligibility must be re-determined after discharge. This determination will include the family's income. As such it is likely that the child will no longer meet Medicaid income criteria.

• ***MEDICAL NECESSITY CRITERIA:*** Once a child is determined eligible for Medicaid he or she must be determined to meet the medical necessity criteria in order for services to be provided. Many services are defined around a "crisis-level" of need which may preclude children whose needs have not escalated to the level of a crisis.

• ***COVERED SERVICES:*** Virginia's Medicaid funding policies create incentives to place children in residential services. While our Medicaid system funds some community-based services through its state plan option services, as well as through FAMIS, it does not cover a full array of services that can prevent children from being placed in residential care. In other states Medicaid funding is used for additional community-based services such as respite care, therapeutic aides, after-school programs, summer camps and therapeutic preschools. (Medicaid funding does cover after-school day treatment and does allow for reimbursement of paraprofessional staff in these programs). Medicaid is by no means the answer to serving all children with mental health disorders, but the development of certain treatment services in Virginia has closely followed changes in Medicaid coverage.

Regardless of the child's length of stay in a Medicaid-approved residential treatment center, Medicaid funding for residential care could, but does not currently cover the cost of education within the treatment facility. (The 2004 Appropriations Act directs DMAS to study this issue). Thus, the cost of residential education must be absorbed either by the parent (if the child is residentially placed by a parent) or by the placing locality via CSA funding (if placed through the local CSA system).

Regardless of the services offered by a state under its state plan, federal law requires a broad range of outreach, coordination, and health services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT), distinct from general state Medicaid requirements. According to DMAS' Medicaid EPSDT manual:

"Treatment is any medically necessary treatment service required to correct or ameliorate defects and physical and mental illnesses and conditions discovered during a screening examination. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS as medically necessary."

A national study by the Bazelon Center for Mental Health Law on the issue of EPSDT usage and parental custody relinquishment found that EPSDT is not used appropriately either because providers do not know the full array of services for which children are eligible, they do not understand how to bill Medicaid for the needed services, or the state does not adequately educate parents of eligible children about the array of services to which they are entitled. While Virginia exceeds national benchmarks for EPSDT screening examinations, DMAS agrees that some providers and families may not be aware of the extent of EPSDT services that are available to correct or ameliorate children's medical conditions. DMAS is proactively working to increase knowledge about the availability and how to access needed services through additional training and providers and notices to families.

Finally, Virginia currently does not include substance abuse treatment services for children or adults in the Medicaid state plan. There are exceptions; children may obtain substance abuse services through EPSDT and substance abuse day and residential treatment are covered services for pregnant and postpartum women. Also, the children's health insurance program (FAMIS) includes substance abuse treatment. Service delivery for adolescents with underlying mental health disorders and substance abuse disorders would be facilitated by the inclusion of substance abuse treatment services in the Medicaid state plan.

• ***SERVICE AVAILABILITY:*** Even when Medicaid covers certain services, these services may or may not be available in a given locality because of the reimbursement rates. If providers do not believe that the Medicaid reimbursement rate can adequately cover the cost of providing the service, providers will often not provide services if the reimbursement rate will not cover them.

3.) **<u>CSA FUNDING RESTRICTIONS:</u>** The Comprehensive Services Act designates certain categories of children eligible to receive funding under the Act as mandated for services: those in foster care and those in special education whose individualized education program require private day or residential schooling, as well as those who qualify for foster care prevention. These children must be served in a sum-sufficient manner. By default, then, all other at-risk children with behavioral health service needs are considered "non-mandated."

The state has set a ceiling on the amount of funding available to each locality as the state match for non-mandated services. It is a local administrative decision whether or not to use the available dollars for the non-mandated population. The match rate for funding to each locality is the same for mandated and non-mandated service expenditures. Localities with great fiscal stress use their local funds to meet the match requirements for mandated services leaving no match to draw down non-mandated funds. At the state level, unused non-mandated funds are "rolled over" into the state match for mandated expenditures.

As a result of this structure, the vast majority of funds are spent on services for mandated children. In FY2003, 96.6 percent of CSA state and local funds were spent for mandated children. The amount of funding spent on non-mandated children statewide has been decreasing since FY2000. Between1999-2003, 30 out of 134 localities did not spend any CSA funds on non-mandated children for non-residential services; 51 localities did not to spend any CSA funds on non-mandated children for residential services during that same time period.

Local variability in CSA funding also exists in the use of the foster care prevention category. The VDSS has not given localities clear guidance on the use of the foster care prevention funding nor offered continuing, specific training or technical assistance on eligibility for these funds. Neither does the VDSS require localities to use these funds for this particular population. As a result,

localities define eligibility for foster care prevention differently. Some localities use this category to provide funding for mental health treatment for children living with their parents whom they determine to be at risk of entering the foster care system because of their treatment needs, rather than due to abuse and neglect. Other localities interpret this funding mandate to be only for families where abuse and neglect, as well as mental health treatment needs, exists.

Yet another area of local variability is the degree to which each locality implements CSA in categorical fashion. In some localities, once a child becomes mandated, through any of the "doors" into the system, that child becomes eligible for any service that he or she may need. In other localities, the services a child is "eligible" for depends on how he or she became mandated. For example, in certain localities a child mandated because of special education is not eligible to receive intensive in-home services unless those services are written into the child's Individualized Education Program (IEP), regardless of his or her need for those services. In those localities, a child would also need to be mandated through foster care or foster care prevention to be eligible to receive in-home services. In other localities, once a child is mandated for any reason, that child is eligible to receive any necessary services.

4.) **EDUCATIONAL RESTRICTIONS:** Federal and state laws specifically provide that children with disabilities and who require special education services to obtain educational benefit can receive mental health services including residential treatment services as a "related service." State and federal regulations define "emotional disturbance" broadly, however, so the determination of what services the local school system must provide to address the emotional disturbance are typically limited to services provided specifically for educational support during the school day in the designated educational facility. As a result, many children's Individualized Education Programs (IEPs) do not require provision of year-round services or services offered during non-school hours in a community or home setting. Frequently, debates arise between parents and school personnel at IEP meetings when determining whether a child requires these related services for educational purposes, or to assist parents in their struggle to safely keep a child with disabilities in their family and ultimately in their custody. In cases in which parents are seeking residential treatment for their children, IEP teams often deny the provision of residential treatment services asserting that this related service is too restrictive and that the child can be adequately maintained in a less restrictive placement in a community based school environment.

For families whose children need residential treatment, this is a serious funding obstacle for obtaining the necessary services for their children. There are few payors for the education portion of residential treatment expenses: the school system if the child is in special education and residential treatment is part of the child's IEP (this is one way of making the child "mandated" for services under CSA); CSA funding if the locality funds residential treatment for non-mandated children; or funding by the parents themselves. As mentioned earlier, Medicaid currently does not reimburse for the educational portion of residential treatment. Parents who do not have the funds themselves, whose children do not have residential services written into their IEP, and who live in communities that either do not fund services for non-mandated children or have depleted their non-mandated funds for the year, find themselves trying to obtain the services through the foster care system, leading to the question of custody relinquishment.

5.) **LACK OF SERVICE AVAILABILITY:** Low Medicaid reimbursement rates for some services is one of several reasons why services are not available in many areas of the state. One primary reason is that there are no state funds available to local entities for use as start up monies for new services. CSA funds and the Mental Health Initiative Funds allocated to Community Services Boards (CSBs) for services for non-mandated youth are child-specific funds, meaning they are disbursed based on individual service plans for specific children. They generally cannot be used to help a CSB or locality defray the start-up costs for developing a new service before they begin billing Medicaid, private insurance, or another third party for that service. CSA as originally passed included a CSA Trust Fund, consisting of a small pool of funds that could be designated to start up new services. After the initial allocations, however, the funds continued to flow to the same programs as continuing support, rather than for starting new services in other localities.

Another factor affecting service availability, particularly in rural areas, is the lack of a "critical mass" of children with the same treatment needs that would make starting a particular service cost-effective. Without start-up funds or technical assistance available to localities, there is little incentive for localities to join together to create regional services for a large enough population of affected children.

A specific challenge to the CSBs is that funding for public community-based mental health services has gone through

significant changes in the past 15 years. During this time, CSB funding has shifted from a reliance on state general funds to a more significant reliance on Medicaid and fee-for-service reimbursements. Given the limitation of state and local funding, the majority of the services available through local CSBs must be billed to a funding source, either self-pay, private insurance, or public funding such as Medicaid or FAMIS. As a result, CSBs generally do not have adequate funding to provide care to persons who do not qualify for financial support. The only state funding going to CSBs that is earmarked for children's mental health services in the state budget is the $6.125 million allocated for Children's Mental Health Initiative to serve children that are "non-mandated" under CSA. (This includes the additional $2 million allocated during the 2004 General Assembly session as part of the "Olmstead Initiative.") Each CSB makes the decision as to how to allocate all other general fund dollars it receives for mental health services. These funding restrictions play a significant role in the CSBs' ability to offer a broad continuum of services for children.

Finally, the number of inpatient beds at state Mental Health Facilities designated for children and adolescents were significantly reduced during the 1990's reducing the availability of inpatient care to children not mandated for CSA funded services.

b. Non-Financial Barriers to Services

1.) <u>FRAGMENTED SYSTEM OF CARE:</u>

Since the mid-1980s, the federal Department of Health and Human Services (currently through SAMHSA), has provided training, grant funding, and technical assistance to states and communities to develop, improve, and expand their systems of care to meet the needs of children with SED and their families. As a result, a set of guiding principles has been developed to create and maintain such systems of care for children and families. The original recommendations to create CSA in Virginia were modeled under systems of care principles, but in practice and implementation, Virginia's CSA system of care falls short of complete incorporation of the core values and guiding principles that define true systems of care. Needed improvements include: incentives for implementation of core values and principles; definitions of who is and who is not served by the system of care; addressing the fragmentation of the service delivery system that was compounded by CSA; evaluation and data collection; and collaboration at all levels of child-serving systems. While it is beyond the scope of this document to offer a comprehensive analysis of the current CSA

system in relation to systems of care principles and values, SAMHSA and CMHS offer a wealth of information on creation of systems of care.

One specific way that current implementation of the CSA system falls short of systems of care principles and goals is that it tends to be crisis-driven rather than prevention-focused. A significant amount of CSA funding is spent on residential services for children, rather than community-based services that might allow children to remain in their own homes. In FY2003, 49 percent of mandated funding and 60 percent of non-mandated funding was spent on residential services for children. The Code of Virginia is explicit in stating that the goals for CSA include providing services to children at risk for serious emotional disturbance, not just those with severe treatment needs, and in the least restrictive environment. Current implementation of CSA largely falls short of these goals.

Many localities are making significant efforts in the areas of prevention and early intervention. Local governments, not the state, primarily develop and fund these initiatives. While some state and federal funds flow to localities for prevention, these are not well coordinated with CSA or other funding streams for behavioral health treatment services.

Family advocacy for children's mental health issues has been sparse in Virginia in comparison to some other states. In short, Virginia lacks the support and infrastructure needed for family participation. Efforts made to date by organizations such as NAMI, PACCT, The Arc, and Voices for Virginia's Children have been critical in providing the base of advocacy that has now developed. However, the primary national organization with the needed infrastructure, guidelines and support needed to create strong family advocacy is Federation of Families for Children's Mental Health, which has been slow to develop in Virginia.

2.) LACK OF CLEAR AUTHORITY FOR PROVIDING CHILDREN'S MENTAL HEALTH SERVICES:

The Code of Virginia offers no clear direction regarding responsibility for serving children with behavioral health needs, except for children mandated to receive services through CSA. Neither localities through CSA, nor CSBs are required to serve non-mandated children.

CSBs are only directed to provide emergency services, and case management services within available resources, and "may include a comprehensive system of inpatient, outpatient, day-support residential, prevention, early intervention, and other appropriate mental health, mental retardation and substance abuse services necessary to provide individualized services and supports to adults, children and adolescents with mental illnesses, mental retardation, or alcohol or other drug abuse problems or dependence." (Code of Virginia, § 37.1-194) This very limited mandate to provide emergency services means that the services available to children at CSBs varies greatly across the Commonwealth; some CSBs offer a wide array of services to children and families, while others offer only limited services. The lack of qualified specialists to treat children, ranging from licensed clinical social workers to psychiatrists, is a significant problem for CSBs. (As with all providers of mental health services, both public and private, standards for service delivery are regulated by DMHMRSAS licensure, DMHMRSAS Human Rights regulations, and other applicable regulations). Further, current regulations do not require providers specializing in the provision of children's services to have specific training in children's mental health issues.

3.) LOCAL VARIABILITY:

Just as there is considerable variability among CSBs in the provision of children's services, there is also wide variability in other local child-serving agencies and in communities. This is evidenced by the differing structures for child-serving systems across the Commonwealth: some local agencies are single jurisdiction, others multi-jurisdiction, and the agencies service areas may not be the same. There are 40 CSBs, 35 court services units, and 111 Local Departments of Social Services (LDSS) to serve the 134 cities and counties in Virginia. CSA structures (community policy and management teams, family assessment and planning teams, coordinators) are unique to each locality. This complexity of the service delivery system adds to the fragmentation of the system described above.

As the Code allows maximum local flexibility for serving children, considerable variability exists in local interpretation and implementation of state policy by any given child-serving agency. Examples include local variability in the use of non-mandated and foster prevention CSA funds, the provision of community-based mental health services, and the practice of implementing non-custodial foster care agreements. This latter example will be explained in a later section of the report. All of this variation leads

to a great deal of confusion of the part of families trying to understand how to access services.

4. Review of Current Options for Obtaining Care Through the Child Welfare/Foster Care System

This section will attempt to clarify the ways in which parents attempt to access mental health services through the child welfare/foster care system. There are several possible avenues. Not all of them are consistently available across the Commonwealth, and not all of them are used by parents. Each option is summarized below in order to offer a comprehensive view. Options that are predicated on parental relinquishment of custody are so noted.

Ways of Entry into the Child Welfare/ Foster Care System for Parents Seeking Access to Mental Health Services for Their Children

There are a range of options and responses for families within the child welfare/foster care system when they seek mental health services for their child. At one end of the spectrum are services to help the family avoid entering into the foster care system -- foster care prevention services. Foster care prevention of a limited duration does not require Juvenile Court involvement. Otherwise, access to the foster care system is typically predicated on a Juvenile Court disposition or voluntary placement agreement, most of which include continuing oversight by the local department of social services (LDSS) and possibly the Juvenile and Domestic Relations Court (J&DR).

Section 3 of the Virginia Department of Social Services' Foster Care Policy Manual (April 2004), states that:

> *"Children enter foster care through court commitment based on an abuse or neglect petition; CHINS (children in need of services) petition, an entrustment, delinquency, a request for relief and non-custodial agreements."*

Depending on the manner in which a child's needs are brought before the Court, the Code Of Virginia outlines the array of dispositional alternatives available to the judge. This range of options is explained below. Each option includes excerpts from relevant sections of the Code of Virginia or the VDSS Foster Care Policy Manual, available online at: http://www.dss.state.va.us/family/fostercare_manual.html.

Sections from the manual that are in upper-case type reference policy that is in the Code or regulation. Quotes from the Code or policy are italicized. In addition to relevant policy or Code cites, each option also includes a description of local variation in application, as well as a description of the effect of that local variation on children and families along with the strengths and limitations of each option.

a. Foster Care Prevention

1.) <u>POLICY SUMMARY:</u>

As referenced in the VDSS Policy Manual (see below), foster care prevention is provided through child protective services (CPS) and the Title IV-B prevention and support services. CPS prevention services are for children at risk of abuse and neglect and whose family has had some involvement with CPS. These CPS prevention services are generally not used for families trying to access mental health services. Title IV-B Prevention and Support services are broader and designed to prevent any out-of-home placement. Families desiring prevention services who are not involved with CPS are more likely to try to access foster care prevention through the FAPT process, which pays for the services through CSA State Pool Funds. Appendix H of the CSA Manual (revised April 2003) (referred to in VDSS Policy) is available in its entirety at http://www.csa.state.va.us/html/forms/pubsmanual.cfm.

VDSS Prevention Policy

2. Foster Care Prevention/Family Preservation

2.1 Services To Be Provided: *SERVICES SHALL BE PROVIDED TO FAMILIES TO PREVENT THE NEED FOR FOSTER CARE PLACEMENT. ANY SERVICE AVAILABLE TO A CHILD IN FOSTER CARE PLACEMENT SHALL BE AVAILABLE TO A CHILD AND HIS FAMILY TO PREVENT FOSTER CARE PLACEMENT BASED ON AN ASSESSMENT OF THE CHILD'S AND FAMILY'S NEEDS. THE COMPREHENSIVE SERVICES ACT FOR AT RISK YOUTH AND FAMILIES (CSA) REQUIRES SERVICES TO CHILDREN AND FAMILIES BE CHILD CENTERED, FAMILY FOCUSED AND COMMUNITY BASED.*

Services to prevent foster care placement may be paid from State Pool Funds, family preservation funds, and Child Protective Service funds. Cases in which in-home services to prevent foster care are delivered are to be entered in VACIS as Prevention and Support cases or into OASIS as Child Protective Services cases. Non-custodial foster care cases, where the local board or other licensed child placing agency places a child and legal custody remains with the parent(s), are foster care cases, not prevention; see section 3.6.5.

2.2 Prevention Policy
The provision of services to prevent foster care placement will be guided by the following policies:

2.2.1 PROTECTIVE SERVICES (Vol. VII, Section III, Chapter A)
Applies to children who are at risk of foster care placement due to child abuse and neglect.

2.2.2 PREVENTION AND SUPPORT SERVICES FOR FAMILIES (Vol. VII, Section II, Chapter E)
Applies to services provided to families to strengthen the family's ability to function more effectively and prevent child abuse and neglect.

2.2.3 APPENDIX H OF THE COMPREHENSIVE SERVICES (CSA) IMPLEMENTATION MANUAL
Provides guidance for use of CSA State Pool Funds for foster care prevention. Services provided to the child and family, per Appendix H, will generally be short-term and intensive in order to prevent foster care placement. If services are needed beyond the initial six months, the Family Assessment and Planning Team (FAPT) must review the case and request approval in writing according to the guidelines in Appendix H.

2.) FOSTER CARE PREVENTION – LOCAL VARIATION:

Foster care prevention is mandated by the Code of Virginia (§63.2-905) for those children identified as needing services to prevent or eliminate the need for foster care.

Data submitted by localities and compiled by the Office of Comprehensive Services for the period July 1, 1998 through December 31, 2003 (5.5 years or 66 months) indicates that the average yearly total of cases funded as foster care prevention for non-residential services is 2,190. Of the 132 local CPMTs in Virginia, 10 funded no foster care prevention cases with CSA funding during the 66-month period. An additional 20 CPMTs funded five (5) or fewer cases in the 66-month period.

As described in a previous section of this report, there is a great deal of local variation with regard to the use of foster care prevention.

3.) EFFECT OF LOCAL VARIATION ON CHILDREN AND FAMILIES – STRENGTHS AND LIMITATIONS:

Funding foster care prevention (FCP) services is mandated for localities. Local variability in terms of clear criteria for eligibility and the services available under this category results in wide variability regarding access to needed services.

Strengths:

- Anecdotally from families, FCP has been helpful in funding some mental health treatment services for children where it is available.
- This option may be a less expensive option for localities if the child's treatment needs can be met with community-based services, rather than residential services.

Limitations:

- FCP funding is limited by policy to six months without approval from the VDSS foster care/adoption permanency consultant. Although the consultants systematically approve requests for extensions, the policy does allow for prevention funds to be disallowed after a six-month period. Should such a disallowance occur, services integral to

maintaining a child in the community and at home would cease.

- This category typically is used for community-based services, not residential treatment. If a child's needs have deteriorated to the point of needing an out-of-home placement, FCP will not help.
- This option will not help families in localities that do not pay for FCP services through CSA.

b. Non-Custodial Foster Care Agreements and CHINS Petitions

2.) <u>POLICY AND CODE SUMMARY:</u>

The initiation of a non-custodial foster care agreement is another avenue available to parents seeking publicly supported access to mental health treatment for their children. A non-custodial foster care agreement is an agreement where a parent retains legal custody of their child while turning over physical custody to the Local Department of Social Services (LDSS) or to another agency approved by the Community and Policy Management Team (CPMT) in order to obtain treatment services for the child. By entering into a non-custodial foster care agreement, the child is thereby eligible for services in the same manner as other foster care children and thus achieves the "mandated" classification for CSA funding purposes. However, the DSS Division of Licensing Programs specifies that licensed child placing agencies may not accept children for foster home placement under a non-custodial agreement entered into with a public agency -- other than a LDSS -- designated by the CPMT (§63.2-1817). As a result, non-custodial foster care agreements with a public agency other than the LDSS may result only in a child's placement in residential facilities or group homes. Further, licensing regulations for treatment foster care services require a child to be in the custody of their LDSS or under a non-custodial agreement.

A non-custodial foster care agreement is secured through two steps that may occur in either order:

- A non-custodial foster care agreement is entered into with the LDSS or another CPMT-approved agency;
- A CHINS (Child in Need of Services) petition is then filed with the Juvenile Court, (This dispositional alternative available to the Court permits the LDSS to implement the non-custodial foster care agreement).

Either the parent or any of a number of public agencies (child welfare, community service boards, schools, probation, etc.) can file a CHINS petition on behalf of a child.
Code sections pertaining to CHINS petitions may be found in Appendix II. Code sections addressing non-custodial foster care and the corresponding VDSS policies follow.

Non-custodial foster care cases are also subject to all of the legal requirements of a foster care case including referral for Medicaid eligibility, child support payments, Title IV-E eligibility determination and judicial oversight. Foster care cases in Virginia are not eligible for Title IV-E federal funding unless these requirements are met. This adds a disincentive for the management of non-custodial agreements by non-DSS agencies.

CHINS PETITIONS - Code of Virginia

§ 16.1-278.4. Children in need of services.

If a child is found to be in need of services or a status offender, the juvenile court or the circuit court may make any of the following orders of disposition for the supervision, care and rehabilitation of the child:

5. Permit the local board of social services or a public agency designated by the community policy and management team to place the child, subject to the provisions of § 16.1-281, in suitable family homes, child caring-institutions, residential facilities, or independent living arrangements with legal custody remaining with the parents or guardians. The local board or public agency and the parents or guardians shall enter into an agreement which shall specify the responsibilities of each for the care and control of the child. The board or public agency that places the child shall have the final authority to determine the appropriate placement for the child.

Any order allowing a local board or public agency to place a child where legal custody remains with the parents or guardians as provided in this section shall be entered only upon a finding by the court that reasonable efforts have been made to prevent placement out of the home and that continued placement in the home would be contrary to the welfare of the child, and the order shall so state.

VDSS Policy Manual on non-custodial foster care agreements

3.5.5 NON-CUSTODIAL FOSTER CARE PLACEMENT

PARENT(S) OR GUARDIANS MAY ENTER INTO AN AGREEMENT WITH THE LOCAL DEPARTMENT OR COMMUNITY PLANNING AND MANAGEMENT TEAM (CPMT) DESIGNATED PUBLIC AGENCY TO VOLUNTARILY PLACE A CHILD UNDER AGE 18 IN FOSTER CARE WHILE RETAINING CUSTODY. SERVICES TO PREVENT THE NEED FOR FOSTER CARE PLACEMENT MUST BE OFFERED AND MUST BE DOCUMENTED IN THE SERVICE PLAN. IN EMERGENCY SITUATIONS WHERE SERVICES CANNOT BE OFFERED, THE REASONS MUST BE RECORDED ON THE SERVICE PLAN.

Before choosing this placement alternative and entering into a non-custodial agreement, the agency must assess and determine that: Leaving custody with the parent(s) or guardians is in the best interests of the child and will not place the child at risk; and The parent(s) or guardians will remain actively involved with the child during the placement.

These determinations must be documented on the Non-Custodial Foster Care Agreement. If these conditions do not exist, transferring custody to the local department of social services should be considered.

Additional VDSS Policy addressing specific provisions of a Non-Custodial Foster Care Agreement (Sec. 3.5.5.1), Court approval of the plan for non-custodial foster care (Sec. 3.5.5.2), entry of the case in the State MIS system (Sec. 3.5.5.3), referral of the child for Medicaid eligibility screening and parental obligations for child support payments (Sec. 3.5.5.4), payment for the child's service and maintenance via Title IV-E and CSA (Sec. 3.5.5.5), case management by an entity other than the local child welfare agency (Sec.3.5.5.6), and return of the child to the parent's home (Sec. 3.5.5.7) may be found in Appendix II.

2.) CHINS AND NON-CUSTODIAL FOSTER CARE AGREEMENTS – LOCAL VARIATION:

a. Discretion of Local Intake Officer: To file a CHINS petition with the court, parents go to a court intake officer. The Code provides the intake officer with discretion in filing petitions:

§ 16.1-260. Intake; petition; investigation. Paragraph C: "In cases in which a child is alleged to be abused, neglected, in need of services, in need of supervision or delinquent, if the intake officer believes that probable cause does not exist, or that the authorization of a petition will not be in the best interest of the family or juvenile or that the matter may be effectively dealt with by some agency

other than the court, he may refuse to authorize the filing of a petition."

Anecdotally, it is reported that some localities, likely due to a lack of resources, restrict access to services by having intake officers deny parents' CHINS petitions. These localities believe that CHINS petitions might lead to orders of non-custodial foster care agreements, thereby requiring provision of services to children for which the CPMT (i.e., the local government) will have to pay because the children will then be considered "mandated" under CSA.

b. **Local Option of Non-Custodial Agreements:** Agencies that file CHINS petitions may not be aware that a court "may make any of the following orders of disposition" as noted in Sec.16.1-278.4. Agencies are not required to offer non-custodial foster care agreements to parents seeking services through a CHINS petition. Some local agencies do not make use of the non-custodial foster care agreements option. Statute provides that: "Any order allowing (an agency) to place a child where legal custody remains with the parents or guardians ...shall be entered only upon a finding by the court that reasonable efforts have been made to prevent placement out of the home and that continued placement in the home would be contrary to the welfare of the child, and the order shall so state."

NOTE: A recent Attorney General's opinion on non-custodial foster care agreements http://oag.state.va.us/media%20center/Opinions/2004opns/04-012w.htm) says that a judge may order a LDSS to enter into a Non-Custodial Foster Care Agreement (NCFC) agreement with a family. However, AG's opinions are advisory, not binding. Some judges may see this opinion as providing firmer footing for ordering these types of agreements; but there is nothing to compel judges who do not wish to order them.

c. **Child Support Payments:** The Code of Virginia requires the collection of child support for all children placed in foster care. Sec. 63.2-910 requires LDSS to address child support in non-custodial foster care cases. However, LDSS foster care workers have the option of claiming "good cause" for the parents if paying child support will interfere with the goal of returning the child to his home (See VDSS Foster Care Policy Manual section 5.6.6). Claiming good

cause means the VDSS Division of Child Support Enforcement (DCSE) will not pursue child support of the identified parent(s).

If good cause is not claimed and the LDSS foster care worker files a child support claim, parents may file an appeal. This appeal is an opportunity for the parents to present to DCSE any other financial information about the family in addition to parents' income, such as amounts paid for mental health treatment in the past on behalf of the child. Sec. 63.2-909 requires the Juvenile and Domestic Relations Court to address child support when a petition is presented for a child entering the foster care system. The judge has several options available regarding this request including reducing the amount of child support payments or allowing the LDSS worker to claim good cause. If DCSE has already established the payment amount, the court may change that amount. The court order setting a payment amount supersedes DCSE's administrative order. Upon receipt of the court order, DCSE enters a new order based on the court order with the appropriate effective date. If good cause is claimed, the foster care worker informs DCSE of the good cause claim and DCSE no longer enforces any collection while good cause exists.

3.) <u>EFFECT OF LOCAL VARIATION ON CHILDREN AND FAMILIES – STRENGTHS AND LIMITATIONS:</u>

a. Discretion of Local Intake Officer: In localities that do not offer parents the options of filing CHINS petitions in an effort to obtain mental health services, the parents possess few options. Typically, the child in question is in crisis or has very intense treatment needs. Mental health professionals often recommend that the child be placed in a residential treatment facility because he is a danger to himself or others and his treatment needs are not being met in the community. The parents have usually exhausted private insurance benefits, make too much money for their child to be eligible for Medicaid, and cannot pay for residential services out of pocket. They are seeking help from the court to get their child referred to the FAPT in hopes that CSA will help pay for the residential placement (or they are appealing a denial from FAPT or a recommendation of less intensive services which they consider inappropriate). Usually, if they have filed the CHINS petition, it means they have already failed to get a

residential placement written into their child's individualized education program (IEP), so their child will not be considered "mandated" by CSA in that category. They have gone to court on a CHINS petition as a last resort to try to access the "mandated" funds through the door of foster care. If they are not allowed access in this way, their child may go without services and remain in the home until a crisis point is reached. At this time, the child usually is committed to an inpatient hospital for a brief stay, after which time the family and community face the same types of decisions about where a child should go after hospitalization if he is clinically unable to return home. Or, the child's behaviors stemming from his mental disorder may result in an arrest and involvement with the juvenile justice system.

b. **Local Option of Non-Custodial Agreements:** In localities that refuse to enter into non-custodial foster care agreements, the court is left with the other options listed in Code, including the court placing the child in the custody of the local DSS. This means the parents lose custody of their child. Many parents will refuse to give up custody of their children, and they are left struggling with no services or inadequate services for a child with intense mental health treatment needs.

c. **Child Support Payments:** Without a claim of good cause regarding child support payments, DCSE will pursue child support and parents will be assessed a variable amount of child support for their child placed in foster care through a non-custodial foster care agreement. If parents do not understand, or do not take advantage of the child support appeal process, detailed information about the debts incurred by the family attempting to obtain mental health treatment for their child will most likely not come to the attention of DCSE to be used in determining the amount of child support payments. Similarly, if the judge is unaware of the family's financial stresses, the child support claim may simply proceed to DCSE with no consideration of extenuating circumstances that could preclude the imposition of child support payments. If a family does not have an advocate who understands these exclusionary provisions nor enacts them on behalf of the family, the parents may be required to pay child support in addition to costs they have incurred until that time for mental health treatment for their child. This can leave parents in a

precarious financial position, both in terms of taking care of the child in question, as well as for the care of other family members.

Strengths of non-custodial foster care agreements:

- Results in the child and family gaining access to publicly-funded services previously unavailable to them.
- Reduces the financial burden on parents from paying for treatment services for the child.
- Allows the state to access Title IV-E federal funds to pay for the cost of care for those children eligible for such funding as opposed to using all state and local funding sources. Given the costly nature of service provision, this access to federal funds saves state dollars.
- Parents retain legal custody of the child.
- Engages the FAPT in interagency planning for the child's needs.
- Engages the FAPT in interagency planning for the child's needs.
- Engages the parents in planning process for child's treatment (through FAPT, the service planning process and court hearings) and continuing participation with child's treatment.
- By requiring non-custodial foster care cases to comply with regular court reviews regular judicial oversight can prevent cases from lingering in the foster care system.
- Law currently allows localities to use this option.

Limitations of non-custodial foster care agreements:

- Too much local discretion in implementation leads to:
    - Variable treatment of parents in regard to child support payments.
    - Variable inclusion of parents in decision making about their child's treatment. Although parents retain legal custody of the child, they do not have final say in their child's placement. Many parents report not being treated with respect as experts on their children, but as part of the problem. As such

some parents do not think their children are receiving appropriate services, even after they have gone through the entire process.

- Some parents report feeling threatened or bullied by the process of entering a non-custodial agreement; if they do not cooperate with the FAPT and DSS, the agency has the option of petitioning the court to have custody transferred to DSS. Parents are also not always clear about their rights under the agreement. However, many of them view non-custodial agreements as their last option for accessing services, so they do not think they have choices.
- Localities are not required to administer non-custodial foster care agreements. Some localities refuse to do so, leaving parents without this option, however flawed, for accessing mental health services.

- The child enters the foster care system when what he really needs is mental health treatment. This uses valuable resources within the foster care system on families for whom the system was not intended, while putting the child at higher risk for exposure to the problems with out-of-home care. Non-custodial foster care is still foster care, a program designed to meet the needs of children whose parents cannot, to some significant extent, meet those needs themselves. The system is not designed for parents who are capable of caring for their own child, and insist upon it, but who lack a payment source for needed services. To those parents, even non-custodial foster care seems intrusive and inappropriate.
- Parents and all adults in the home are subject to a criminal background check and CPS central registry search before the child can be returned to the home (Code of Virginia §63.2-901.1, requirement for all children in foster care before they can be returned home). Again, the system is attempting to fit a family with a child in need of mental health services into a system that is designed to protect children from abuse and neglect.
- It is time consuming to access services through the court process. Meanwhile, the children are usually in crisis or have a very high level of need for intense services which they are not getting while the process is being worked out.
- Non-custodial foster care was designed to give parents a non-adversarial process to obtain services for their children

when the larger child-serving system did not provide ways to access services earlier, before a child reaches crisis or needs such intensive, restrictive, and expensive services. Waiting to grant access to services until a crisis occurs inflicts greater damage on the child and family and is more costly to the public system.

- A family entering a non-custodial foster care agreement may feel like it is losing all custody and control of the child since other individuals are making decisions regarding the child. This effect of the non-custodial agreement may be lessened or made worse by the attitudes and behaviors of the service providers, the agency with whom the family entered the non-custodial agreement, the FAPT, the courts and the community. For the parents mentioned in this report, entering a non-custodial foster care agreement felt like losing custody, even though technically, they retained legal custody while the agency involved had "physical custody" of the child. These parents said that entering the agreement was devastating to them as parents and to their children. They report that their children were unable to understand the distinction between legal and physical custody and as a result, simply felt abandoned or "sent away" by their parents.
- Policy governing the use of non-custodial foster care does not adequately cover the roles and responsibilities of all individuals involved in the agreement nor does it provide adequate guidance regarding the more adversarial components of the process, and how they should be managed. In addition, certain placement services (i.e., foster home placement) are denied for those children who enter foster care through an agreement with a public agency other than the LDSS. Such a prohibition denies children the opportunity to step-down to community living after spending time in a residential program or to access this less intensive level of care from the very beginning.
- Policies and procedures governing how much child support a family may pay are numerous and complex. Workers and judges must be aware of, understand, and implement these complex procedures in order to prevent child support collections from becoming a burden on an already overwhelmed family. Currently, there is no systemic way for families to be made aware of these policies and procedures.

c. Entrustments

1.) <u>POLICY SUMMARY:</u>

Parents may contact the LDSS if they wish to enter into a temporary or permanent entrustment for their child. Temporary entrustments are not often, but can be used by, parents seeking mental health treatment for their children. Entrustments for less than 90 days do not require court involvement. Temporary entrustments for more than 90 days require a court hearing. The VDSS policy manual spells out requirements for these hearings (not included here).

VDSS Policy Manual

3.5.2 TEMPORARY ENTRUSTMENT AGREEMENT (§63.2-903, 16.1-277.01)
PARENT(S) OR GUARDIANS MAY VOLUNTARILY REQUEST THAT THE AGENCY TAKE CUSTODY OF THE CHILD FOR A TEMPORARY PERIOD. IN THIS CASE, THE LOCAL BOARD MAY ACCEPT THE CHILD THROUGH A TEMPORARY ENTRUSTMENT AGREEMENT FOR UP TO 180 DAYS. TITLE IV-E ELIGIBILITY CAN EXTEND BEYOND 180 DAYS ONLY WHEN THE COURT APPROVES THE TEMPORARY ENTRUSTMENT WITHIN 180 DAYS OF PLACEMENT AND DETERMINES THAT THE BEST INTERESTS AND REASONABLE EFFORTS REQUIREMENTS HAVE BEEN MET.
CONDITIONS FOR USE OF TEMPORARY ENTRUSTMENT AGREEMENTS ARE:

- *THE PRIMARY GOAL OF TEMPORARY ENTRUSTMENT AGREEMENTS IS TO RETURN THE CHILD HOME. A TEMPORARY ENTRUSTMENT AGREEMENT MAY ALSO BE USED FOR PURPOSES OF ADOPTION PLANNING. IT IS NOT TO BE USED WHERE THE GOAL FOR THE CHILD IS OTHER THAN RETURN HOME OR ADOPTION PLANNING.*
- *THE AGREEMENT SHALL SPECIFY THE RIGHTS AND OBLIGATIONS OF THE CHILD, THE PARENT(S) OR GUARDIANS AND THE AGENCY. IT MUST INCLUDE THE RESPONSIBILITY OF THE PARENT(S) FOR FINANCIAL SUPPORT OF THE CHILD AND THE AUTHORITY OF PARENT(S) AND AGENCY FOR MEDICAL CARE OF THE CHILD.*
- *ENTRUSTMENTS CANNOT BE USED FOR EDUCATIONAL PURPOSES OR TO MAKE THE CHILD ELIGIBLE FOR MEDICAID.*
- *AN ENTRUSTMENT CANNOT EXTEND BEYOND THE CHILD'S 18TH BIRTHDAY.*
- *PARENT(S) OR PRIOR CUSTODIANS MAY REQUEST RETURN OF THE CHILD TO THEIR HOME. THE AGREEMENT IS CONSIDERED TO BE REVOKED UNLESS THE AGENCY OPPOSES THE REQUEST AND OBTAINS A JUDICIAL DECISION THAT RETURN IS NOT IN THE CHILD'S BEST INTEREST.*
- *THERE ARE TWO TYPES OF TEMPORARY ENTRUSTMENTS, THOSE ISSUED FOR LESS THAN 90 DAYS, AND THOSE ISSUED FOR MORE THAN 90 DAYS.*

Permanent entrustment agreements are a mechanism by which a parent may give up permanent custody and terminate parental rights, typically of an infant, for the purpose of adoption. Permanent entrustments are not used to obtain mental health services.

Temporary entrustments may be used by a parent to access foster care placement for their child in a children's residential facility, independent foster home, or a licensed child placing agency foster home (§63.2-1817). However, if the child remains in the child placing agency foster home beyond 90 days, all foster care provisions (e.g., court hearings, service plans, etc.) must be enacted (§16.1-277.01).

a. Entrustments – Local Variation

Entrustments are not widely used by the population of parents being discussed in this report. The purpose of both temporary and permanent entrustments is narrowly defined and is not intended for the purpose of obtaining mental health treatment. As a result, the guidance to LDSS on administering entrustment agreements does not address the issue of parental roles and responsibilities when a child is entrusted for the purpose of obtaining treatment services.

b. Effect of Local Variation on Children and Families – Strengths and Limitations

Because entrustment agreements are not intended to be used for the purpose of helping parents access mental health treatment for their children, this option is typically not used in such a manner.

Strengths:

- Temporary entrustments could be a means of parents' placing their children in therapeutic foster homes, as an alternative to residential treatment centers.

Limitations:

- In those rare situations where a temporary entrustment is used for the purpose of obtaining mental health treatment, parents temporarily lose both legal and physical custody and all the measures of parental control that go with that. It is up to the LDSS to outline the parameters of authority for the child's medical care between the parents and DSS, so

the parents may not have a say in treatment decisions although parents are still expected to be a partner in developing and carrying out the treatment plan for the child.

- As most children with severe mental health treatment needs require services for longer than 90 days, this will require regular and specified court involvement and compliance with all other provisions of foster care placement, including referral to child support collections.
- When a temporary entrustment is used for the purpose of obtaining mental health treatment, requirements about parental involvement while the child is entrusted to LDSS are not specified, other than financial requirements. This means that requirements such as the need for the parents to stay involved with their child during treatment are not specified.

d. Relief of Care and Custody

1.) POLICY SUMMARY:

The Code of Virginia provides parents the opportunity to request that a court approve a temporary relief of care and custody of their child. When a parent files a petition for relief of care and custody, the court is required to refer that request to the LDSS for investigation and for services. If temporary relief of custody is granted, custody is given to LDSS and the court must hold another hearing within 75 days. While this is not an option the parents who are the subjects of this report are inclined to seek, there are cases in which this path is taken in order to address the child's mental health treatment needs.

Under this code section, a parent may also request a permanent relief of care and custody. Both temporary and permanent relief of care and custody result in placement of the child in foster care; however, the permanent relief of care and custody requires a termination of parental rights. The child is then available for other permanent placement arrangements including adoption. Before granting this request for permanent relief of care and custody, the court must find by clear and convincing evidence that termination of parental rights is in the child's best interest.

VDSS Policy Manual

3.5.4 RELIEF OF CARE AND CUSTODY (§16.1-277.02 and §16.1-278.3)
PARENTS MAY REQUEST TEMPORARY OR PERMANENT RELIEF OF CARE AND CUSTODY.

ON RECEIPT OF A PETITION FOR RELIEF OF CUSTODY, THE COURT MUST REFER REQUESTS FOR RELIEF TO LOCAL DEPARTMENTS INITIALLY FOR INVESTIGATION AND PROVISION OF SERVICES. The intent of this requirement is to determine whether the provision of services will prevent placement.

AT THE HEARING, THE COURT WILL DETERMINE, BASED ON EVIDENCE PRESENTED, INCLUDING THE REPORT FROM SOCIAL SERVICES, WHETHER THE PARENT SHOULD BE RELIEVED OF CUSTODY. IF PERMANENT RELIEF IS REQUESTED, THE COURT WILL DETERMINE WHETHER, BASED ON CLEAR AND CONVINCING EVIDENCE, TERMINATION OF PARENTAL RIGHTS IS IN THE CHILD'S BEST INTERESTS. PARENTAL RIGHTS CAN BE TERMINATED ONLY UPON A FINDING BY THE COURT THAT REASONABLE EFFORTS HAVE BEEN MADE TO PREVENT REMOVAL AND THAT CONTINUED PLACEMENT IN THE HOME WOULD BE CONTRARY TO THE WELFARE OF THE CHILD. (§16.1-277.02)

IF A PARENT IS INCARCERATED, THE COURT MAY AUTHORIZE THE DEPARTMENT OF CORRECTIONS TO HAVE THE PRISONER TRANSPORTED TO PROVIDE NECESSARY TESTIMONY IN HEARINGS RELATED TO CHILD WELFARE. THE TESTIMONY OF PRISONERS CAN ALSO BE ACQUIRED USING ELECTRONIC VIDEO AND AUDIO COMMUNICATION SYSTEMS OR TELEPHONIC COMMUNICATION SYSTEMS IN LIEU OF A PERSONAL APPEARANCE IF AUTHORIZED BY THE COURT.

IF TEMPORARY RELIEF IS GRANTED, THE COURT WILL SCHEDULE A HEARING WITHIN 75 DAYS.
IF PERMANENT RELIEF OF CUSTODY IS GRANTED AND TERMINATION OF PARENTAL RIGHTS IS ORDERED, THE AGENCY WILL SUBMIT AN ADOPTION PROGRESS REPORT TO THE COURT WITHIN SIX MONTHS OF THE HEARING.

2.) <u>LOCAL VARIATION IN IMPLEMENTATION:</u>

The extent to which these options are utilized voluntarily by parents in Virginia is undocumented. Anecdotally, local child welfare agencies generally do not support a petition for permanent relief of care and custody and J&DR courts appear reluctant to grant such permanent relief. The Code of Virginia specifically states that one of the purposes of J&DR courts is "to separate a child from …the child's parents…only when the child's welfare is endangered or it is in the interest of public safety and then only after consideration of alternatives to out-of-home placement which

afford effective protection to the child, his family and the community." The circumstances of parents who request temporary or permanent relief of care and custody varies considerably and the number of such parents who so solely to obtain treatment services for their child is unknown.

3.) EFFECT OF LOCAL VARIATION ON CHILDREN AND FAMILIES –STRENGTHS AND LIMITATIONS:

Losing custody of a child is a devastating result for parents who tried to meet their child's mental health needs but see no other option. It is also devastating to the children involved because it may send the message that their parents no longer want them. In the context of this study, such an outcome is undesirable and counterproductive from both a parental and public policy perspective.

Strengths:

- In those localities not using non-custodial foster care agreements, a request for temporary or permanent relief of care and custody means localities may be required to investigate and provide needed services to a child and family.

Limitations:

- Local variation in use of permanent and temporary relief of care and custody means parents experience different methods of assistance depending on where they live.

E. PRELIMINARY REVIEW OF BEST PRACTICES

Developing an understanding of "best practices" that provide access to treatment services for children without requiring custody relinquishment on the part of their parent(s) necessitates not only a thorough examination of existing successful practices within the state of Virginia and other states, but also consideration of a number of opportunities and options available to Virginia, not yet embraced or implemented.

In addition to examining best practices and models, it is also important to recognize that a change in the current culture, at the state and local level, is necessary to effectively address the custody relinquishment issue. A change that fully acknowledges that custody relinquishment is an unacceptable response to a tragic situation – a situation in which children with serious emotional disorders require access to the resources and services necessary to address their needs.

As detailed earlier in this report, recommendations for best practices and opportunities to improve Virginia's system fall within four broad categories and relate to the workgroup's identification of barriers. These categories are: (1) System Reform, (2) Funding Expansion and Efficient Use of Existing Resources, (3) Changes in Policy/Code, and (4) Service Improvements and Program Development.

It is important to note that carrying out this study's recommendations will be most successful and best able to achieve positive outcomes for children and their families when implemented from a Systems of Care approach (SOC). Each of the following philosophical SOC building blocks needs to permeate the entire children's services system at the practice (line staff), program (management) and policy (administrative) levels to ensure an accessible, coordinated and collaborative network designed to achieve effective and efficient use of funding resources, staffing resources and expertise.

Specifically, the service delivery system needs to be **family driven** and include parents, guardians, and youth (where appropriate), in a collaborative and inclusive manner that involves them in service selection, participation in treatment, allows for active involvement in service monitoring and seeks input from them with regard to their satisfaction of the services they receive. The system needs to be **culturally competent**, linguistically supportive and respectful of cultural differences. It needs to provide **strength-based** interventions, building on existing capacities and resources – both categorical and non-categorical, and it needs to recognize family expertise, not impose "expertise."

The service delivery system also needs to be **preventative** and include early identification and intervention as a key component. It needs to include a range of **least restrictive treatment** approaches, provide an adequate intensity of services in the home, school or community to avoid unnecessary (and often counterproductive) splintering of the family through the use of long-term residential placements.

The system needs to be **community-based** and have a broad continuum of services available that encompass both mental health and non-mental health services, that maximize state and community resources that may be considered non-traditional in the context of children's mental health service delivery. And, finally, the system must ensure an **adequate distribution of the continuum of services** so that families can effectively access services regardless of their need or geographic location.

To embrace the approach described above, a number of efforts are underway across the country that facilitates non-categorical access to funding for children with behavioral health needs. Two specific examples of current model Systems of Care (SOC) developed along the SAMHSA guidelines, values and principles include: (1) the state of New Jersey, and (2) Wraparound Milwaukee. Both of these models were developed utilizing the processes promulgated by SAMHSA for developing a SOC.

Specific operational characteristics of a SOC include: collaboration across agencies; partnership with families; blended, braided or coordinated financing; shared governance across systems and with families; shared outcomes across systems; organized pathway to services and supports; interagency/family services planning teams; interagency/family services monitoring teams; single plan of care; cultural and linguistic competence; one accountable care manager; cross-agency care coordination; individualized services and supports "wrapped around" the child/family; home- and community-based alternatives; a broad, flexible array of services and supports; integration of clinical treatment services and natural supports; integration of evidence-based and effective practices; and cross-agency MIS. (Source: "Primer Hands On: The Skill Building Curriculum (2nd Edition)," by Sheila Pires, Human Services Collaborative, in partnership with Katherine J. Lazear, Research & Training Center for Children's Mental Health, University of South Florida, Tampa, Florida, and Lisa Conlan, Federation of Families for Children's Mental Health).

1. Overview of the New Jersey and Wraparound Milwaukee System of Care Models:

- **New Jersey** - The state of New Jersey planned, developed and implemented its System of Care for children with serious emotional disturbance at the statewide level with intensive coordination among state-level child-serving agencies. In this model, each eligible child is issued either a Medicaid or a Medicaid-look-alike card and has access to an identical system of care and array of services. In New Jersey's model, the complex decisions of which funding stream to access and whether the child meets eligibility requirements for a particular funding stream are removed from the provider level. Instead, the provider or case manager focuses on implementing the array of services that best meets the child and family's need, instead of spending time in determining which and accessing a particular funding stream that the child is eligible for. Funding and eligibility is determined at the state level. The goal is for providers in New Jersey's system of care to simply bill under the Medicaid or Medicaid-look-alike card and the responsibility for pulling down funds under particular funding streams is made at the state level.

- **Wraparound Milwaukee** - Wraparound Milwaukee is a Medicaid managed care behavioral health carve-out program for children and adolescents with serious emotional disturbances. The program started in 1994 with a CMHS System of Care grant and the 25 Kid Project, which was designed to use a wraparound approach for youth in residential treatment centers to return them to the community. Due to its success in a number of arenas (including treatment outcomes, fiscal efficiency, reduction in residential treatment), the program was expanded and in 1997, became a Medicaid managed care program. It receives a monthly capitation rate for each Medicaid-eligible child and blended funding from child welfare and juvenile justice.

Program goals include minimizing out-of-home placements, supporting families to function as autonomously as possible, building on family strength, helping families access an array of services and supports, coordinating care, developing community-based service capacity, and delivering cost effective services. Wraparound Milwaukee includes 120 provider agencies that offer a wide range of services and supports. The program has reduced the use of restrictive placements, participants show significant improvement in functioning, and the average monthly cost of care has been significantly reduced from the much higher costs associated with residential and inpatient care. These savings are reinvested in increasing service capacity and serving more children and families. Program outcomes have included a 65 percent reduction in the use of residential treatment placements, a reduction in Medicaid psychiatric hospital inpatient days from 5,000 days in 1995 to 250 days in 2000, and improvement in functioning as determined by CAFAS scores. (Sources: 1. "Overcoming Barriers to Serving Children in the Community," Advocates for Human Potential, Inc. from www.olmsteadcommunity.org; and 2. Juvenile Justice Journal, Volume VII, Number 1, "Implementation: Wraparound Milwaukee: Aiding Youth with Mental Health Needs," from www.ncjrs.org).

2. **State Statues on Custody Relinquishment:** Other efforts underway across the country designed to facilitate access to treatment services and minimize custody relinquishment are cited in the Bazelon Center for Mental Health Law study, *Relinquishing Custody: the Tragic Result of Failure to Meet Children's Mental Health Needs* (March 2000.) Specific states cited in the report that have **statutes** on custody relinquishment are: Colorado, Connecticut, Idaho, Maine, North Dakota, Oregon, Rhode Island, and Vermont. While each of these states' statutes requires further examination, one important feature to highlight that each of the statutes has in common is that parents are not required to relinquish custody when the sole reason for the voluntary, parental placement is to access behavioral health treatment services.

3. **Medicaid Policy Options:** A subsequent study by the Bazelon Center for Mental Health Law, *Avoiding Cruel Choices: A guide for policymakers and family organizations on Medicaid's role in preventing custody relinquishment* (November 2002), cites a number of **policy options** available to states through the federal-state Medicaid program to address the behavioral treatment needs of children. While the majority of Medicaid's requirements for funding eligibility are based on a family's income, these rules offer an exception in at least two options available to states. They are the (1) TEFRA option (Tax Equity and Fiscal Responsibility Act of 1982), also known as the Katie Beckett option, and (2) the home- and community-based services waiver under section 1915(c) of Medicaid law.2002.)

   Previous Virginia Efforts to Enhance CSA: Since the inception of the **TEFRA** option allows eligibility to be based on a child's disability and care needs, rather than family income. While certain conditions must be met, children who qualify

under TEFRA are provided Medicaid and all of the state Medicaid rules then apply. In other words, the child is eligible for the same array of services as other Medicaid eligible children. The TEFRA option allows states to cover in-home and community-based services, thus facilitate children with disabilities to continue to live at home. It is important to note that not all states with the TEFRA option qualify children as a result of a mental or emotional disorder. Specific states with the TEFRA option where children with mental and emotional disorders do qualify include: Alaska, Arkansas, Minnesota, Maine, Mississippi, New Hampshire, Vermont, West Virginia, and Wisconsin (Bazelon, 2002.)

4. The **home- and community-based services waivers** are another option available to states to address the behavioral health treatment needs of children. While states must generally follow Medicaid rules, Medicaid law does allow states to "waive" certain federal rules. This is achieved by pursing permission for a waiver through the federal Centers for Medicare and Medicaid Service (CMS). One such waiver permitted is the home- and community-based waiver that allows for an expanded array of services that can be provided to children (or adults) with disabilities as an alternative to institutional care. In addition to expanding the array of services, these waivers permit states to provide Medicaid coverage to some children who would otherwise not be eligible for Medicaid because of the family's income and resources. As with the TEFRA option, certain conditions must be met in order for children to be eligible (qualify) for the home- and community-based waiver. Three states have chosen to pursue a federal home- and community-based waiver. They are: Kansas, New York and Vermont (Bazelon, CSA, many **studies** have been commissioned, either by the General Assembly or the State Executive Council (SEC), to examine the funding, resources and services provided under the CSA. Further, legislation has been enacted year after year with the intent of improving and/or enhancing Virginia's child serving system. A most recent example of these efforts is the Virginia Commission on Youth, *Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*. This report provides a collection of empirically sound research on the treatment modalities and practices that have proven most effective for children and adolescents with mental health treatment needs. Further, it seeks to benefit professionals, communities, parents, and others working with children with mental health treatment needs, by providing a collection of research on evidence-based treatment modalities. While this report does not in itself expand funding and/or service resources to meet children's behavioral health treatment needs, it does serve as an invaluable resource to those involved in meeting children's treatment needs. It does encourage the use of evidence-based, proven treatment modalities in serving children and youth by providing a ready resource for practitioners and families.

5. **Best Practices in Virginia:** As part of this Relinquishment of Custody study, local CSA Coordinators were solicited to provide feedback regarding examples currently implemented within their respective **Virginia locality of best practices or models** that facilitate children with behavioral health treatment needs

remaining in the custody of their families. Specifically, CSA Coordinators were asked about their locality's use of non-mandated funds, mental health initiative funds, and non-custodial agreements. As discussed earlier in this report, these issues are complex and while a number of localities were identified as implementing funding and organizational structures to expand access to care and thereby reduce the use of custody relinquishment, because of the variability that exists across localities regarding the application of policies and practices, a further review of these "Virginia solutions" is recommended as a follow-up to this study in order to better determine the extent to which the described successes are supported by data and to identify opportunities to use these practices as models for other communities to follow. Given the time constraints for finalizing this initial report, an extensive examination of the specific locality practices was not able to be accomplished; however, it is recommended that this be included in the on-going efforts of the SEC related to addressing the custody relinquishment issue.

Dedication

This report is dedicated to the memory of Sue Ann Morgan, whose tireless passion and commitment to the needs of youth and families made her a leader in advocating for improvements in Virginia's system of care.

F. APPENDICES

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Comprehensive Services Act Best Practices

2. Glossary of Terms

Adoption and Safe Families Act (AFSA) of 1997 (P.L. 105-89) - Federal legislation effective 1997 which mandates policies to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. This new law makes changes and clarifications in a wide range of policies established under the Adoption Assistance and Child Welfare Act (P.L. 96-272), the major federal law enacted in 1980 to assist the states in protecting and caring for abused and neglected children. (Child Welfare League of America, http://www.cwla.org/advocacy/asfapl105-89summary.htm)

Child in Need of Services (CHINS) - (i) a child whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of the child or (ii) a child under the age of 14 whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of another person; however, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be a child in need of services nor shall any child who habitually remains away from or habitually deserts or abandons his family as a result of what the court or the local child protective services unit determines to be incidents of physical, emotional or sexual abuse in the home be considered a child in need of services for that reason alone.

However, to find that a child falls within these provisions, (i) the conduct complained of must present a clear and substantial danger to the child's life or health or to the life or health of another person, (ii) the child or his family is in need of treatment, rehabilitation or services not presently being received, and (iii) the intervention of the court is essential to provide the treatment, rehabilitation or services needed by the child or his family. (Code of Virginia, http://legis.state.va.us/Laws/CodeofVa.htm)

Community Services Board (CSB) - the relationship between the CSB and its local government or governments. While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments.

Comprehensive Services Act for At-Risk Youth and Families (CSA) - 1993 Virginia law that provided for the pooling of eight specific funding streams used to purchase services for high-risk youth. These funds are returned to the localities with a required state/ local match and are managed by local interagency teams. The purpose of the act is to provide high quality, child centered, family focused, cost effective, community-based services to high-risk youth and their families. (CSA Fact Sheet, http://165.176.249.117/html/about/about.cfm)

Legislation that created a collaborative system of services and funding that is child-centered, family-focused, and community-based to address the strength and needs of troubled and at-risk youth and their families. (Virginia DSS Foster Care Manual, http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Community Policy and Management Team (CPMT) - team established by the comprehensive services act for at-risk youth and families. The team is appointed by local governing bodies to manage the cooperative effort in each community to serve the needs of troubled and at-risk youth and their families and to maximize the use of state and community resources. The team develops local policies and procedures for provision of services to children and families (§§2.2-5204; 2.2-5206). (Virginia DSS Foster Care Manual,
http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

CSA pool funds - Children and youth who are at risk of already experiencing emotional/behavioral problems, but especially though at risk of or in need of out-of-home placement, and their families, are eligible to access CSA pool funds under the Comprehensive Services Act.

This population includes a child or youth or is less than eighteen years of age; **and** is within the jurisdiction of the county providing services; **and** has emotional or behavioral problems which:

a. has persisted over a significant period of time, or though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
b. are significantly disabling and are present in several community settings, such as home, school or with peers; and
c. require services or resources that are unavailable or inaccessible, or that are beyond the regular agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies; or
d. place the child or youth at imminent risk of entering purchased residential care.

(Note: Exceptions can be made for certain populations of children up to the age of 21).

Within this eligible population, the CPMT requires that priority access to CSA pool funds be given to the following populations:

1. Children or youth requiring special education private tuition school placements (**mandated**);

2. Children for whom services are being provided to prevent foster care placements, and children entrusted or committed to the Department of Social Services (DSS) by their parent(s) or guardians or committed to DSS by any court of competent jurisdiction for the purposes of placement in a suitable family, child-caring institutions, residential facilities, or independent living arrangement, as authorized by Code of Virginia §63.1-56 (**mandated**);

3. Children or youth in residential facilities as of July 1, 1993 whose placements but be continued according to an IFSP or IEP (**mandated**);

4. Children or youth under the jurisdiction of the Juvenile Court who are court ordered into residential care or court ordered to receive non-residential services (**non-mandated**).

To the extent that CSA pool funds remain unavailable within the annual allocation for eligible but non-mandated populations, priority will be given to the following:

1. Children or youth at risk for out-of-home placement, as indicated by problems that are significantly disabling and present in multiple community settings, e.g., home, school, with peers, and for whom, with sufficient support, placement may be avoided (**non-mandated)**;

2. Children or youth whose behavior presents a danger to the family or community (**non-mandated**).

(Fairfax CSA Policy Manual, http://infoweb/hs/csa/pdf/manuals/fy04localpolicymanual.pdf)

Family Assessment and Planning Team (FAPT) - The local team created through the Comprehensive Services Act to assess the strength and needs of troubled youths and families who are referred to the team. The team identifies and determines the complement of services required to meet these unique needs. (Virginia DSS Foster Care Manual, http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Foster Care - Foster care and foster care placement is intended to be a temporary, rather than a long-term solution to family problems. A placement may be with a foster family, in a group living arrangement, in a residential treatment facility, or in an independent living situation. Services provided to children and their families may include, but are not limited to, counseling and treatment, day care, medical, educational, employment, family planning, independent living, housing, respite care, legal, socialization and recreation services. (Virginia Department of Social Services Foster Care Manual, Volume VII, Section III, Chapter B)

Foster Care Prevention - Services designed to strengthen the family's ability to function more effectively and independently in order to prevent family break-up due to abuse, neglect, or dependency (without parents or a parent figure). These services may be purchased with mandated CSA pool funds and can include in-home services and short-term out-of-home respite placement (FY 2003 Fairfax-Falls Church CSA Policy and Procedures Manual, p. 40).

Foster Care Services - The provision of a full range of casework, treatment, and community services for a planned period of time to a child who is abused or neglected as defined in §16.1-228, and his family when a child (i) has been identified as needing services to prevent or eliminate the need for foster care placement (ii), has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, (iii) has been committed or entrusted to a local board or licensed child placing agency (§63.2-905). (Virginia DSS Foster Care Manual,
http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Foster Child - A person who has been placed into foster care through a non-custodial foster care agreement, entrustment, or commitment before 18 years old and who may continue to receive foster care services to age 21. (Virginia DSS Foster Care Manual,
http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Individualized Education Program (IEP) - a written statement for a child with a disability that is developed, reviewed, and revised in a team meeting. The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the needs.

Individual Family Service Plan (IFSP) - The plan for services developed by the Family Assessment and Planning Team under the Comprehensive Services Act. (Virginia DSS Foster Care Manual,
http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Local Department of Social Services (a.k.a. LDSS, Department of Family Services, Department of Human Development, local department) - local agency providing social services to citizens of the community.

Mental Health Initiative - Funds appropriated by the General Assembly to provide mental health services for non-mandated youth. Each Community Service Board or local mental health authority receives this appropriation annually. There is $4,000,000 available statewide ("Funding Sources" provided by Sue Ann Morgan, Department of Juvenile Justice).

Non-Custodial Foster Care Agreement - The agreement that specifies the conditions for care and control of the child that the agency or public agency designated by the Community Policy and Management Team enters into with the parent(s) or guardians to place a child in foster care when the parent(s) or guardian(s) retain custody. (Virginia DSS Foster Care Manual,
http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Permanent Entrustment - The agreement between the parent(s) and the local department of social services that provides a method for the parent(s) to voluntarily relinquish parental rights and give the agency the authority to place the child for adoption (Virginia DSS Foster Care Manual, http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Relief of Custody - Parents or custodians of children will ask the juvenile court to relieve them of their legal right and responsibility to care for a child. Before a judge will hear such a case, however, the law requires that the family be referred to the Department of Social Services for investigation and services, if appropriate. After the case comes to the Court for a decision on the Petition, the judge can grant or deny the Petition and can enter a number of different orders that the judge may determine are in the best interest of the child. The parent has the burden of proving that he/she is entitled to be relieved of custody of the child. (Alexandria Juvenile and Domestic Court website, http://ci.alexandria.va.us/courts/jdrdc/jdrdc_relief_of_custody.phtml)

Serious Emotional Disturbance (SED) - a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified in DSM-IV-R and has resulted in functional impairment that substantially interferes with or limits the child's birth to age 18 role or functioning in family, school, community activities.

Temporary Entrustment - Parent(s) or guardians may voluntarily request that the agency take custody of the child for a temporary period. In this case, the local board may accept the child through a temporary entrustment agreement up to 180 days. Title IV-E eligibility can extend beyond 180 days only when the court approves the temporary entrustment within 180 days of placement and determines that the best interests and reasonable efforts requirements have been met. (Virginia DSS Foster Care Manual, http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Title IV-E - The title of the Social Services Act that authorizes federal funds for foster care and adoption assistance (Virginia DSS Foster Care Manual, http://www.localagency.dss.state.va.us/divisions/dfs/fc/files/manual/fcchapterfinal.pdf)

Virginia Department of Social Services (VDSS) - the state department supervising the provision of social services in Virginia. VDSS consists of Appeals and Fair Hearings, Benefit Programs (BP), Child Care and Development (CCD), Child Support Enforcement (DCSE), Community Programs (CP), Family Services (FS), Finance (DOF), General Services (GS), Human Resource Management (DHRM), Information Systems (DIS) , Legislative and Regulatory Affairs, Licensing Programs (DOLP), Office of Audit Services (OAS), Audit, Fraud Management, Public Affairs, and Quality Management (QM) (http://www.localagency.dss.state.va.us/divisions/index.html)

3. Additional Resources

Bazelon Center for Mental Health Law (2002). A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment. Washington DC: Bazelon Center for Mental Health Law.

Bazelon Center for Mental Health Law (1999). Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services. Washington DC: Bazelon Center for Mental Health Law.

Bazelon Center for Mental Health Law (2003). Teaming Up: Using the IDEA and Medicaid to Secure Comprehensive Mental Health Services for Children and Youth. Washington DC: Bazelon Center for Mental Health Law.

DMHMRSAS Child and Adolescent Special Populations Workgroup (August 2004). Final Report and Recommendations to the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Restructuring Policy Advisory Committee. Richmond, VA: Virginia Department of Mental Health Mental Retardation and Substance Abuse Services.

Nimmo, Margaret L. (2000). Issues in Children's Mental Health. Richmond, VA: Action Alliance for Virginia's Children and Youth.

Lezak, Anne and MacBeth, Gary (2002). Overcoming Barriers to Serving Our Children in the Community: Making the Olmstead Decision Work for Children with Mental Health Needs and Their Families. Delmar, NY: Advocates for Human Potential, Inc. prepared under contract for Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Friedman, K. & Walker, J. (September 2002). Relinquishing Custody: An Act of Desperation. Columbia, MD: Maryland Coalition of Families for Children's Mental Health.

McCarthy, J. & McCullough, C. (March 2003). Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: A Series of the Health Care Reform Tracking Project. Washington, DC: Georgetown University Center for Child and Human Development.

Pires, Sheila A. (Spring 2002) Building Systems of Care: A Primer. Washington, DC: Human Services Collaborative for National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center; supported by Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Reinhard, J. (June 2003). A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 329-G, 2002 Appropriations Act). Richmond, Virginia: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Report to the Governor and Chairmen of the House Appropriations and Senate Finance Committees of the General Assembly.

Stroul, Beth (2002). Systems of Care: A Framework for System Reform in Children's Mental Health. Washington, DC: Georgetown University Center for Child and Human Development.

U.S. Department of Health and Human Services. (October 2001). Children's Systems of Care: A Guide for Mental Health Planning + Advisory Councils. Washington, DC: Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) and The National Association of Mental Health Planning and Advisory Councils (NAMHPAC).

ADDITIONAL RESOURCES:

Bazelon Center for Mental Health Law
http://www.bazelon.org/

CMHS Knowledge Exchange Network (KEN)
http://www.mentalhealth.org/child

Federation of Families for Children's Mental Health
http://www.ffcmh.org/

Maryland Coalition for Children's Mental Health
http://www.mdcoalition.org/

National Alliance for the Mentally Ill (NAMI)
http://www.nami.org/

National Mental Health Association
http://www.nmha.org/

National Evaluation of the Comprehensive Community Mental Health Services Program
Macro International, Inc.
http://www.macroint.com/

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
http://www.gucdc.georgetown.edu/

Research and Training Center on Family Support and Children's Mental Health
http://www.rtc.pdx.edu/

Research and Training Center for Children's Mental Health
http://www.fmhi.usf.edu/

Technical Assistance Partnership for Child and Family Mental Health
http://www.cecp.air.org/tapartnership

U.S. Department of Health and Human Services Administration for Children and Families
http://nccanch.acf.hhs.gov/

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/

University of South Florida The Louis de la Parte Florida Mental Health Institute
http://www.fmhi.usf.edu/institute/pubs/bysubject.html

Virginia Commission on Youth
http://coy.state.va.us/

Virginia Department of Mental Health Mental Retardation and Substance Abuse Services
http://www.dmhmrsas.state.va.us/

Virginia Department of Medical Assistance Services
http://www.dmas.virginia.gov/

Virginia Office of Comprehensive Services
http://www.csa.state.va.us/

Voices For Virginia's Children
http://www.vakids.org/

Wraparound Milwaukee
http://www.milwaukeecounty.org/Service/OrganizationDetail.asp?org=6450&audience=