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United States General Accounting Office
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August 11, 2003

ERRATA

CHILD WELFARE AND JUVENILE JUSTICE: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services (GAO-03-397, April 21, 2003)

Page 3, paragraph 1, third sentence should read:

"Child welfare directors in 6 other states and the District of Columbia advised us that their states do not allow parents to place children voluntarily with child welfare agencies to access such services.[6]"

Page 3, footnote 6 should read:

"The 6 states are Florida, Hawaii, Missouri, Montana, New Hampshire, and Texas, based on information received in response to our survey concerning placements in fiscal year 2001. However, New Hampshire indicated that the state introduced voluntary services in state fiscal year 2002 and that it anticipates that some parents will seek placement for their children."

Page 14, footnote 14 should read:

"Nineteen states provided estimates. Eleven states could not provide the data requested, 6 states and the District of Columbia said the practice was either not legal in their states or that the state generally did not allow parents to place their children solely to receive mental health services, and 10 states could not provide the data requested but indicated that voluntary placement happens. Four states did not respond to the survey.

Page 15, Table 2, the following states should have only the following table notes:

"Georgia	b"
"Kansas	b"
"Montana	c"

Page 16, Table 2, table note 'c' should read:

"[c]The practice of voluntary placement or relinquishment is either not legal in the state or the state generally does not allow parents to place their children solely to receive mental health services."

United States General Accounting Office

GAO

Report to Congressional Requesters

April 2003

CHILD WELFARE AND JUVENILE JUSTICE

Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services

GAO-03-397

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Highlights

Highlights of GAO-03-397, a report to Congressional Requesters

Why GAO Did This Study

Recent news articles in over 30 states describe the difficulty many parents have in accessing mental health services for their children, and some parents choose to place their children in the child welfare or juvenile justice systems in order to obtain the services they need. GAO was asked to determine: (1) the number and characteristics of children voluntarily placed in the child welfare and juvenile justice systems to receive mental health services, (2) the factors that influence such placements, and (3) promising state and local practices that may reduce the need for child welfare and juvenile justice placements.

What GAO Recommends

The Departments of Health and Human Services (HHS) and Justice (DOJ) should consider the feasibility of tracking children placed by their parents in the child welfare and juvenile justice systems to obtain mental health services. HHS, DOJ, and the Department of Education (Education) should develop an interagency working group to identify the causes of the misunderstandings at the state and local levels and create an action plan to address those causes. These agencies should also continue to encourage states to evaluate the programs that the states fund or initiate and determine the most effective means of disseminating the results of these and other available studies.

www.gao.gov/cgi-bin/getrpt?GAO-03-397.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cornelia Ashby at (202) 512-8403 or ashbyc@gao.gov.

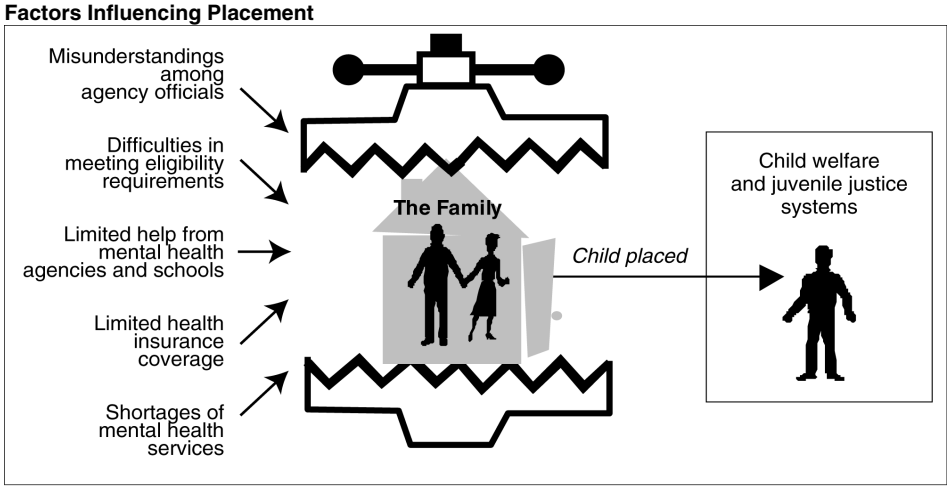
What GAO Found

Child welfare directors in 19 states and juvenile justice officials in 30 counties estimated that in fiscal year 2001 parents placed over 12,700 children into the child welfare or juvenile justice systems so that these children could receive mental health services. Nationwide, this number is likely higher because many state child welfare directors did not provide data and we had limited coverage of county juvenile justice officials. Although no agency tracks these children or maintains data on their characteristics, officials said most are male, adolescent, often have multiple problems, and many exhibit behaviors that threaten the safety of themselves and others.

Neither the child welfare nor the juvenile justice system was designed to serve children who have not been abused or neglected, or who have not committed a delinquent act. According to officials in the 6 states we visited, limitations of both public and private health insurance, inadequate supplies of mental health services, limited availability of services through mental health agencies and schools, and difficulties meeting eligibility rules for services influence such placements. Despite guidance issued by the various federal agencies with responsibilities for serving children with mental illness, misunderstandings among state and local officials regarding the roles of the various agencies that provide such services pose additional challenges to parents seeking such services for their children.

Officials in the states we visited identified practices that they believe may reduce the need for some child welfare or juvenile justice placements. These included finding new ways to reduce the cost of or to fund mental health services, improving access to mental health services, and expanding the array of available services. Few of these practices have been rigorously evaluated.

Factors Influencing Placement



Source: GAO.

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Abbreviations

ACF	Administration for Children and Families
AFCARS	Adoption and Foster Care Analysis and Reporting System
CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
EPSDT	Early Periodic Screening, Diagnostic and Treatment
ERISA	Employee Retirement Income Security Act
HCBS	Home and Community-Based Services
HHS	Health and Human Services
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
JADE	Juvenile Alternative Defense Effort
MHPA	Mental Health Parity Act
OSERS	Office of Special Education and Rehabilitative Services
OJJDP	Office of Juvenile Justice and Delinquency Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SED	serious emotional disturbances
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBS	Therapeutic Behavioral Services
TEFRA	Tax Equity and Fiscal Responsibility Act

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

April 21, 2003

The Honorable Susan M. Collins
United States Senate

The Honorable Pete Stark
The Honorable Patrick Kennedy
House of Representatives

Recent news articles in over 30 states and prominent mental health advocacy organizations have reported on the difficulty many parents have accessing mental health services for their children with severe mental illness.[1] In some cases, parents must choose to keep their children at home without receiving the mental health and supportive services that they need or to remove them from their home and seek alternative living arrangements by inappropriately placing them in the child welfare or juvenile justice system to obtain mental health services—two systems not designed to care for children solely because of their mental health needs.[2] Although the people and conditions described in the reports varied, all documented that many children with severe mental illness needed services

[1]Federal agencies and states have varying definitions for children with serious emotional disturbances (SED). For example, the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) defines SED as a diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities. Because of these differences, we use the term "children with severe mental illness" throughout this report.

[2]Child welfare systems are designed to protect children who have been abused or neglected by, for example, placing children in foster care or providing family preservation services; and juvenile justice systems are designed to rehabilitate children who have committed criminal or delinquent acts and to prevent such acts from occurring. Consequently, the goals of these systems and the background and training of their staff reflect these purposes. In addition, parents cannot voluntarily place their children in the juvenile justice system—children are detained in this system as a result of their delinquent acts or status offenses—that is, according to the Department of Justice (DOJ), behaviors that are law violations only if committed by juveniles. However, parents sometimes request that police arrest their children for delinquent behaviors or status offenses that are related to or stem from their mental illness when they cannot obtain services through other means. In this report, we use the term "placed" to refer both to children who have been voluntarily placed in the child welfare system and children who enter the juvenile justice system to receive mental health services. Because information was not available, we were not able to report on whether parents relinquished custody of their children to obtain the services.

such as psychiatric and family support services that are not readily accessible in their communities. Various federal laws require that state and local agencies provide services to disabled children, including children with a mental illness, in the least restrictive setting appropriate to their needs; that is, children have a right to receive services in their communities unless their needs can only be met by the state in residential or institutional placements.

Several federal agencies have various responsibilities for children with mental health needs. For example, HHS's SAMHSA provides funds and guidance to help states and localities address the needs of children with mental illness. HHS's Centers for Medicare & Medicaid Services (CMS) administers both the Medicaid Program and the State Children's Health Insurance Program (SCHIP). These programs provide funds to states for public health insurance programs, which can cover mental health services, for the approximately 26.5 million enrolled children who are members of low-income families and certain children with disabilities. Similarly, the Department of Education's (Education) Office of Special Education and Rehabilitative Services (OSERS) provides funding and technical assistance to help states provide needed services, including mental health services, to disabled children with special education needs. Title IV-E of the Social Security Act provides reimbursement for foster care maintenance payments to states, which is available when child welfare agencies place eligible children in approved out-of-home settings, including some residential treatment facilities.[3, 4] In many cases, these costs are high; residential treatment facilities can cost over $250,000 a year for one child. Federal law does not require parents to relinquish their parental rights to place their children with child welfare agencies. However, after children have been in care for a specific period of time, the law requires the court to review the child's status and determine the best interest of the child—which, in some cases, may include termination of parental rights.

[3]In commenting on a draft of this report, HHS said that federal reimbursement is only available for children placed by a juvenile justice agency when that agency has an agreement with a child welfare agency under Title IV-E. HHS also said that many facilities that treat children with serious mental health issues are not considered within the scope of foster care and the Title IV-E program. Some states have developed procedures for using Title IV-E funding for the residential placement of children with mental health needs by arranging for courts to make similar findings in these cases as are required for the placement of children removed for safety reasons in situations of abuse and neglect.

[4]A residential treatment facility is an inpatient facility, other than a hospital, that provides psychiatric services to individuals under age 21.

State laws addressing the ability of parents to place their children in child welfare systems vary across states. Nationwide, laws in 11 states allow parents to place children in child welfare systems on a voluntary basis in order to access mental health services for as long as necessary without relinquishing custody of the child to the state.[5] Child welfare directors in 6 other states and the District of Columbia advised us that their states do not allow parents to place child voluntarily in child welfare agencies to access such services.[6] Laws in the remaining states are generally silent regarding voluntary placements for mental health. (See app. II for a description of state placement statutes.)

You asked us to determine: (1) the numbers and characteristics of children voluntarily placed in the child welfare and juvenile justice systems in order to receive mental health services, (2) the factors that influence such placements, and (3) promising state and local practices that may reduce the need for some child welfare and juvenile justice placements.

To address your questions, we surveyed state child welfare directors in all states and the District of Columbia and juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18. We surveyed juvenile justice officials at the county level, rather than at the state level, because of the decentralized nature of the juvenile justice system. In addition, we researched state laws and regulations regarding voluntary placement and relinquishment of parental rights, and interviewed officials of child-serving agencies,[7] caseworkers, and parents in 6 states (Arkansas, California, Kansas, Maryland, Minnesota, and New Jersey) and judges in 5 states. We chose these states because they represented diversity in geographical location, legal requirements concerning children's placement, use of Medicaid waivers and optional

[5]The 11 states are: Alaska, Colorado, Connecticut, Iowa, Maine, Minnesota, North Dakota, Oregon, Rhode Island, Wisconsin, and Vermont.

[6]The 6 states are Florida, Hawaii, Missouri, Montana, New Hampshire, and Texas, based on information received in response to our survey concerning placements in fiscal year 2001. However, New Hampshire indicated that the state introduced voluntary services in state fiscal year 2002 and that it anticipates that some parents will seek placement for their children.

[7]Child-serving agencies include mental health, Medicaid and SCHIP, juvenile justice, education, and child welfare.

services,[8] and the role of state and county agencies in administering child welfare and juvenile justice programs. Also, we observed programs that state officials identified as model programs in those 6 states and interviewed key federal officials and national experts. A more detailed discussion of our scope and methodology appears in appendix I. We conducted our work between March 2002 and February 2003 in accordance with generally accepted government auditing standards.

Results in Brief

State child welfare officials in 19 states and county juvenile justice officials in 30 counties who responded to our surveys estimated that in fiscal year 2001 parents in their jurisdictions placed over 12,700 children—mostly adolescent males—into the child welfare or juvenile justice systems so that these children could receive mental health services. However, this estimate understates the prevalence of these children for two reasons. First, 32 state officials, including officials of 5 states with the largest populations of children, did not provide us with data. However, officials in 11 of those states indicated that although they could not provide an estimate, such placements occurred in their state. Also, we surveyed juvenile justice officials in only 33 counties, 30 of which responded with an estimate. Moreover, no formal or comprehensive federal or state tracking of such placements occurs. According to the officials we interviewed, many of these children exhibited behavior that threatened their safety and the safety of others. In addition, these officials said children who were placed came from families of all financial levels and that the seriousness of the child's illness strained the family's ability to function. For example, some parents found they were not able to meet the needs of other children in the family or fulfill job-related responsibilities.

[8]Medicaid is a federal-state health financing program for certain low-income individuals established by Title XIX of the Social Security Act; under Medicaid, states must meet minimum federal rules of coverage in order to receive federal matching dollars. People eligible for Medicaid can generally be divided into three categories: (1) the mandatory categorically needy, (2) the optional categorically needy, and (3) the medically needy. States have several methods by which they can customize their Medicaid program to meet the needs of these enrollees. States can choose to cover certain optional services, such as prescription drugs, or certain optional populations; for example, several states have expanded eligibility for Medicaid to certain groups of children who would not otherwise qualify for the program because their families' incomes are too high. A limited number of states can also request that HHS waive certain statutory requirements for a specified period of time.

A variety of factors influenced whether parents placed their children in the child welfare and juvenile justice systems to receive mental health services for them. Some parents we spoke to in all 6 states reported these factors often created delays or prevented them from obtaining the mental health services that their children needed. According to child welfare, child mental health, and juvenile justice officials, a number of parents placed children in the child welfare and juvenile justice systems because their health insurance had limitations, such as restrictions on mental health services. These same officials said some mental health services, such as child psychiatric and residential services, were in short supply. In all the states we visited, some parents who could not afford or access needed mental health services said they sought help from mental health agencies and schools but reported these agencies had limited resources. Parents seeking placements for children in residential treatment facilities faced further challenges. Mental health and education officials in the 6 states we visited did not support residential placement for children except in extraordinary situations because federal law requires that mental health officials provide services for children in the least restrictive setting as possible and requires education officials to educate children with disabilities with children who are not disabled to the maximum extent possible. These officials believed providing services in a community-based program is a better option for children and families than providing services in residential treatment facilities. In addition, some parents in all 6 states said gaps in services occurred because child-serving agencies have different eligibility requirements for programs and this made it difficult for them to access the child mental health and family support services they needed from various agencies. For example, children who were eligible for psychological services under Medicaid could lose these services if their families' income increases beyond eligibility thresholds. Finally, state and local officials' views of the roles of their own agency and other agencies, such as mental health, child welfare, education, and juvenile justice, showed that they misunderstood those roles and, therefore, could not effectively give parents complete and accurate information about available services their agency and other agencies could provide. Federal officials, experts, and service providers agreed that agencies must work together to meet the needs of children. Although federal officials work together on various advisory and information-sharing committees, co-sponsor programs designed to help children with a mental illness, and disseminate much guidance regarding their policies and programs, some state and local officials with responsibilities for children with a mental illness did not understand the program requirements and capacities of their agencies and other child-serving agencies.

Officials in all 6 states that we visited identified a range of practices in their states that they believe may help reduce the need for some child welfare and juvenile justice placements. Overall, these practices are consistent with those suggested by federal agencies and child mental health experts, and most parents we spoke with who had children in these programs found these practices helpful. However, the effectiveness of the practices is generally unknown because many were new and few were rigorously evaluated. In addition, many of these practices served a small number of children or only served children in specific locations. To fund mental health services, some state and county officials developed practices that increased the use of less expensive services and providers and distributed mental health costs among several agencies so no single agency paid the entire cost of a child's care. For example, a program in Minnesota used experienced, masters-level staff to supervise less experienced, bachelor-level staff instead of using the more costly master's level workers as the primary service provider. States and counties identified several practices that may improve access to mental health services, such as providing a variety of services for children in a convenient public facility and creating a single entity with responsibility for meeting children's mental health needs. For example, a service provider in Kansas operated a facility that housed a variety of county child welfare, juvenile justice, and education service providers as well as county child mental health providers. States and counties also identified several practices that may improve the treatment of children with a mental illness, such as expanding the array of available mental health services for children and addressing the needs of the family to help the family maintain children with a mental illness at home. For example, in one city in Kansas, caseworkers from one mental health center worked with families of children with severe mental illness to identify community supports and services, such as mentors and after-school programs, which support the entire family.

To determine the extent to which children may be placed inappropriately in the child welfare and juvenile justice systems in order to obtain mental health services, we are recommending that the Secretary of HHS and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these placements. To help reduce misunderstandings at the state and local level, we also recommend that the Secretaries of HHS and Education and the Attorney General develop an interagency working group to identify the causes of these misunderstandings and create an action plan to address those causes. We further recommend that these agencies continue to encourage states to evaluate the child mental health programs that the states fund or initiate

and that the Secretaries of HHS and Education and the Attorney General determine the most effective means of disseminating the results of these and other available studies to state and local entities. In commenting on a draft of this report, Education, HHS, and DOJ generally agreed with our findings but did not fully concur with the recommendations. Education said that it did not understand how tracking the children discussed in this report will increase the likelihood of progressive practices to provide children's mental health services and noted that no recommendations were made for increased grant spending to duplicate or disseminate the positive features of such practices. HHS said that asking the agencies to track this population of children in foster care does not address the larger point of the lack of mental health resources for families and communities and does not address the problems of the children or their parents. DOJ agreed that tracking should occur, but only in the short term, and said that HHS should take the lead in this activity. All three agencies said they would participate in any interagency working group that might be established based on our recommendation and DOJ suggested an existing group as the forum. HHS, however, said that such a group would do little to address the lack of resources. Education also said we should be more specific on the role of the interagency working group and added that such a group would not have the power to address congressional lawmaking.

Background

As defined by the President's New Freedom Commission on Mental Health, the mental health system in the United States collectively refers to the full array of private and public programs for individuals with mental illness that deliver or pay for treatment and services. The federal government plays a major role in funding mental health services through public insurance—Medicaid and SCHIP—and grants to states and local agencies, and state and local governments play a major role in delivering services. Most families depend on private and public insurance to pay for mental health services because such services are expensive; although, as we discussed in a previous report, children may face certain limitations depending on their type of coverage and where they lived.[9]

At the federal level, several federal agencies—including HHS's SAMHSA, CMS, and the Administration for Children and Families (ACF); DOJ's

[9]U.S. General Accounting Office, *Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown*, GAO-02-813 (Washington, D.C.: Aug. 22, 2002).

Office of Juvenile Justice and Delinquency Prevention (OJJDP); and Education's OSERS—have a role in addressing the mental health needs of children. However, all have individual mandates, target different but often overlapping populations, and share responsibilities to varying degrees with state and county agencies. (See table 1.)

Table 1: Characteristics of Key Agencies with Responsibilities for Children with a Mental Illness

Department and agency	Key activities related to children's mental health	Authorizing Statute	Population targeted and definition of mental illness
HHS (CMS)	Administers the Medicaid and SCHIP programs that provide health insurance coverage, including some coverage for severe mental illness. Awards research grants. Provides technical assistance to state agencies.	Title XIX of the Social Security Act	Certain low-income individuals and certain disabled individuals. Uses a clinical classification of diseases to identify children with a mental illness.
HHS (ACF)	Oversees the Adoption and Safe Families Act of 1997 (ASFA) that improves the safety of children and promotes adoption and permanent homes for children who need them and supports families. Administers Title IV-B of the Social Security Act that provides funds to states for services that protect the welfare of children. For example, these services address problems that may result in the abuse and neglect of children. The funds may also be used to provide services to families of children with a mental illness. Administers the Title IV-E Foster Care Funds Program that provides funds to states to partially cover the costs of room and board for eligible children from low-income families who are placed in approved out-of-home living arrangements. Maintains the Adoption and Foster Care Analysis and Reporting System (AFCARS), to which states report demographic data on children in foster care, including diagnoses of mental illness. Awards development, training, research, and demonstration grants. Disseminates research. Provides technical assistance.	Title IV, Part E of the Social Security Act ASFA	Children and families. Uses a clinical classification to identify children with a mental illness and accepts classifications used by individual states in identifying children with mental health needs.

Department and agency	Key activities related to children's mental health	Authorizing Statute	Population targeted and definition of mental illness
Education (OSERS)	Monitors the implementation of the Individuals with Disabilities Education Act (IDEA). IDEA established the right of disabled children—including children with mental illness—to receive special education and related services, such as mental health services, designed to meet their unique needs and prepare them for employment and independent living when such services are needed for children to make adequate progress in school. IDEA requires schools to evaluate children who are referred for special education services and, if services are required, develop an individualized education program (IEP) that documents the type and intensity of services that will be provided. Funds formula and discretionary grants. Provides technical assistance. Disseminates research.	IDEA	Promotes improvement in educational results for infants, toddlers, and children with disabilities. Under IDEA, the term "child with a disability" means a child, who by reason of a physical or mental disability, needs special education and related services.
HHS (SAMHSA)	Provides funds to states and local entities to help them administer, support, or establish programs that specifically target the mental health needs of children and provides block grant funding that enables the states to maintain and enhance mental health services. Sponsors the Systems of Care Initiative to help children and adolescents with severe mental illnesses and their families receive a variety of services from schools, community mental health centers, and social services organizations and facilitate coordination among these service providers. Awards formula and discretionary development and demonstration grants. Disseminates research. Provides technical assistance.	Public Health Service Act	Individuals with substance abuse problems, mental illness or at risk of substance abuse and mental illness. Children served meet the following criteria: • age 0 to 18 and • have a diagnosed mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that results in impairment that substantially interferes with or limits the child's functioning in family, school, or community activities.
DOJ (OJJDP)	Helps oversee juvenile justice programs across the nation and supports states and local communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. Helps improve the juvenile justice system's ability to protect public safety, hold offenders accountable, and provide mental health treatment and rehabilitative services. Funds formula and discretionary grants. Provides technical assistance. Disseminates research.	Juvenile Justice and Delinquency Prevention Act	Children who commit crimes or are delinquent and children at risk for delinquency. Accepts mental illness classifications used by states to identify children with mental health needs.

Source: GAO.

Note: Other agencies, such as HHS's Social Security Administration, Department of DOJ's Division of Civil Rights, and HHS's and Education's Office of Civil Rights, also have responsibilities for children with disabilities, including children with a mental illness.

Federal agencies with responsibilities for children with mental illness support interagency collaboration at the federal and local level. For example, officials at SAMHSA are collaborating with Safe and Drug Free Schools officials at Education and OJJDP to improve mental health services for children with emotional and behavioral disorders who are at risk of violent behavior by developing and implementing a large grant program that targets these children. This program awarded grants—about $53.2 million in fiscal year 2001—to some local school districts that formed partnerships with local mental health and law enforcement agencies to provide comprehensive planning and services for children with emotional and behavioral disorders. In addition, ACF, Education, SAMHSA, and a private foundation are jointly administering a program that assesses the collaborative processes being used to provide multiagency services to very young children affected by mental illness and substance abuse. At the state and county level, a similar array of agencies provides or funds services for children with a mental illness, and state and federal laws and policies often determine their roles and responsibilities. In addition, federal agencies play an important role in funding research and evaluation studies and disseminating the findings of these efforts. For example, SAMSHA, OJJDP, and OSERS fund research and evaluation studies that target children with mental illness and disseminate the findings of these efforts, descriptions of promising practices, and other information through their clearinghouses, journals, and Web sites.

Despite their differences, programs run by agencies at all levels of government generally adhere to the principle of the "least restrictive environment."[10] This principle assumes that children, like adults, have liberty interests that include the right to live in a family situation. Under this principal, the state has the burden of demonstrating that state-funded out-of-home placements are necessary for the protection of the child or society. In 1999, the Supreme Court established this principle as a right for disabled children. In Olmstead v. L.C., the Court held that, under Title II of the Americans with Disabilities Act, states may be required to serve people with disabilities in community settings when such placements can be reasonably accommodated.

Mental health treatment can be very expensive and most families rely upon insurance to help cover the cost of these services. For example, one

[10]IDEA requires that, to the maximum extent possible, children with disabilities are to be educated with children who are not disabled, based on the needs of the child.

outpatient therapy session can cost more than $100, and residential treatment facilities, which provide 24 hours of care, 7 days a week, can cost $250,000 a year or more. Nationwide, 88 percent of American children are covered by private or public health insurance plans. Private plans, such as employer-sponsored or individually purchased plans, provide health insurance coverage to about 68 percent of American children, and public programs, such as Medicaid and SCHIP, provide health insurance coverage to about 19 percent.[11]

Most private health insurance plans offer different coverage for mental health services than for physical health services. To ensure more comparable coverage, the federal government passed the federal Mental Health Parity Act (MHPA) of 1996. MHPA prohibited certain employer-sponsored group plans from imposing annual or lifetime restrictions on mental health benefits that are lower than those imposed on other benefits. However, the act did not eliminate other restrictions and limitations on mental health coverage, such as limiting the number of treatments per year that are reimbursable. In addition, the law does not apply to plans sponsored by employers with 50 or fewer employees, group plans that experience an increase in plan claims costs of at least 1 percent because of compliance, and coverage sold in the individual market. According to the National Council of State Legislatures, as of November 2001, 46 states have passed mental heath parity bills. Most of these laws meet or exceed the federal MHPA standard. However, the Employee Retirement Income Security Act (ERISA) of 1974 preempts states from directly regulating self-funded, employer-sponsored health plans; under such circumstances, state requirements usually do not apply.

For more than 30 years, Medicaid has provided comprehensive health coverage for children from low-income families. Although individual states determine many coverage, eligibility, and administrative details, the federal government has established certain requirements for state Medicaid programs. These requirements include providing preventive screening and necessary treatment of any detected health condition for children. Under Medicaid, a state may apply for waivers from the federal government, which exempt the state from certain provisions of the Medicaid statute in order to operate a specific program, change the benefits offered under Medicaid, or make comprehensive changes to their

[11]U.S. General Accounting Office, *Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals*, GAO-03-191 (Washington, D.C.: Oct. 25, 2002).

Medicaid or SCHIP programs. For example, states can use the Home and Community-Based Services (HCBS) (section 1915(c) of the Social Security Act) waiver to provide home and community-based long-term care services to targeted groups of individuals who would otherwise require care in a hospital, skilled nursing facility, or intermediate care facility. To receive the HCBS waiver, states must demonstrate that the cost of the services to be provided under the waiver is no more than the cost of institutionalized care plus any other Medicaid services provided to institutionalized individuals. Additional flexibility is available to states under the "Katie Beckett" option, which enables states to use federal Medicaid funds more flexibly to cover the costs of health care services in the home and community rather than just in institutional settings, regardless of the income and assets of the family.[12] States choosing this option provide Medicaid coverage for children under age 19 who meet certain standards for disability, would be eligible for Medicaid if they were in an institution, and are receiving medical care at home that would be provided in an institution. Although family income and resources are not considered in determining eligibility for services under the Katie Beckett option, states can require families to contribute to the cost of the program. The Rehabilitation option allows states to provide optional Medicaid services such as psychiatric rehabilitation and other diagnostic, screening, and preventive services. Under this option, children can obtain services in nonmedical settings, including school-based or other day treatment and home-based services.

States can expand public health insurance for uninsured children from low-income families by implementing SCHIP programs. States have three options in designing SCHIP programs. They may (1) expand Medicaid programs to include children from low-income families with earnings too high to qualify for Medicaid, (2) develop a separate child health insurance program with benefits that differ from those offered under Medicaid, or (3) provide a combination of both. Twenty-four states are implementing SCHIP by expanding Medicaid. Fourteen states are enrolling children into separate non-Medicaid plans. Other states use a combination of Medicaid and non-Medicaid plans to serve children in families at different income levels. If a state elects to implement SCHIP by expanding Medicaid, it must

[12]This waiver authority for seriously ill children was inspired by the case of a ventilator dependent child, Katie Beckett. Katie's mother successfully argued that the nursing services her daughter required could be provided in her home and at a cost less than that of providing the same care in a hospital. What resulted was the so-called "Katie Beckett Waiver," enacted as part of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.

offer the same benefit package to SCHIP beneficiaries as it does to Medicaid beneficiaries.

In addition, states operating SCHIP Medicaid-expansion or Medicaid-combination programs must also screen children for various conditions so that health problems can be found early and treated before they worsen. This Medicaid requirement for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) requires states to provide children and adolescents under age 21 with access to comprehensive, periodic evaluations of health, developmental and nutritional status, as well as vision, hearing, and dental needs. States must provide all services needed for conditions discovered through routine pediatric screenings regardless of whether the service is covered for other beneficiaries by the state Medicaid plan. In 2000, more than 1 million children were enrolled in SCHIP Medicaid expansion programs and were, therefore, eligible for EPSDT screens.

Certain disabled children, including children with a mental illness, may qualify for monthly Supplemental Security Income (SSI) if they and their families have little or no income and resources and they meet SSI's definition of disability. To meet SSI's definition, a child must have a physical or mental condition or conditions that can be medically proven, and which result in marked and severe functional limitations; the condition or conditions must last or be expected to last at least 12 months or be expected to result in death; and the child may not work at a job that is considered substantial work. The monthly SSI depends generally on where the child lives and his or her parents' assets. However, the monthly SSI payment for children living in certain institutions throughout a month, where private health insurance paid for their care or when Medicaid paid more than half of the cost of their care, is currently capped at $30.[13]

[13]Not all severely limited children with a mental illness who meet SSI's income requirements are eligible for SSI payments because of SSI's strict definition of disability. Federal SSI payments for disabled children range from $1 to $545 and some states supplement these payments. Although most children who receive SSI payments are eligible for Medicaid, some are not.

While No Formal Tracking Occurs, Available Estimates Indicate That Many Children Were Placed with the State—Primarily Adolescent Males—to Access Mental Health Services

State child welfare and county juvenile justice officials estimated that parents in their jurisdictions placed over 12,700 children in fiscal year 2001, generally adolescent males, to child welfare and juvenile justice agencies so that the children could receive mental health services. Nationwide, the number is likely higher because officials in 32 states, including the 5 states with the largest populations of children, did not provide us with estimates. Additionally, officials in 11 states that could not provide estimates indicated that such placements occurred in their state. Moreover, we surveyed juvenile justice officials in only 33 counties, with 30 providing estimates. Only estimates were available because no federal or state agency tracked children placed to obtain mental health services in a formal or comprehensive manner. Officials in the 6 states we visited reported that placed children came from families of all financial levels and said that the seriousness of the children's illnesses strained families' abilities to function. For example, some parents are not able to meet the needs of children in the home and some found that they were less able to meet work demands.

Some Officials Estimate That Parents Placed Over 12,700 Children to Access Mental Health Services

The state child welfare officials and county juvenile justice officials who responded to our surveys estimated that over 12,700 children entered the child welfare or juvenile justice systems in order to receive mental health services in fiscal year 2001. Of these children, about 3,700 entered the child welfare system. State child welfare officials reported estimates that ranged from 0 to 1,071 children, with a median of 71. Table 2 provides detailed information about the number of children placed in the child welfare system.[14] Approximately 9,000 children entered the juvenile justice system. County juvenile justice officials reported estimates that ranged from 0 to 1,750, with a median of 140. Table 3 provides details on the estimated number of children placed in the juvenile justice system.

[14]Nineteen states provided estimates. Eleven states could not provide the data requested, 6 states and the District of Columbia said the practice was either not legal in their states or that the state generally did not allow parents to place their children solvely to receive mental health services, and 10 states could not provide the data requested but indicated that voluntary placement happens. Four states did not respond to the survey.

Table 2: States' Estimated Number of Children Placed in the Child Welfare System to Obtain Mental Health Services in Fiscal Year 2001

State	Number of children placed
Alaska	[a]
Alabama	130
Arkansas	[d]
Arizona	[d]
California	[b]
Colorado	[b]
Connecticut	738
District of Columbia	[c]
Delaware	0
Florida	[c]
Georgia	[b]
Hawaii	[c]
Iowa	[d]
Idaho	123
Illinois	[a]
Indiana	0
Kansas	[b]
Kentucky	14
Louisiana	[a]
Massachusetts	[b]
Maryland	54
Maine	[d]
Michigan	[b]
Minnesota	1,071
Missouri	[c]
Mississippi	13
Montana	[c]
North Carolina	440
North Dakota	[d]
Nebraska	[b]
New Hampshire	[c]
New Jersey	[b]
New Mexico	[b]
Nevada	20
New York	[b]
Ohio	[d]
Oklahoma	3
Oregon	101
Pennsylvania	71
Rhode Island	279
South Carolina	[a]

State	Number of children placed
South Dakota	[d]
Tennessee	[d]
Texas	[c]
Utah	[d]
Virginia	[d]
Vermont	60
Washington	423
Wisconsin	[b]
West Virginia	135
Wyoming	5
Total	**3,680**

Source: GAO survey.

[a]State did not respond to our survey.

[b]State could not provide the data requested.

[c]The practice of voluntary placement or relinquishment is either not legal in the state or the state generally does not allow parents to place their children solely to receive mental health services.

[d]State could not provide the data requested, but indicated that voluntary placement happens.

Table 3: Estimated Number of Children Placed in the Juvenile Justice System in 33 Counties to Obtain Mental Health Services in Fiscal Year 2001

State	County	Number of children placed
Arizona	Maricopa	60
Arizona	Pima	1,750
California	Los Angeles	[a]
California	San Diego	200
Colorado	El Paso	40
Colorado	Jefferson	100
Florida	Broward	0
Florida	Miami-Dade	999
Georgia	Fulton	172
Georgia	Gwinnett	100
Illinois	Cook	0
Illinois	DuPage	35
Indiana	Lake	600
Indiana	Marion	100
Louisiana	Jefferson Parish	50
Michigan	Oakland	160
Michigan	Wayne	400
New Jersey	Bergen	[a]
New Jersey	Middlesex	999
New York	Brooklyn	74
New York	Queens	49
Ohio	Cuyahoga	[a]
Ohio	Franklin	363
Pennsylvania	Montgomery	20
Pennsylvania	Philadelphia	500
Texas	Dallas	200
Texas	Harris	200
Virginia	Fairfax	350
Virginia	Prince William	840
Washington	King	575
Washington	Pierce	0
Wisconsin	Dane	120
Wisconsin	Milwaukee	0
Total		**9,056**

Source: GAO survey.

[a]County was unable to estimate the number of children.

Nationwide, the number of children placed is likely to be higher. Eleven states reported that they could not provide us with an estimate even though they were aware that such placements occurred. Moreover,

officials in 9 additional states that responded to our survey did not provide an estimate and did not mention whether or not parents turned to the child welfare system to access mental health services. However, child welfare workers we interviewed in 2 of these 9 states—California and New Jersey—confirmed that these placements did in fact occur. Although some of the state child welfare officials that we visited in California said children do not enter that system to obtain mental health services, county child welfare workers said that they knew of such placements and explained how the cases were coded in their system. Four states did not respond to the survey.[15] Information on the prevalence of children present in the juvenile justice system is also limited in this report since we surveyed only 33 counties. In 3 of those counties, juvenile justice officials reported that while they were not able to provide estimates, they knew that children were entering the system to obtain mental health services because they were not able to access such services in other ways.

Federal and state systems that track children in the juvenile justice and child welfare systems do not track in a formal or comprehensive way children placed to receive mental health services. For example, ACF's AFCARS, which contains data reported by states about children in foster care or adopted out of foster care, does not have a data element that identifies this population. Similarly, every 2 years OJJDP conducts the Census of Juveniles in Residential Placement, which gathers information on children in juvenile residential facilities and their characteristics but no database variable exists to isolate children whose parents sought the help of the juvenile justice system to meet children's mental health needs from other children in the juvenile justice system who may also have mental health problems. OSERS maintains extensive data about children who receive special education services, but data are aggregated at the state level and do not include information about who has custody of the child.

Officials Said Placed Children Were Mostly Adolescent Males with Severe Mental Health Problems

According to our survey of state child welfare directors, placed children are more likely to be boys than girls and are more likely to be adolescent. Child welfare directors in 19 states reported that, in fiscal year 2001, 65 percent of placed children were male and 67 percent were between the ages of 13 and 18. While juvenile justice officials could not provide information about the gender and ages of children placed in their system,

[15]These 4 states were Alaska, Illinois, Louisiana, and South Carolina.

most children in the juvenile justice population are male and range in age from 13 to 18.[16]

The officials from state and county child-serving agencies and parents we interviewed in the 6 states that we visited said that children who were placed had severe mental illnesses, sometimes in combination with other disorders, and their parents believed they required intense treatment that could not be provided in their homes. Many of these children were violent and had tried to hurt themselves, their parents, or their siblings and often prevented their parents from meeting the needs of the other children in the family. For example, in Kansas, one parent reported that her three other children refused to remain in the home with her son who has bipolar disorder,[17] is very aggressive, and has molested other children in the past. In Maryland, officials from both state and county child-serving agencies told us about a teenage boy who was mentally ill, developmentally disabled, autistic, and hospitalized. Because the boy was both violent and sexually aggressive, the county told his mother that if she brought him home from a stay in the hospital, they would remove her other children from the house. Caring for children who are seriously mentally ill can also prevent parents from obtaining full-time work or cause disruptions in their work lives. For example, an Arkansas parent now raising her grandchild does not work because of the time necessary to care for her mentally ill granddaughter. State and county officials from child-serving agencies in 5 of the 6 states that we visited told us that finding placements for children who were mentally ill and who also had other developmental disabilities was particularly difficult. One such child in Maryland was rejected by facilities that serve the developmentally disabled because he was mentally ill and rejected by facilities that serve the mentally ill because he was developmentally disabled. Moreover, parents and officials in 4 of the 6 states that we visited also told us of youth who were not only mentally ill, but who also abused illegal drugs and alcohol as a way to self-medicate their mental illnesses.

Children who are placed or are at risk of placement come from families that span a variety of economic levels. Officials from state and county

[16]In commenting on a draft of this report, DOJ said that, in the absence of formal tracking and official data, describing with any certainty the characteristics of youth placed voluntarily by their parents in the juvenile justice system is impossible.

[17]Bipolar disorder is characterized by the occurrence of one or more major depressive episodes accompanied by at least one manic episode over a brief time interval.

child-serving agencies in all 6 states that we visited reported that families of all economic levels have placed children or are at risk of doing so. Officials in child-serving agencies in all of the 6 states that we visited said children from middle class families are more likely to be placed because they are not eligible for Medicaid and their families do not have the funds to pay for treatments not covered by insurance.

Multiple Factors Influence Decisions to Place Children

Multiple factors influence parents' decisions to place their children in the child welfare and juvenile justice systems so that they can obtain mental health services for them. Private health insurance plans often have gaps and limitations in the mental health coverage they provide—for example, some may not cover certain mental illnesses and others may limit the amount and type of services that are covered—and not all children covered by Medicaid received needed services. Even when parents could afford mental health services, some could not access services—such as child psychiatric services—at times when they needed those services because of an inadequate supply of such services. In other instances, some mental health agencies and schools have limited resources to provide mental health services and are required to serve children in the least restrictive environment possible or to educate eligible disabled children with children who are not disabled to the maximum extent possible, respectively—which can limit the alternatives available to parents whose children need residential placements. In other instances, parents sometimes have difficulty obtaining all needed services for their children in their communities because eligibility requirements for services provided by various agencies differ. Furthermore, some officials and service providers have misunderstood the role of their own and other agencies and, therefore, gave parents inaccurate or incomplete information about available services for families. These misunderstandings created gaps in services for some children.

Limitations in Private and Public Insurance Often Restrict Access to Mental Health Care, and Some Services are Limited

Almost all state child welfare directors and county juvenile justice officials who responded to our surveys reported that private health insurance limitations were increasing the number of child welfare and juvenile justice placements to obtain mental health services, and well over half reported Medicaid rules also increased such placements. For example, according to parents and state and local officials in all 6 states that we visited, many private insurance plans and separate SCHIP plans offered

limited coverage for traditional or clinical treatments, such as psychotherapy or psychiatric consultations,[18] and did not cover residential treatment placements. In addition, state officials in 3 of the 6 states we visited said that Medicaid rules in some states that require the preauthorization of services could result in delays and denials of community-based services.

The legislatures in the 6 states that we visited passed health insurance parity laws to increase the coverage that was available for mental health services by requiring insurance companies to provide mental health coverage that was comparable to what they offered for physical health care. Although these laws met or exceeded the standard established by the federal MHPA, they did not require private plans to cover intensive, long term, and nontraditional services such as respite care and wrap-around services,[19] although mental health officials and service providers in the states that we visited said these services were often necessary to help families maintain their severely children with a mental illness in their homes. Furthermore, federal law[20] preempts states from directly regulating self-funded, employer-sponsored health insurance plans and in doing so exempted many families from the enhanced benefits and protections found in state parity laws. Table 4 shows the key features of these laws.

[18]These services are generally provided by licensed or certified psychiatrists, psychologists, or master's level social workers.

[19]Respite care refers to the supervision of mentally ill or other disabled children by a trained caretaker for brief periods of time in order to provide parents relief from the strain of caring for a child with serious mental illness. Wrap-around services encompass a variety of community supports, including counseling, mentoring, tutoring, and economic services that are designed to meet the individual needs of children and their families.

[20]See ERISA, 29 U.S.C. sections 1001-1461.

Table 4: Key Features of Health Insurance Parity Laws in 6 States

State	Major provisions	Meets FMPHA	Exceeds FMHPA
Arkansas	• Does not apply to state employees and companies with less than 50 workers. • Exempts any group health plan whose costs increase 1 percent or more due to the act's application. • Does not apply to health insurance plans if the act's application to these plans will result in an increase in the cost of the health plan of at least 1.5 percent.		✓
California	• Applies generally to all employers, regardless of size. • Applies to all health plans that provide benefits. • Coverage is limited to 20 outpatient visits and 30 days of inpatient care for mental illnesses that do not meet the state's SED criteria. • Covers severely emotionally disturbed children with certain categories of mental illness.		✓
Kansas	• Applies to health insurance plans that provide mental health benefits. • Plans must provide coverage for psychotherapeutic drugs used for the treatment of mental health under conditions no less favorable than for other drugs. • Coverage is limited to 45 outpatient visits and 45 days of inpatient care.		✓
Maryland	• Applies to all health insurance policies that provide coverage on an expense-incurred basis. • Includes drug and alcohol disorders. • Co-payments and deductibles must be equal to those for other conditions. • Outpatient coverage schedule provides for 80 percent coverage for the first five visits in a 12-month period, 65 percent for the 6–30th visits, and 50 percent for the 31st and subsequent visits.		✓
Minnesota	• Applies to all health plans that provide mental health benefits. • Applies to all health plans that provide benefits except self-insured health insurance plans. • Plans with 100 subscribers or more can limit mental health coverage to 80 percent of the customary charge for the first 10 hours of treatment over a 12-month period and 75 percent for additional treatment over the same 12-month period.		✓
New Jersey	• Every individual health insurance policy must provide coverage for biologically based mental illness. • Covers biologically based mental illness under the same terms as other sicknesses.		✓

Source: GAO analysis.

In the 6 states that we visited, state and local mental health officials agreed that Medicaid had far fewer restrictions and limitations than private health insurance plans. In addition, mental health officials in Arkansas, California, and Maryland told us that differences between private insurance and Medicaid programs had created two distinct systems of child mental health services. Under these systems, children covered by Medicaid had greater coverage for mental health services than children covered by private insurance.

All 6 of the states that we visited covered optional Medicaid and SCHIP services by expanding their programs for children with mental illness who were ineligible for Medicaid on the basis of their families' income. These included the HCBS waivers, Katie Beckett option, Rehabilitation option,

and SCHIP programs. See table 5 for Medicaid and SCHIP programs used in the states that we visited.

Table 5: Key Medicaid and SCHIP Programs for Children with Mental Illness in 6 States

	Waivers	Types of optional services		Types of SCHIP programs		
State	Home and Community-Based Services[a]	Katie Beckett	Rehabilitation	Medicaid expansion	Separate (non-Medicaid) program	Combination (Medicaid expansion and separate) program
Arkansas		X	X	X		
California	X		X			X
Kansas	X		X		X	
Maryland	X	X	X			X
Minnesota	X	X	X	X		
New Jersey			X			X

Source: GAO analysis.

[a]Of the 4 of the 6 states that we visited that had a HCBS waiver, only Kansas had a waiver specifically for children with serious emotional disturbances.

States used different approaches to expand Medicaid coverage. For example, Medicaid officials in Kansas received permission from CMS to implement a HCBS waiver to expand coverage for community-based mental health services for a limited number of children who are chronically mentally ill. Although Medicaid officials in New Jersey financed its new child mental health system through a Medicaid Rehabilitation option, the option extends Medicaid coverage to only a limited number of children who have exhausted benefits under other insurance and who have chronic and severe mental illness. This option provides 60 days of community-based services and limited hospitalization.[21] Arkansas, Maryland, and Minnesota used Medicaid's Katie Beckett option to expand Medicaid coverage to physically or mentally disabled children who meet CMS's requirements for institutional care. Arkansas's program did not require parents to share program costs to receive services, but Minnesota's program required parents to pay according to their ability as defined by a sliding scale.

While states chose to use different waivers and options to expand access to mental health services, all 6 states used SCHIP programs to extend

[21]In commenting on a draft of this report, Kansas said that services the state provides under the Rehabilitation option are not limited to 60 days, but are based on the individual clinical and medical needs of a child.

health insurance coverage to low-income families whose incomes exceeded allowable limits under Medicaid. Kansas offered a separate child health (non-Medicaid) expansion program. Arkansas and Minnesota offered expanded Medicaid coverage and California, Maryland, and New Jersey offered both and Medicaid-expansion and separate child health programs to low-income families of different income levels. However, mental health officials in 3 states said that their separate SCHIP programs generally resemble many private insurance plans in terms of limits and restrictions. For example, New Jersey's separate SCHIP plan limits some mental health services. California's plan, however, entitles children who meet the state's definition of severely emotionally disturbed to receive the same services from county mental health services as children covered by Medicaid.

Although Medicaid's EPSDT provision requires Medicaid coverage for all medically necessary health services that are identified during routine periodic screening as long as the treatment is reimbursable under federal Medicaid guidelines, some state officials said many eligible children are unable to access necessary services through Medicaid because practitioners in the states implement EPSDT unevenly. For example, a Medicaid official in Maryland told us that the implementation of EPSDT varied from county to county. Medicaid officials in California said implementation varied from practitioner to practitioner although access to EPSDT services was increasing as a result of litigation. These officials explained that some practitioners are reluctant to recommend services if such services are not available, some do not have the time to question parents about their child's mental health, and others are not well informed about children's mental health issues. In a previous report, we recommended that the Administrator of CMS work with states to develop criteria and time frames for consistently assessing and improving EPSDT reporting and provision of services.[22] As we stated in that report, comprehensive national data on the implementation of EPSDT are needed to judge states' success in implementing EPSDT requirements.

Low Medicaid reimbursement rates may restrict mental health providers' participation in the program and thus further restrict services. In all 6 states, officials from a variety of agencies said Medicaid rates for some services are lower than the usual and customary rates in their areas and, in

[22]U.S. General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

some areas, psychiatrists and psychotherapists will not accept Medicaid patients or expand the number that they are presently seeing because of low Medicaid reimbursements. For example, a psychologist in Minnesota told us that Medicaid reimbursement for a psychotherapy session is about half the customary rate, and a mental health official in New Jersey said that Medicaid reimburses only $5 per visit for monitoring the use and effects of psychotherapeutic medication.

Even when insurance covered the costs of mental health services, some mental health officials and parents indicated parents often could not access services or placements in their community because the supplies of these services were limited. Fifteen of the 28 child welfare officials and 9 of the 23 juvenile justice officials who responded to our survey question on the relationship between community mental health services and voluntary placements indicated that the lack of such services increased voluntary placements. In every site we visited, officials of state and local child-serving agencies and parents reported inadequate supplies of mental health service providers and specialized mental health placements. Many of these officials said that shortages of child psychiatrists, child psychologists, respite care workers, and behavior therapists existed on statewide levels and were worse in rural areas. For example, state and local mental health officials in Arkansas, California, Kansas, Maryland, and Minnesota told us that some rural counties had very limited or no child mental health services. Also, specialized, out-of-home mental health placements, such as psychiatric in-patient services and residential treatment facilities, were often not available or had long waiting lists. For example, Arkansas officials said the state has no state-run psychiatric hospital placements for children under age 12, and, in California, some children have to wait about 8 months for a residential placement. Child welfare, mental health, and juvenile justice officials in California, Maryland, and New Jersey noted that relatively fewer residential placements are available for girls than are available for boys and that few placements would accept children with histories of arson and sexual aggression. Moreover, these officials noted children placed in the child welfare or juvenile justice systems received preference for services, particularly when the services were court-ordered.

Difficulties Accessing Services through Certain Agencies, Difficulties in Meeting Service Eligibility Requirements, and Misunderstandings among Officials and Service Providers Can Influence Placements

In the 6 states that we visited, limited resources in mental health agencies and public schools to fund mental health services and agency officials' attempts to minimize the use of residential services posed additional challenges for parents seeking services and placements for their children. In addition, some children who needed multiple supports experienced gaps in services because of differences in the eligibility requirements for obtaining such services. Moreover, some officials and service providers often misunderstood the responsibilities and resources of their own and other agencies and communicated the misunderstandings to parents, compounding service gaps and delays.

Difficulties Accessing Services through Mental Health or Education Agencies

According to some mental health and education officials, budgetary shortfalls in the 6 states that we visited contributed to agencies' attempts to cut or control costs, including the cost of mental health services. Mental health agencies used a variety of strategies to control costs, such as reducing spending, requiring that services covered by Medicaid be approved before they are provided, and limiting the number of children served. In each state we visited, some parents believed the strategies affected the quality of the services their children received and created unnecessary delays in getting services. In Arkansas, private, nonprofit mental health providers that contract with the state to provide community mental health said that state officials cut their funding and, as a result, they had to reduce the length of counseling and therapy sessions and increase the length of waiting lists. In 3 of the states that we visited—Arkansas, Maryland, and New Jersey—state officials said that they contracted with private, nonprofit agencies to authorize the medical necessity of mental health services covered by Medicaid. Arkansas required preauthorization of all Medicaid-financed mental health services, including those that were legally required, such as the screening of foster children for mental health services. A variety of officials in this state and a parent reported that the preauthorization agency often denied services for children because they had not benefited from similar services in the past. For example, this parent said the preauthorization agency refused her son's therapist's request to hospitalize him to treat his suicidal behavior because past hospitalizations for suicide attempts had not reduced the behavior. In New Jersey, state mental health officials reduced the number of counties that had been targeted to implement the state's new child mental health system and limited the number of children served by the system. For example, officials from a variety of county agencies reported that the new system of care limited the number of children receiving the highest level of care in their county to 180 a year, although juvenile justice officials said that at least 500 children in their system alone needed such services. Officials from child welfare, mental health, and juvenile justice

agencies said eligible children who did not receive the highest level of care were placed on waiting lists and provided less intensive services.

Other ways of controlling costs in the states that we visited included limiting placements of children in residential treatment facilities. Mental health officials said community-based services supported the right of children with a mental illness to receive services in the least restrictive setting, were more effective than residential services in helping children and their families, and cost less, thus allowing more children to receive services. To implement the limits and to ensure placements are necessary, states required interagency review boards to approve such placements or reduced the time spent in residential placements. For example, local mental health agency officials in Maryland explained that they could not place children in private residential facilities even if they presented a danger to themselves and others because the state did not allow them to pay for such placements. These officials further explained that private residential placements had to be approved by a county interagency coordinating committee and subsequently reviewed by a state coordinating committee that could return requests for further consideration. A parent in this county said the approval process took 6 months. In New Jersey, child welfare officials said a goal of the new child mental health system is to reduce the average stay at residential treatment facilities from 18 to 6 months, and some parents in Maryland told us that funding limits, rather than the success of the treatment, determine the date children will be discharged from residential treatment.

Officials from a variety of county agencies and some parents also reported that public schools in their county—in order to control costs—were often reluctant to provide individualized mental health services for special education children beyond services that are routinely available. For example, child welfare officials in three locations we visited said schools fit children with a mental illness into preexisting programs, and school officials in two of these locations agreed, stating that children's IEPs could only contain services that were available in the schools. Almost all the parents that we interviewed said that school officials were reluctant to evaluate their children to determine eligibility for special education services or provide specialized services for them. For example, a parent of a child with a mental illness in Kansas said officials in her daughter's school refused to evaluate the child for a year and a half. After this evaluation, the school recommended that the child work with a learning disability specialist for 30 minutes a week, even though the parent said this service was insufficient and did not address her daughter's destructive, violent, and aggressive behavior.

As a result of the difficulties encountered at both mental health agencies and schools, some parents could not access the community-based services they needed to care for their child at home nor place their child in a residential treatment facility. In 4 of the 6 states that we visited, some teachers and mental health service providers encouraged parents to refuse to bring their child home from a hospital or other supervised placement, such as a detention center, when they were informed their child was being discharged in order to obtain mental services from child welfare agencies. Although these parents realized they were abandoning their child and, as a result, could be arrested and lose custody, they believed that this was the only alternative that remained to obtain services. Some parents that we interviewed told child welfare workers they would physically abuse their child in their presence to force them to place the child in their system if they could not get help for their child any other way, and juvenile justice officials told us other parents asked the police to arrest their children. However, state officials in 2 of the states that we visited said children often remain hospitalized or in a shelter for months without appropriate services because child welfare agencies did not have the resources to provide the needed level of services or specialized placement, could not obtain resources from other agencies, or could not access appropriate services or placements that had the capacity to treat another child. In addition, although federal law does not require custody relinquishment to obtain mental health services, state child welfare officials in 2 states that we visited said that their state required parents to relinquish custody of their child to the state after the voluntary placement period ends. In 1 state, these officials misconstrued federal requirements and believed that they required relinquishment and in the other state, officials said relinquishment enabled them to have more control over the child's care.

Difficulties Meeting Eligibility Requirements for Mental Health Services

Eligibility requirements for obtaining mental health services pose several challenges for parents. For example, state and local Medicaid officials in 3 states told us that some children lose their eligibility for Medicaid-funded services because their families' income increased beyond Medicaid's threshold or move in and out of eligibility as their families' income fluctuates. Also, some child welfare officials said some children receive Medicaid because they are in foster care and lose their eligibility when they return home if the family is not eligible. Alternatively, juvenile justice officials in 6 states said that children in juvenile justice correctional or detention facilities lose Medicaid eligibility and have to reapply to resume coverage when they are released from the facility.

In addition, in all 6 of the school districts we visited, schools used different eligibility criteria for mental health services than mental health or other

child-serving agencies in their area. For example, school officials in four districts told us that some children with a mental illness are not eligible for mental health services through their special education programs because they were making adequate educational progress or because behavior problems—rather than mental illness—prevented them from making adequate progress. However, mental health officials who work with children attending some of these schools reported that schools often have a narrow definition of educational progress and do not recognize that inappropriate behavior might be a symptom of mental illness. For example, a parent of a child with attention deficit[23] and bipolar disorders said her son's school refused to provide special education services for him because his lack of educational progress was due to his failure to pay attention and to get his work done, rather than his mental illness, and a parent of a bipolar, schizophrenic son[24] said school officials told her that she was responsible for her son's behavior and poor school performance.

Although a variety of officials said schools had more restrictive eligibility requirements for mental health than other child-serving agencies, school officials in a county in California said that their county mental health agency used a more restrictive definition than the schools. In California, state law required that county mental health agencies treat children covered by Medicaid and SCHIP who were diagnosed as SED or who were eligible for special education services.[25] California also requires that children be evaluated by county mental health agencies and fit a statutory definition of SED. School officials said that these children get priority and their services consumed all available county child mental health resources. According to these officials, other children, including children with dual diagnoses of mental illness and substance abuse, mental retardation, or autism-related disorders and children without the required diagnoses have to wait for county mental health services or might not receive services at all, although some may receive services through their school guidance counselors or social workers.

[23]Attention deficit disorder is a syndrome characterized by serious and persistent difficulties in attention span, impulse control, and, sometimes, hyperactivity.

[24]Schizophrenia is a cluster of disorders characterized by delusions, hallucinations, disordered thinking, and emotional unresponsiveness.

[25]The California legislature transferred the responsibility for providing mental health services to children in special education from schools to counties in the late 1980s.

Some parents bypass eligibility restrictions for special education services and procedures for receiving child welfare, mental health, and juvenile justice services by petitioning the court to provide mental health and specific education services for their child. These petitions have varying names. For example, Maryland refers to them as CINS (children in need of supervision) petitions and Arkansas refers to them as FINS (family in need of services) petitions. Three of the states that we visited—Arkansas, Maryland, and Minnesota—allowed parents to directly petition the court to order mental health services for the child. In Arkansas, a child in a court-ordered residential placement was automatically eligible for Medicaid regardless of his or her family's income. In that state, a variety of officials told us that court-ordered placement was the most common way for parents to obtain residential mental health and education services for their child. Juvenile court officials told us that parents often come to court requesting residential treatment and lobbying judges for placement in a specific facility. Some state officials were concerned that this practice could result in inappropriate placements for some children because judges can make placement decisions with no clinical input. Mental health and juvenile justice officials told us staff from private residential facilities often evaluate children on a pro bono basis and, based on these evaluations, recommend that judges place the children in their facility. These officials said that they were concerned about the objectivity of such evaluations.

Misunderstandings of Agencies' Responsibilities and Resources

Program officials' and service providers' misunderstandings of agencies' responsibilities and resources also affect service provision.[26] For example, misunderstandings about Medicaid coverage created gaps and delays in services. In 3 states, some state and county officials did not know the Katie Beckett option could expand Medicaid coverage for children with a mental illness regardless of family status. In 1 of these states, a parent told us that county Medicaid officials incorrectly told her that her son was ineligible for coverage under this option because he had a two-parent family. In 2 other states, county mental health officials erroneously told us that this option applied only to children with very severe medical conditions. In another state, a Medicaid official did not know that children enrolled in SCHIP Medicaid expansion programs were entitled to EPSDT services. Furthermore, state child welfare officials in 2 states and mental

[26]In commenting on a draft of this report, Education said that most of the federal laws concerning this population are purposely vague, open to interpretation, and (in the case of IDEA) actively supportive of state determination of actual procedures and how they will be interpreted.

health workers in a third did not know Medicaid's EPSDT provision includes mental health screenings, diagnosis, and treatment and thought the provision covered only physical health services.

In all 6 states, some parents, a variety of state and local officials, mental health service providers, caseworkers, and judges misunderstood the role and responsibilities of schools in implementing IDEA. For example, some parents we interviewed in 5 of these states said that their children waited over a year to receive special education services because they and the mental health professionals they worked with did not understand the procedures IDEA required schools to follow. For example, some parents were told that referrals for special education had to be in writing. Also, some parents and professionals misunderstood that IDEA gives all eligible children, including children with a mental illness, the right to a free appropriate education and parents did not know that they could appeal a school's decision about providing special education services. For example, a parent in Kansas agreed to home-school her 10 year old, sexually aggressive, child with a mental illness because the school would not put the child in a setting that would ensure the safety of his classmates. Despite her long-term involvement with a community mental health agency, this parent believed home schooling was her child's only option.

States Have Developed a Range of Practices That May Reduce the Need for Some Mental Health-Related Child Welfare and Juvenile Justice Placements

Although few strategies were developed specifically to prevent mental health-related child welfare and juvenile justice placements, state and local officials identified a range of practices that they believe may prevent such placements by addressing key issues that have limited access to child mental health services in their state. State and local practices focused on three main areas: finding new ways to reduce costs or to fund services, consolidating services in a single location, and expanding community mental health services and supporting families. Many of these practices were developed to reduce treatment costs and provide a better way to treat children with a mental illness in their communities. Although some programs were modeled on practices that had been evaluated in other settings, the effectiveness of the practices is unknown because many of them were implemented on a small scale in one location or with a small target group or were too new to be rigorously evaluated.

Finding New Ways to Reduce Costs or to Fund Services May Help Agencies Pay for Mental Health Treatment

According to officials in the 6 states that we visited, one way to reduce the cost of services is to better match children's needs to the appropriate level of service. One goal of some of the programs we reviewed was to ensure that children with lower-level needs were appropriately served with lower-level and less expensive services, reserving the more expensive services for children with more severe mental illnesses. Under New Jersey's Systems of Care Initiative, the state contracted with a private, nonprofit organization for a variety of services, such as mental health screenings and assessments to determine the level of care needed, authorization of service, insurance determination, billing, and care coordination across all agencies involved with the children. When the Initiative is fully implemented statewide, the contractor in each county will use standardized tools to assess children's mental health and uniform protocols to determine appropriate levels of care—children requiring lower levels of care will be referred to community-based providers, while children requiring a higher level of care will be approved to receive services from local Care Management Organizations specifically created to serve them. Presently, the System of Care Initiative has been implemented in 5 of the state's 21 counties.

As another cost-saving method, some programs substituted expensive traditional mental health providers with nontraditional and less expensive providers. Many state and local officials we interviewed in 5 of the states we visited told us that the historic way to treat children with a mental illness included psychiatrists and residential placements. However, officials in New Jersey, Kansas, and Minnesota said their states had switched their focus to using less expensive providers such as using nurses to distribute medicines instead of psychiatrists or nontraditional bachelor-level workers for case management instead of masters-level social workers. For example, Uniting Networks for Youth—a private, county-based provider in Minnesota—used two commercially available, highly structured programs that allowed them to substitute lower-credentialed bachelor-level staff under the supervision of a masters-level clinician as the primary service provider instead of using higher-level clinicians. County officials told us this structured program has many safeguards, including the collection of extensive data from providers, teachers, and families that allow masters-level clinicians to review the appropriateness and effectiveness of provided mental health services.

State officials in 5 states also recommended increasing the use of volunteer and charitable organizations to reduce the cost of services because these organizations can provide inexpensive or free supportive services to children with a mental illness and their families. While these

services were not therapeutic, officials said that they helped families cope with problems associated with mental illness and kept some mental health problems from escalating. For example, the Four County Mental Health Center in Kansas used volunteers from churches, community agencies, and charities, such as the Salvation Army, to provide services such as mentoring and tutoring for children with a mental illness. A county in New Jersey increased its reliance on Big Brother-Big Sister volunteers and the local YMCA to provide after school supervision and mentoring for children with severe mental illness.

In addition to reducing the cost of services, state officials in all 6 states identified the blending of funds from multiple sources as another way to pay for services, thus working around agencies' limitations on the types of mental health services and placement settings each can fund. For example, in a county in Maryland, a local Coordinating Council blends funds from multiple agencies to provide community-based services to children with a mental illness involved with the judicial, child welfare, and mental health systems and with district special education programs. The Council, headed by a judge, leveraged funding by inviting key decision makers—those that could commit resources—from a variety of child-serving agencies and organizations, including the local departments of social services and juvenile justice, the public defenders office, prosecutors, attorneys, and Catholic Charities, to serve on the Council. The Juvenile Alternative Defense Effort (JADE), a county juvenile justice diversion program in California, combines funds from a federal Juvenile Accountability Incentive Block Grant and the state Temporary Assistance for Needy Families Program (TANF)[27] to provide the range of mental health services necessary to prevent a juvenile justice placement for mentally ill youths. In Kansas, the Family Service and Guidance Center blends funds from federal Medicaid and Department of Transportation programs, designated funds from the state's Master Tobacco Settlement and Attorney General's Office, funds from county juvenile justice and social services agencies, county general funds, the United Way, and several local philanthropic clubs to provide a wide range of mental health and supportive services for children who are seriously mentally ill in its county.

[27]TANF, created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, provides assistance and work opportunities to needy families by granting states federal funds and flexibility to develop and implement their own welfare programs.

In addition to blending funds to pay for services, state officials in 4 of the 6 states that we visited identified the use of flexible funds, with few restrictions, to pay for nontraditional services that are not generally allowable under state guidelines. For example, Arkansas's Together We Can Program used flexible funds from a federal Social Services Block Grant, state general revenue, and the Title IV-B program to provide a wide range of nontraditional supportive services and items to children with a mental illness and their families. Using these funds, the program provided services and items such as in-home counseling, community activities, respite care, mentoring, tutoring, clothing, and furniture that helped the family care for the child at home and supported the child in his community.

Bringing Mental Health Services into a Single Location May Improve Access

To improve access to mental health services and bring clarity to a confusing mental health system, 3 of the states that we visited developed a facility to be a single point of entry into the mental health system. Typically, several agencies are represented at the facility and children are assessed with a common instrument and eligible for the same services regardless of what agency had primary responsibility. Kansas's Shawnee County Child and Family Resource Center is a one-stop facility and, according to state mental health officials, a model for the rest of the state. The center houses workers from 11 social services agencies, including mental health, child welfare, juvenile justice, and education. All children with mental health needs, regardless of which agency first encountered the child, are referred to the center. Case managers at the Center assess the child's psychological, educational, and functional needs, determine appropriate services and placements, make referrals, provide some direct counseling services, and determine how to pay for services. The facility includes four bedrooms for children who need to be removed from their homes for short periods of time and a secure juvenile justice intake suite that is staffed 24 hours a day. County officials from a variety of agencies told us that the center ended service fragmentation and prevented duplication of services for children with a mental illness and their families by implementing one intake procedure for all county social services. For example, case managers work with police to prevent the placement of children with mental illness in correctional facilities. If a mental illness is identified during the intake assessment, the intake workers immediately link the child with a mental health worker. Working collaboratively with juvenile justice, school, and other appropriate officials, the case manager

develops a diversion[28] plan all can agree to that is aimed at preventing the need for juvenile justice or child welfare custody, or residential or other out-of-home placements with the goal of keeping the child at home with the child's own family.

State officials in all 6 of the states that we visited also identified co-locating services in public facilities such as schools and community centers as another way to improve access. In California, Los Angeles county officials told us that integrating mental health services into the school system has been a very effective way of reaching poor families without transportation and working families, and helps to ensure regular participation in mental health services. In Harford County, Maryland, for example, mental health services are collocated at an elementary school specifically to improve access to care for students with mental illness. Using county health and mental health funds, the school developed an in-house mental health clinic that provides mental health services through a bachelor-level social worker, a nurse practitioner, and consultative services from a physician and a psychiatrist. In addition, the school has a variety of internal support staff available to children with a mental illness, including a guidance counselor, a behavior specialist, a home visitor who supports families and assesses the home situation, and a pupil personnel worker who visits homes and helps with transportation issues. The school has several programs available to children with a mental illness, including the Classroom Support Program, an intensive, in-school program for children with a mental illness staffed with a full-time school psychologist for individual counseling; the Teen 2000 program, a mentoring program for teens that uses paid school staff, high school students, and volunteer community members to provide a combination of homework support, play, and social skills development; the School Outreach Advocacy Program, a program that provides counseling, tutoring, recreation, social skills groups, home visits, referrals and some psychiatric rehabilitation services; Project Prepare, a program to identify mentally ill elementary school children and increase their access to services; and two collaborative programs with contracted mental health providers that provide community support and prevention services and intensive case management services.

[28]Diversion programs attempt to prevent or reduce the time children spend in inappropriate placements.

Expanding Community Mental Health Services and Supporting Families May Improve Treatment for Children with a Mental Illness

Officials from child-serving agencies in all 6 states we visited identified the expansion of the number and range of community-based services to provide an entire continuum of care as a way to improve treatment for children with a mental illness. Some programs we reviewed developed a complete range of community-based mental health services for children, including early intervention, diversion, transitional services, and crisis intervention. In addition, some programs supported families of children with a mental illness and encouraged parent involvement in their children's care. State and county officials we spoke with in all 6 states stressed the importance of early identification of children at risk of mental illness and the provision of therapeutic services when they were young in hopes of preventing the need for extensive, and costly, residential services later on. Examples of these programs follow.

Early Intervention: Working with local hospitals, workers from the Family Service and Guidance Center in Shawnee County, Kansas, screen newborns in local hospitals. If babies appear at-risk, social workers conduct home visits and refer families to health care professionals or others for support. The Center also developed a therapeutic preschool practice directed at 3-5 year old children, with or without a mental illness diagnosis, who were likely to need special education services when they entered kindergarten. The program serves 32-36 children and provides a half-day of services.

Diversion: Los Angeles' JADE was designed to prevent or reduce the time of expensive juvenile justice placements for youths with mental illness, by arranging assessments, providing referrals to mental health providers and advocating for these youth to ensure they receive the treatment they need. Upon referral to JADE, a psychiatric social worker performs an extensive psychosocial evaluation, including a developmental history, family history, and educational history that include failures and successes, gang-related behaviors, delinquency behaviors, and a mental health status exam. Based on the evaluation, the social worker makes placement and service recommendations to the juvenile court judge who makes the final decisions. JADE officials said that the evaluations and recommendations give the judges the information they need to consider alternatives to incarceration.

Transitional Services: State and county juvenile justice and mental health officials in the 6 states we visited stressed the importance of including transitional services in a continuum of care. These services are typically provided to a child leaving a residential setting and returning to his or her home or community. For example, Minnesota's Red Wing facility

is a secure juvenile justice facility that provides in-house mental health services and places a strong focus on transitional services so youth can successfully reenter their own community. Red Wing officials told us that transition planning and reintegration efforts are very important in preventing recidivism and they take several steps to ensure a successful transition. The program is designed in levels that reward good behavior by allowing youth to move to lower levels of supervision. For instance, at level 4, youth begin to transition back to the community by making periodic visits, called furloughs, to their homes. Officials see furloughs as an opportunity for youth to try out the new positive behaviors that they have learned. At level 5, youth move to a transitional living unit at Red Wing that focuses on applying new skills to activities in their homes and communities. After youth leave Red Wing, a county juvenile justice worker monitors them for 90 days.

Out of frustration with the difficulties it had finding appropriate services for mentally ill youth who were aging out of child mental health programs, The Sycamores, a residential mental health facility in Los Angeles County, California, created community-based transitional homes for older teens who were leaving their facility and were unable to return to their own homes. Its Emancipated Youth Program provides an apartment for every two residents, a youth advocate worker to provide support, and case managers to coordinate services. For this program, the Sycamores uses reasonably priced private apartments in the community, instead of a group home that would house several mentally ill youths in the same building. When the youths become able to live independently, the Sycamores turns the leases over to them. They also started a business card company at one community center to provide vocational training for adolescents aging out of their program.

Crisis Intervention: Programs we reviewed in 4 states had a mobile crisis unit. These units consist of teams of staff that visit homes to stabilize crisis situations. Funding, staffing, and authority of these teams vary. Some of the crisis teams can provide direct mental health services; others conduct assessments and make emergency petitions to psychiatric hospitals on behalf of the family. One of the difficulties noted by program officials is determining how to pay for crisis services since these services may not be covered by insurance and families may not have the ability to pay. In Harford County, Maryland, the mobile crisis team is not a fee-for-service provider but is funded by a grant. The team—a psychiatrist, a psychologist, and a licensed social worker—provide direct mental health services and are authorized to do an emergency petition to get a child with a mental illness admitted to a hospital psychiatric unit.

A second way some states improve treatment for children with a mental illness is to provide services to support families and encourage parental involvement in their child's care. State and local officials in all 6 states pointed out that involving parents was a fundamental change in philosophy. Previously, services were provided solely to the children and parents were not included in the decisions about their child's care. Now, the focus is on providing the services parents need to maintain the child in the home and helping parents make informed decisions about their child's care. For example, The Sycamores works extensively with parents of children who are seriously mentally ill at the facility and requires their participation. To help parents successfully prepare for and keep their child with a mental illness at home, The Sycamores provides a variety of supportive services—anything the family needs to make a child's return home successful—including household items like refrigerators, washers, dryers, stoves, and car seats, and services such as transportation to and from the facility. In addition, as part of its transitional Home-Based Program, The Sycamores trains parents to use Therapeutic Behavioral Services (TBS), one-on-one, in-home services provided whenever needed 24 hours a day, 7 days a week. TBS workers model good parenting skills so parents will be prepared for their child's return home, such as modeling for the parents how to get their child with a mental illness who may have violent outbursts ready for the school bus in the morning without incident. The Four County Mental Health Center in Kansas's provides free parenting classes designed to teach effective parenting skills for children with mental illness and a parent support coordinator who can provide support and information on mental health services for children. The Center also works with Kansas's Keys for Networking, a statewide parent advocacy organization that educates parents about their child's right to services and advocates on their behalf to obtain needed services.

Conclusions

Some parents are placing their children, mostly adolescent boys with severe mental illness, in the child welfare and juvenile justice systems to access mental health services. Although these children may not have been abused or neglected, or may not have committed a criminal or delinquent act, parents are turning to these agencies because they see no alternatives for obtaining comprehensive services for them. Because federal, state, and local agencies do not systematically track these children, the extent and outcomes of these placements are not fully known.

Experts, agency officials, and service providers agree that agencies must work together to meet the needs of children who are severely mentally ill because these children have complex problems and are likely to need

services from multiple community agencies, such as mental health and education, if they are to remain in their communities or if they are to successfully transition from a residential facility back to their community. However, in some cases, state and local officials' misunderstandings of each agency's service requirements, responsibilities, and resources prevent the provision of interagency services that have the potential to address the needs of these children and their families. Opportunities exist for HHS, DOJ, and Education to determine the causes for these misunderstandings at the state and local level and to identify ways to reduce them.

Although states and counties are implementing practices that may reduce the need for parents to place their children with child welfare or juvenile justice agencies, many of the programs are new, small, and only serve children in specific localities. Furthermore, their effectiveness in achieving their multiple goals—such as reducing the cost of mental health services, supporting families, and helping children overcome their mental illnesses—has not yet been fully evaluated. Given that states and localities are developing new approaches to meeting the needs of children with mental illness, it is important that the federal government continue its role in supporting evaluations of these programs and disseminating the results.

Recommendations

To determine the extent to which children may be placed inappropriately in the child welfare and juvenile justice systems in order to obtain mental health services, we recommend that the Secretary of HHS and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these placements. To help reduce misunderstandings at the state and local level, we also recommend that the Secretaries of HHS and Education and the Attorney General develop an interagency working group (including representatives from CMS, SAMHSA, and ACF) to identify the causes of these misunderstandings and create an action plan to address those causes. We further recommend that these agencies continue to encourage states to evaluate the child mental health programs that they fund or initiate and that the Secretaries of HHS and Education and the Attorney General determine the most effective means of disseminating the results of these and other available studies to state and local entities.

Agency Comments

We provided a draft of this report to Education, HHS, and DOJ to obtain their comments. Each agency provided comments, which are reproduced

in appendixes III, IV, and V. These agencies also provided technical clarifications, which we incorporated when appropriate.

Education generally agreed with the findings of our report, but asked that we change some terminology to be consistent with terminology used in IDEA. We changed this terminology to reflect IDEA when needed. HHS also generally agreed with the findings and said that the report is comprehensive, interesting, and provides an informative overview of the concerns with which child welfare agencies and juvenile justice systems are confronted when children and youth do not receive adequate mental health services within the community. However, HHS also said that the report is relatively critical of state and local agencies for "inappropriately" using child welfare and juvenile justice placements to get services to children who need them and cannot access them through other channels. HHS further stated that a broader look at the status of children's mental health services in general would be useful because the problems leading parents to place their children in child welfare and juvenile justice systems to obtain mental health services are part of the bigger problem of children's mental health services in general, such as limited or non-existent services, a lack of access, and a lack of quality providers. Although a broad assessment of the availability and effectiveness of children's mental health services was beyond the scope of this report, we have conducted studies relevant to these problems and reference to them can be found in the related products list at the end of this report. The purpose of this report was to shed light on the number of children placed in the two systems solely to receive mental health services and the factors that lead to those placements. In doing so, this report does not criticize state and local child welfare and juvenile justice agencies that place these children, but instead identifies the circumstances under which these agencies play a role in meeting mental health needs, as well as the roles that other agencies should play. DOJ also generally agreed with our findings but was concerned that the estimates of children placed provided by child welfare and juvenile justice officials would be taken as solid and conclusive and be used for policy changes without further study being undertaken. We explicitly acknowledged the limitations of these estimates in the report and we recommended that the Secretary of HHS and the Attorney General investigate the feasibility of obtaining more precise numbers by tracking these children. Doing so will allow the agencies to determine the extent of the problem.

In commenting on the recommendations, Education said that it was not clear to them how collecting more data and tracking outcomes will increase the likelihood of progressive practices to provide children's

mental health services. HHS said that asking the agencies to track this population of children in foster care does not address the larger point of the lack of mental health resources for families and communities and does not address the problems of the children or their parents. HHS also said we failed to identify to what end these data would be used and that a request for appropriate funding for states and federal agencies involved in tracking should accompany the recommendation for tracking. DOJ agreed that tracking should take place, but only in the short term, and that HHS should take the lead in such an effort. As we stated in our recommendation, we believe HHS and DOJ should determine the feasibility of tracking children to identify the extent and outcomes of the mental health placements discussed in the report. Knowledge of the extent of this practice is a necessary first step to determine what corrective actions might be taken and might be useful in identifying which progressive practices will most benefit these children. In addition, without this basic information, the agencies may unknowingly limit the action steps that they develop to alleviate state and local officials misunderstandings and thus fail to maximize access to and the use of existing resources. While the report recognizes that some mental health resources may be limited, it also describes the misunderstandings that exist among state and local officials regarding each agency's service requirements, responsibilities, and resources. If such misunderstandings could be corrected, more children could possibly be served by the agencies better designed to meet their mental health needs. Since HHS and DOJ already track various characteristics of all children placed in the child welfare and juvenile justice systems, these agencies should determine the feasibility of adding data elements regarding placement solely to receive mental health services and determine appropriate time frames for collecting these data.

HHS also said that our estimate of the number of children placed was presented without context, and asked how the number compares with various groups—such as the total number of children placed in the two systems and the number of children who remain outside the system but are in need of the same kinds of services. We could not, however, make these comparisons because no agency was tracking these children and we necessarily relied on the estimates provided, which we believe to be an underestimate for the reasons stated in this report.

All three agencies said they would participate in any interagency working group that might be established based on our recommendation and DOJ recommended using the existing Coordinating Council on Juvenile Justice and Delinquency Prevention. We believe several organizational entities

may be appropriate and that the member agencies forming this group should determine the entity that is best suited. HHS, however, said that an interagency working group would do little to address the lack of resources. We believe that identifying the causes of the misunderstandings that are occurring is a first step toward addressing the lack of resources. Such a group, by promoting a more consistent understanding of the roles and resources of state and local agencies, may improve access to services and result in more effective utilization of existing resources. Education commented that we should be more specific on the role of the working group in addressing major differences in terminology and definitions across various legislation, enormous differences in local interpretation of federal definitions, and in local practices for establishing eligibility. Education added that such a group would not have the power to address congressional lawmaking and noted that no recommendations were made for increased grant spending to duplicate or disseminate the positive features of such practices. We believe that our recommendation is broad enough to encompass the list of issues Education mentions. We also believe that our recommendation does not preclude the group from recommending legislative changes as part of its action plan. Regarding Education's comment on information dissemination, we added a recommendation to that effect.

DOJ also said that while evaluating child mental health programs is a worthwhile goal, states should consider evaluating their entire systems of care for children to determine (1) how many children with serious mental illness are in need of care but unable to obtain it, (2) how state and local child-serving agencies attempt to address the needs of these children, and (3) how effective these systemic efforts are in actually meeting these needs and those of their families. While we concur that such evaluations are worthwhile, including this suggestion is beyond the scope of our report.

We also provided a copy of our draft to state officials in the 6 states we visited (Arkansas, California, Kansas, Maryland, Minnesota, and New Jersey). Kansas provided technical clarifications, which we incorporated when appropriate. Minnesota made a general comment that required no changes in the report, and California said that it had no suggested corrections or edits.

We are sending copies of this report to the Secretaries of HHS and Education and the Attorney General, appropriate congressional committees, state child welfare directors, selected juvenile justice

officials, and others who are interested. We will also make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions, or wish to discuss this material further, please call me at (202) 512-8403 or Diana Pietrowiak at (202) 512-6239. Key contributors to this report are listed in appendix VI.

Cornelia M. Ashby
Director, Education, Workforce,
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Appendix I: Scope and Methodology

To obtain estimates of the number and characteristics of children voluntarily placed in the child welfare and juvenile justice systems to receive mental health services, we conducted two surveys. We sent the first survey to state child welfare directors in the 50 states and the District of Columbia. We conducted the second survey by telephoning directors of county juvenile justice agencies in large counties in the 17 states with the largest populations of children under age 18. Overall, 71 percent of the children in juvenile justice facilities resided in these states. In most cases, we interviewed juvenile justice agencies in the two largest counties in each state. We chose to survey a sample of juvenile justice officials at the county level because, unlike child welfare, all states do not have a juvenile justice agency. Also, children who enter the juvenile justice system for mental health services are more difficult to identify than children who enter through child welfare systems because parents cannot directly place children in juvenile justice systems and children cannot enter juvenile justice solely to access mental health services. Telephone contacts with local juvenile justice officials allowed us to obtain information from individuals who were more likely than state officials to have direct knowledge of how children enter the juvenile justice system.

We asked both groups to estimate[1] the number of children voluntarily placed in their system by actions of their parents in order to obtain mental health services, the characteristics of the children, and factors influencing the rate of placements. Table 6 provides survey numbers and response rates for the surveys.

Table 6: Survey Numbers and Response Rates

Survey of	Number of surveys conducted	Number of survey responses received
Child welfare directors	51	47
Juvenile justice officials	33	33

Source: GAO.

Not all respondents to the surveys answered every survey question. For example, 19 respondents to the child welfare survey and 30 respondents to the juvenile justice survey provided estimates of number of children

[1]Child welfare directors and juvenile justice officials used a variety of means to estimate the numbers of children placed. For example, some child welfare directors spoke to their counterparts at the local level and asked them to provide estimates. In other instances, the directors estimated based on the number of children receiving the highest level of mental health services.

placed. Some respondents indicated that they were unable to access information to generate estimates.

Site Visits

To determine the factors that influence child welfare and juvenile justice placements for mental health services, we included questions on these issues in our surveys and interviewed federal, state, and local officials and national child mental health experts. We interviewed officials at the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and Education. We spoke with state and local officials in 6 states—Arkansas, California, Kansas, Maryland, Minnesota, and New Jersey—and in one county in each of these states. The officials represented state and county agencies that were responsible for child welfare, child mental health, Medicaid, juvenile justice and education services. We also interviewed judges in 5 states and caseworkers and parents in all 6 states. Staff of community mental health centers and other programs serving families with children with a mental illness, such as a Family Support Organization and a residential treatment facility, selected parents of children with, or who had, severe mental illness and invited them to attend our interviews. We selected states that varied in geographical location, legal requirements concerning placement, the use of Medicaid options and waivers, and the authority of state and county agencies in administering child welfare and juvenile justice programs; and counties that varied in demographic characteristics.

To identify promising practices that may reduce the need for some child welfare and juvenile justice placements by meeting the needs of children with a mental illness and their families, we asked national experts and state and local officials to identify such practices in the states that we visited. We visited 16 programs that embodied these practices.

We conducted our work between March 2002 and February 2003 in accordance with generally accepted government auditing standards.

Appendix II: State Statutes Containing Language Allowing Voluntary Placement to Obtain Mental Health Services

Table 7: Statutes in 11 States Allowing Parents to Place Children in Child Welfare Systems in Order to Obtain Mental Health Services While Retaining Custody of the Child

State	Statute citation	Statute
Alaska	M.S.A. Section 260C.201 (3)	Where a parent enters into a voluntary placement agreement, the agreement may not preclude the parent from regaining care of the child at any time.
Colorado	C.R.S.A. Section 19-3-701(1)	Where a parent voluntarily places a child out of the home for the purpose of obtaining treatment for an emotional disability solely because the parent is unable to provide care, relinquishment of legal custody is not required.
Connecticut	C.G.S. A. Section 17a-129	Their shall be no requirement for the Department to seek custody or protective supervision of a child or youth who needs or is receiving voluntary services unless the child or youth is otherwise alleged to be neglected or abused.
Iowa	I.C.A. Section 232.1784 and 232.182 (5) (d)	Petitions for voluntary placements shall describe the child's emotional disability which requires care and treatment; the reasonable efforts to maintain the child in the child's home; a determination of whether services or support provided to the family will enable the family to continue to care for the child in the child's home; and the reason the child's parent has requested a foster care placement. A court may only order foster care placement if it makes a determination that services or support provided to the family will not enable the family to continue to care for the child in the child's home. If the court finds that reasonable efforts have not been made and that services or support are available to prevent placement, the court may order the services or support to be provided to the child.
Maine	22 M.R.S.A. Section 4004-A(1) and (2)	If certain conditions are met, a parent may enter into a voluntary placement agreement in which the parent retains legal custody of the child.
Minnesota	M.S.A. Section 260C.201(3)	If a court determines a child is in need of special services to treat a mental disability, the court may order the child's parent or health plan company to provide such services. If the parent or the health plan is unable to provide care, the court may order that treatment be provided. If the child's disability is not the result of abuse or neglect by the parent, the court shall not transfer legal custody of the child in order to obtain treatment solely because the parent is unable to provide care.
North Dakota	N.D.C.C. 50-06-06.13	The Department of Human Services may not require a parent to relinquish legal custody in order to have the child voluntarily placed.
Oregon	O.R.S. Section 418.312(1)and (2)	To have a child placed in a foster home, group home, or institutional child care setting for the sole purpose of obtaining services for the child's emotional or mental disorder, a parent is not required to transfer legal custody. Rather, the child is placed pursuant to a voluntary placement agreement that specifies the rights and obligations of the parent, the child, and the Department of Human Services.
Rhode Island	R.I.S.T. Section 14-1-11.1	Where a parent voluntarily places a child with an emotional disorder with the Department of Human services for the purpose of accessing an out-of-home program, relinquishment of legal custody is not required.
Wisconsin	W.S.A. Section 48.13(4) and 938.34(6)(a) and (ar)	Where a parent is financially unable to provide treatment for a child, the parent may sign a petition giving a court exclusive jurisdiction. The court may then order an appropriate agency to provide treatment whether or not legal custody has been taken from the parent.
Vermont	33 V.S.A. Section 4305(g)	A child with an emotional disorder may receive services, including an out-of-home placement, without a parent surrendering legal custody.

Source: GAO analysis.

Appendix III: Comments from the Department of Education

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

MAR 19 2003

THE ASSISTANT SECRETARY

Ms. Cornelia Ashby
Director, Education, Workforce, and
Income Security Issues
General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Ashby:

Thank you for the opportunity to review Draft Report GAO-03-397, Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services. I am pleased to respond on behalf of the Department of Education.

We have shared with your staff a range of comments, suggestions and editorial observations, some of which we consider significant. It would be desirable in our view for your final report to use terminology consistent with the terminology used in the Individuals with Disabilities Education Act (IDEA) and supporting regulations when discussing special education and related services, and educational settings. Many of our comments are directed at increasing technical accuracy and hopefully reducing confusion in recognition of the fact that "children with mental illness" is not a term used in IDEA. "Emotional disturbance" is defined at 34 CFR 300.7(c)(4), however. "Autism" and "other health impairment" are also defined at 300.7. Similarly, the term "mental health services" is not used in IDEA, but certain "related services" such as counseling services or psychological services may be provided to students in special education.

In addition to my program responsibilities at the Department I have been representing Secretary Rod Paige on the President's New Freedom Commission on Mental Health, which is mentioned in the draft report. The Commission has considered information about the relinquishment issue and a reference to this may be found on the Commission's website at:
http://www.mentalhealthcommission.gov/subcommittee/rights022803.doc

The Department would, of course, participate in any interagency working group to be established according to the recommendation on page 38 of the draft report.

I hope our comments have been helpful.

Sincerely,

Robert H. Pasternack, Ph.D.

400 MARYLAND AVE., S.W. WASHINGTON, D.C. 20202-2500

Our mission is to ensure equal access to education and to promote educational excellence throughout the Nation.

Child Welfare and Juvenile Justice Draft Report

Substantive Changes

1. Page ii in the list of abbreviations, IEP is incorrectly defined. IEP stands for "Individualized Education Program." Also make correction on Table on page 8.
2. Eligibility for special education and related services (including mental health services) needs to be clarified. It needs to be clear that a diagnosis of mental illness does not necessarily qualify a child for special education and related services. The student must be a "child with a disability" as defined by IDEA. The following pages in the document need clarification in this regard:

    a. Page 2, middle of the page. The sentence that reads: "Similarly, the Department of Educations' (Education) Office of Special Education and Rehabilitative Services (OSERS) provides funding and technical assistance to help states provide needed services to disabled children with special education needs – including those with mental illness."
    b. Page 28, second paragraph
    c. Page 8 identifies the children IDEA serves as "children with mental illness. That terminology is not in the IDEA statute or regulations. A child with "emotional disturbance" (ED) is defined in the regulations and should be used here. Further, the definition of eligibility used in this table indicates that "Only children who fail to make adequate progress because of their disability are eligible for special education or related services such as mental health services." This is NOT consistent with the IDEA. Many students with ED are relatively high functioning and, especially when they receive necessary supports and services, can be academically successful. Furthermore, many students "with mental illness" in terms of other funding agencies are actually served under different (from ED) categories within IDEA, notably "autism" and "other health impaired." See attached page for specific revisions to this table. Be sure the table is revised consistent with IDEA.
    d. Page 19, section on "Multiple Factors Influence Decisions to Place Children."
    e. Page 30, second paragraph, "Also, some parents and professionals misunderstood that IDEA gives all disabled children, including mentally ill children, the right to a free and appropriate education…." This sentence is confusing and unclear. IDEA requires that FAPE be made available to all children eligible under IDEA. It should be noted that "free appropriate public education does not contain the word "and."

3. Page 28, first full paragraph: It should be noted that the use of the terms "adequate educational progress," "adequate progress" and "educational progress" is not consistent with the provisions of the IDEA and the regulations. The standard used in the regulations is whether the disability "adversely affects a child's educational performance." See 34 CFR 300.7. A student can be making

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progress and advancing from grade to grade but may still require and be eligible for special education or related services.

4. The "least restrictive environment" and the individualized nature of special education services need to be clarified. The sentence "… did not support residential placement for children except in extraordinary situations because federal law requires that they provide services for all disabled children including mentally ill children in the least restrictive setting as possible…" (page 5, first sentence) does not accurately reflect the individualized nature of special education. The requirement under IDEA is not the "least restrictive environment" as possible. Rather, under IDEA, to the maximum extent appropriate, children with disabilities are to be educated with children who are not disabled, based on the needs of the child. Although this conception is attributed to the "officials," it may convey an impression that the IDEA requires the most "possibly" LRE. Similarly, the reference to "least restrictive alternative" on page 9 (second paragraph), oversimplifies the construct of LRE under IDEA which includes a broad range of appropriate service locations/levels. See also, Page 19, section on "Multiple Factors Influence Decisions to Place Children."
5. The "large grant program" [$52 million] (p. 9, 1st par.) with collaboration across OJJDP, SAMHSA, and Education is managed, within the Dept. ED, by Safe and Drug Free Schools (SDFS), without involvement by OSERS. That should be noted, since OSERS is the only Dept. ED POC/program identified in the document.
6. "Wrap-around services...." described in Footnote 15, p. 20, should include education, or "instruction." Which is an important component of wrap-around services for children and their families.
7. Page 17, last sentence regarding OSERS data base. It should be noted that OSERS does collect data (number and percent) of children with disabilities age 6 through 21 served in correctional facilities by state and by race.
8. Page 29, second paragraph, first sentence, refers to "specialized education services." Is this different than "special education"?
9. Page 30, second paragraph, should make clear that it is not a federal requirement that referrals for special education must be in writing.
10. Throughout the document, numerous references are made to "misunderstandings" on the part of state and local personnel in interpreting Federal law (example, p. 38, middle paragraph, last sentence). This characterization may be both prejudicial and, in many instances, incorrect. Most of the various federal laws concerning this population are purposely vague, open to interpretation, and (in the case of IDEA) actively supportive of State determination of actual procedures and how they will be interpreted. This is particularly apparent for students with emotional disturbance. Each State defines eligibility for these students, using the federal definition as guidance. States vary greatly in terms of the labels they use for this population. More States use variants of "emotional and behavioral disorders" than the terminology of "emotionally disturbed," which is generally considered pejorative. If the term "misunderstandings" is retained the following phrase should be added: "regarding the roles of the various agencies that provide mental health services…"

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11. The recommendations do not well address the findings of the report. For example- The conclusion and recommendations sections talk a lot about tracking data on placements and outcomes (though outcomes are not defined). However, the bulk of the report speaks to the real issues of the logistical, policy, and resource limitations that limit the availability of and access to MH services for kids. Starting on page 31, several positive examples of more effective practices are also featured. It is not clear how collecting more data and tracking unspecified outcomes will increase likelihood of these more progressive practices. The recommendations do little to build on these strong practices, and no recommendations are made for increased grant spending to duplicate or disseminate these positive features.

    At a minimum, the report should be more specific about some of the objectives that the workgroup should address and include key issues like major differences in terminology and definition across various legislation, enormous differences in local interpretation of federal definitions and in local practices for establishing eligibility.

Similarly, attention should be given to the multiplicity, fractionalization, and incongruity of legislation and funding for these populations as a major impediment to any cohesive coordination of services across agencies, at Federal, State, and local levels. A federal (executive) panel is not the sort of body empowered, or appropriate, to address Congressional law-making on these services, but can the GAO recommend an independent organization for that guidance, and explicitly suggest that they examine inconsistencies and other problems in the multiple pieces of legislation and programs?

12. The draft report does not mention the Independent Living Services Program administered by the Rehabilitation Services Administration (RSA), a component of OSERS. We believe that independent living programs are a potential resource for supportive services for children with mental illness and their families.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 3 2003

Ms. Cornelia M. Ashby
Director, Education, Workforce,
and Income Security Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Ashby:

Enclosed are the department's comments on your draft report entitled, "Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services." The comments represent the tentative position of the department and are subject to reevaluation when the final version of this report is received.

The department also provided several technical comments directly to your staff.

The department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Dennis J. Duquette
Acting Principal Deputy Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the department's response to this draft report in our capacity as the department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office's Draft Report, "Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services" (GAO-03-397)

The Department of Health and Human Services (department) appreciates the opportunity to comment on this draft report which addresses the causes for and possible solutions to the high number of children placed in the child welfare and juvenile justice systems solely to obtain mental health services.

General Comments

The department agrees that this report is comprehensive, interesting and provides an informative overview of the concerns with which child welfare agencies and juvenile justice systems are confronted when children and youth do not receive adequate mental health services within the community. The family scenarios are realistic, presenting the challenges families face in obtaining mental health services for severely, emotionally disturbed children.

The GAO's use of multiple methods to highlight the deficiencies in how these clients are currently served increases our federal understanding of the problems.

The GAO's major concern appears to be access to and availability of mental health services for adolescents outside of state child welfare systems. The GAO identifies and illustrates the core issue well; mental health services, particularly community based alternatives, are under-funded and it is the scarcity of these resources that causes parents to seek placement to meet the mental health needs of their children. Thus, the problem is not really with the child welfare or juvenile justice systems, but caused by a lack of appropriate mental health services at the state and local levels, and the inadequacy of mental health insurance coverage in general. The report is relatively critical of state and local agencies for "inappropriately" using child welfare and juvenile justice placements to get services to children who need them and who cannot access them through other channels. The department is concerned that unless or until alternative ways of accessing services are available, condemning agencies that do what they can to meet families' needs may further impede access for families seeking treatment for children's serious mental health conditions.

The GAO identifies in its report that child welfare agencies often have the same difficulty accessing services that parents face. Committing a child to the custody of child welfare does not assure his/her mental health needs will be met. Such commitments are often made in order to access the funds that child welfare or juvenile justice has available to pay for residential treatment services, and may not address other mental health services.

The Administration for Children and Families (ACF) uses the child and family services review (CFSR) process to identify states' success in meeting children's mental health

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needs. In part, the CFSRs allow ACF and states to evaluate the outcomes for children involved with the child welfare agency and develop plans to improve the outcomes when they are inconsistent with federal standards and requirements. The CFSRs are comprehensive, focusing on all children receiving child welfare services in their own homes or in foster care placements. Many of the findings in the GAO report mirror what the CFSRs have found to date:

- Mental health services are in short supply and often inaccessible to the children and families who need them.
- Children with mental health problems are often committed to the custody of the child welfare system which is ill equipped to serve them.
- State Systems of Care offer effective means of serving children with high-end needs.

Some of the findings of the CFSRs with regard to mental health services include:

- All 32 states reviewed to date will need to enter into Program Improvement Plans (PIP) to strengthen the quality of needs assessment and service delivery to children and families. This is a critical issue since caseworkers often fail to identify important needs of children, including mental health needs, when they develop case plans and provide services.
- Thirty-one of the 32 states failed to achieve positive ratings on the indicator in the CFSR that addresses the provision of physical and mental health services. Most often, it is the mental health area that is lacking.
- Access to services is one of the weakest areas of performance identified among the 32 states reviewed. Most often, the more specialized services, such as children's mental health services and substance abuse treatment, are among the services that are either lacking or inaccessible due to wait lists, location, etc.

GAO Recommendations for Executive Action

To determine the extent to which children may be placed inappropriately in the child welfare and juvenile justice systems in order to obtain mental health services, we recommend that the Secretary of HHS and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these placements. To help reduce misunderstanding at the state and local levels, we also recommend that the Secretaries of HHS and Education, and the Attorney General develop an interagency working group to identify the causes of these misunderstandings and create an action plan to address those causes. We further recommend that these agencies continue to encourage states to evaluate the child mental health programs they fund or initiate.

Department Response

The report articulates significant problems already identified, yet basically recommends further study. The recommendation to track this population of children in foster care

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does not address the larger point of lack of mental health resources for families and communities and does not address the problems of the children or their parents. While the department is not fundamentally opposed to collecting data on the number of children who enter foster care solely for mental health reasons, GAO fails to identify to what end this data would be used. Appropriate funding for states and the federal agencies involved in tracking should accompany the request for further tracking.

We are not opposed to meeting with our federal counterparts and have, in fact, identified it as an activity that ACF needs to undertake to further the goals of the CFSR. We require interagency coordination at the state level and ACF intends to model such behavior at the federal level. We would be glad to participate in a special workgroup or utilize one of the interagency bodies already established such as the Public-Private Partnership on Mental Health Services for Children and Youth to thoroughly examine the issue. If a special workgroup were chosen as the best way to examine the problem, ACF would agree to co-chair this activity with appropriate staff from the Substance Abuse and Mental Health Services Administration (SAMHSA). However, once again, we fail to see how GAO's recommendation will truly address the core issue. Forming an interagency group to look at state and local misunderstandings of agency roles and program requirements and educating state agencies with respect to federal requirements, roles, and responsibilities will do little to address the lack of resources.

Other comments

In order to address the specific problem under study, a broader look at the status of children's mental health services in general would be useful. The report could go further in stating explicitly that the problems in children's mental health that lead to parents committing their children to the child welfare or juvenile justice system in order to obtain services are part of the bigger problem of children's mental health services in general, i.e., limited or non-existent services, lack of access, lack of quality providers, etc.

The data on the Highlights page are presented without context, i.e., 12,700 children were placed in order to receive mental health services. What percentage is that of the total number of children placed in these two systems? And how many children remained "outside" the system but in need of the same kind of deep-end, seriously emotionally disturbed-type services? Without a comparison group there is no sense of proportion or scale. Is this a relatively small percentage/low base rate occurrence? Is this number "bad" or a traumatic decision for any parent to make, or is it an unnecessary drain on the public coffers?

The report would benefit from the inclusion of more detail about the terms "voluntary placement" and "custody relinquishment." What is the exact meaning of these terms and what are the legal and other implications for parents and children? In a few pages, e.g., on page 27, the question of "custody relinquishment" is mentioned.

The GAO stated that, "Although Federal law does not require custody relinquishment to obtain mental health services, state child welfare officials in two states that they visited

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said that their state required parents to relinquish custody of their child to the state after the voluntary placement period ended." In one state these officials misconstrued federal requirements and believed that they required relinquishment and in the other state officials said relinquishment enabled them to have more control over the child's care. We would like to see a more fundamental and basic discussion on such questions as whether relinquishment of custody may be permanent or reversible, how this may differ from state to state, or exactly how custody relinquishment may affect parents and children. It would be helpful if these terms and questions were defined and discussed in a discrete section in the beginning of the report.

Input provided by SAMHSA concerning "voluntary" placement was not accurately reflected in the report. Voluntary placement is a legal term (in the states that allow this process to be used) which allows custody to automatically return to the parents at the end of the treatment for the mental health issues. This term is used in the report as an act on the part of the parents.

We have some concern about the completeness of the study and the conclusions it draws based on the sample, to the extent they were included in the study, that a large group of vested individuals--the parents of the children who were relinquished--could have provided additional information regarding their motivations and the outcomes of their decisions to place children within the child welfare system. Responses to the questions below could provide valuable insight into this issue:

- Who helped the parents to see this relinquishment as a solution to the problem?
- How did the parents approach the child welfare agency or did the agency approach them?
- Were they satisfied, e.g. did their child receive the services they needed or the services that the parents wanted for them?
- Did those services help their child and did things get better (whatever measure the parents used) for their child?
- Did parents try to "undo" these relinquishments?
- Did agencies actually deliver on the services?
- Did the kids get what they needed to have better lives?

The report gives a short view of the system's placement record with these children. This missing outcome piece gives an incomplete picture of the problem.

The GAO mentioned two big caveats, but did not address them as such in the conclusions. The conclusions should at least include caveats, e.g., there are no formal or comprehensive federal or state tracking placement occurrences and the findings may not have any statistical significance. Data was not provided from the five states that have the largest populations of children.

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Appendix V: Comments from the Department of Justice

U.S. Department of Justice

Office of Justice Programs

Office of the Assistant Attorney General

Washington, D.C. 20531

APR 07 2003

Cornelia M. Ashby
Director
Education, Workforce, and Income Security Issues
General Accounting Office
441 G Street, NW, Room 5928
Washington, DC 20548

Dear Ms. Ashby:

This letter is in response to the General Accounting Office (GAO) draft report entitled, *"CHILD WELFARE AND JUVENILE JUSTICE: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services"(GAO-03-397).*

It is clear from this report that GAO conducted an in-depth and comprehensive review under very difficult circumstances. None of the states surveyed collected data on these children and their families, and information provided by state officials was most often offered in anecdotal form. While we consider the draft report to be both thorough and well-written, we believe that it could be further refined and strengthened.

In general, we are concerned that the report presents the information provided by state officials as being solid and conclusive, when, in fact, it is highly speculative. The danger here is that readers of the report will conclude that state officials' statements are sufficiently accurate and reliable to form the basis for recommended changes in policy and practice. We believe that the tenuous nature of the data precludes its use as a sound basis for policy change. Instead, we would recommend that the report emphasize both the lack of empirical support for state officials' statements, as well as the urgent need for state and local jurisdictions to develop and implement plans for the collection of reliable, valid, and relevant data.

A number of statements in the report suggest that the evidence base regarding voluntary custody relinquishment is sufficiently strong to support recommendations for policy change. The reality, however, is that data on this issue are minimal, if not non-existent. On the "Highlights" page, for example, a sentence in the first paragraph states, "Although no agency tracks these children or maintains data on their characteristics, officials said most are male, adolescent, often have multiple problems, and many exhibit behaviors that threaten the safety of themselves and others." If no agency maintains relevant data, then it is unclear how officials could have developed such specific characterizations of these children. The report should

provide some information regarding how officials have reached these conclusions in the absence of reliable statistics.

The report contains recommendations that apply specifically to the Attorney General. While we concur with the general outline of these recommendations, we believe that certain revisions are appropriate. The report recommends, "...that the Secretary of [Health and Human Services] and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these [inappropriate] placements." As noted in the enclosure, we strongly encourage the collection of relevant data to determine the nature and extent of these inappropriate placements. Institution of a long-term tracking program, however, appears premature, as we currently have no data regarding the true scope of the problem. Our ultimate goal is to eliminate any need for parents to place their children in the child welfare or juvenile justice systems to obtain needed mental health services. Tracking inappropriate placements does little to further this goal.

Because the primary source of the problem appears to be a lack of available mental health care services, Health and Human Services (HHS) should take the lead in this investigation. The Attorney General should also play a role, especially in data collection from within the juvenile justice system. Special considerations (e.g., confidentiality, coordination with defense and prosecuting attorneys) may apply to data obtained from youth and families involved with the juvenile court, and Department of Justice (DOJ) will be glad to assist HHS in understanding the complexities of data collection in juvenile justice settings.

The second recommendation involves the creation of an interagency working group by the Secretaries of HHS and Education and the Attorney General "to help reduce misunderstandings at the state and local level.....[and] to identify the causes of these misunderstandings and create an action plan to address those causes." We agree with the importance of an interagency effort to elucidate the causes of this problem, and to identify policy and programmatic changes that would address those causes. We recommend that the existing, statutorily mandated Coordinating Council on Juvenile Justice and Delinquency Prevention[1], which contains representatives from all the identified Federal agencies, serve as the vehicle for implementing this recommendation.

GAO concludes the report by recommending that, "...these agencies continue to encourage states to evaluate the child mental health programs that they fund or initiate." Although the evaluation of child mental health programs is a worthwhile goal, it does not appear to address the specific issues raised by this report. The report does not identify ineffectiveness of existing mental health programs as a source of inappropriate placement. Rather, the key issue is a lack of placement opportunities in existing mental health facilities. States should consider evaluating their entire systems of care for children, in order to determine: a) how many children with serious mental illness are in need of care but unable to obtain it; b) how the state and local child-serving agencies (e.g. education, child welfare, mental health, juvenile justice) attempt to

[1] 42 U.S.C. § 5616.

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address the needs of these children; and c) how effective these systemic efforts are in actually meeting the mental health needs of these youth and their families.

We appreciate the opportunity to provide comments to the draft report. Additional specific comments are enclosed for GAO's consideration. If you have any questions concerning this response, please contact me on (202) 307-5933, or LeToya Johnson, Office of Justice Programs Audit Liaison, on (202) 514-0692.

Sincerely,

Deborah J. Daniels
Assistant Attorney General

Enclosure

cc: J. Robert Flores, Administrator
Office of Juvenile Justice and Delinquency Prevention

Cynthia J. Schwimer
Comptroller, OJP

LeToya A. Johnson
Audit Liaison, OJP

Vickie L. Sloan
Audit Liaison, DOJ

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Appendix VI: GAO Contacts and Acknowledgments

GAO Contacts

Diana Pietrowiak (202) 512-6239
Kathleen D. White (202) 512-8512

Acknowledgments

In addition to those named above, Karen A. Brown, Erin Williams, and Katherine L. Wulff made key contributions to the report. Rebecca Shea, Patrick Dibattista, Alice London, Behn Miller, and Carolyn Yocom provided key technical assistance.

Related GAO Products

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown. GAO-02-813. Washington, D.C.: August 22, 2002.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns. GAO-02-817. Washington, D.C.: July 12, 2002.

Foster Care: Recent Legislation Helps States Focus on Finding Permanent Homes for Children, but Longstanding Barriers Remain. GAO-02-585. Washington, D.C.: June 28, 2002.

Long-term Care: Implications of Supreme Court's Olmstead Decision Are Still Unfolding. GAO-01-1167T. Washington, DC: September 24, 2001.

Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care. GAO-01-883. Washington, D.C.: September 10, 2001.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Medicaid Managed Care: States' Safeguards for Children With Special Needs Vary Significantly. GAO/HEHS-00-169. Washington, D.C.: September 29, 2000.

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Mental Health Parity Act: Employer's Mental Health Benefits Remain Limited Despite New Federal Standards. GAO/T-HEHS-00-113. Washington, D.C.: May 18, 2000.

Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited. GAO/HEHS-00-95. Washington, D.C.: May 10, 2000.

Medicaid Managed Care: Challenges in Implementing Safeguards for Children with Special Needs. GAO/HEHS-00-37. Washington, D.C.: March 3, 2000.

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