Relinquishing Custody for Mental Health Services:
Progress and Challenges

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Executive Summary

Custody Relinquishment Revisited

Custody relinquishment for mental health services refers to situations in which parents transfer legal and physical custody of their child to the state in order to access services that the child could not obtain otherwise. In these cases, no maltreatment (abuse or neglect) is alleged; rather, parents agree to give up custody of their children in order to receive mental health services, often residential interventions (Cannon, 2012; Friesen, Giliberti, Katz-Leavy, Osher, and Pullman, 2003; Giliberti, 2005). In their desperation, they are forced to “trade custody for care,” a practice that has been referred to as “tragic” and “inhumane” (Bazelon Center for Mental Health Law [Bazelon Center], 2000 and 2003; Gruttadaro, 2005; Maryland Coalition of Families, 2002; Mental Health America, 2015; NAMI Ohio, 2005).

In the majority of cases, the child welfare agency assumes custody, although the juvenile justice system may assume custody if the child’s behavior is defined as “delinquent.” Some families reach a breaking point, and as a last resort, refuse to allow their children to come home from psychiatric hospitals or similar locations, hoping that the state will then take custody and their child will receive additional treatment — a practice that has become known as “psychiatric lockouts” (The Family Defense Center, 2012; Herman, 2018). Similarly, children may become “stuck” in hospital emergency rooms for extensive periods of time awaiting placement, when their families do not feel that they can safely take them home, which may also create a risk for custody relinquishment (Chedekel, 2017; Goldberg, 2008; Schoenberg, 2017).

Several national and state analyses have explored this problem and identified potential solutions, most notably those conducted by the Bazelon Center for Mental Health Law (2000) and the U.S. General Accounting Office (GAO, 2003). These analyses found extensive use of custody relinquishment for services and cited devastating consequences for families and children, but concluded that despite these consequences, custody relinquishment continued to be used as a “passport to services” (Bazelon Center, 2003).

Since these studies, there was little recent information about custody relinquishment solely to obtain needed treatment beyond anecdotes and stories. As a result, the Institute for Innovation and Implementation at the University of Maryland School of Social Work undertook a project to revisit the problem nationwide. The project involved an informational scan and telephone discussions with state child welfare and/or mental health agency representatives in all 50 states and three territories, as well as with leaders of family-run organizations (FROs) in 18 different states. The intent was to obtain up-to-date information about the extent to which custody relinquishment for this purpose continues, progress that has been achieved, and strategies used by states to eliminate the practice, as well as strategies to increase the availability of home- and community-based services and supports (HCBS) that might mitigate the need to relinquish custody. Highlights of the findings are summarized below.

Frequency and Causes

How Often It Occurs

- Custody relinquishment for services is reportedly occurring less frequently than in the past, with most states (64 percent) reporting that it now occurs rarely.
- Substantial progress was reported since the 2000 Bazelon Center report in reducing the occurrence of custody relinquishment for the sole purpose of mental health treatment. The majority of states (74 percent) reported substantial or extensive progress.
Similar to previous analyses, two-thirds of states do not systematically collect data on custody relinquishment for the express purpose of obtaining mental health services and rely on estimates.

**When and Why It Occurs**
State officials and FROs reported that custody relinquishment may occur when mental health conditions are so severe that children or adolescents are judged to be dangerous to themselves or others and require intensive services. In these situations, three primary factors may lead to relinquishment:

- **Lack of availability or accessibility of intensive HCBS**: Forty percent of states reported that a lack of availability of HCBS is somewhat or very common as a contributing cause, as well as variable access to HCBS across geographic areas. Without adequate HCBS, residential interventions may be seen as the only option for accessing treatment.

- **Lack of payment mechanisms for high-cost services**: Private insurance was ranked as the most problematic among payment sources. Underidentification of mental health conditions and lack of funding for mental health services under the Individuals with Disabilities Education Act (IDEA) were also reported. Payment under public insurance (Medicaid and the Children’s Health Insurance Program) was ranked lowest as a cause of relinquishment, but about one-third of states did cite inadequate coverage for HCBS in these programs as potential causes.

- **Court-ordered placement of youth in state custody for treatment**: Courts order youth into state custody for treatment, particularly residential treatment, a decision that may be made without the input of mental health professionals or providers of intensive HCBS.

These factors are similar to those identified in previous analyses. Although they may continue to set the stage for custody relinquishment today, this analysis found that they currently occur to a lesser degree. This is attributed to state efforts to eliminate this practice and to provide and finance needed services without resorting to custody transfer.

**Strategies to Prevent Custody Relinquishment**
States have implemented strategies specifically designed to prevent custody relinquishment for mental health services, as well as strategies to increase the availability of the intensive HCBS that can reduce the need for relinquishment. Both types of interventions are needed, since “just banning the practice closes one door to services without opening another” (Bazelon Center News, 2003). Both types of strategies are summarized below.

**State Strategies to Directly Address Custody Relinquishment**
- **Mandates**: About two-thirds of states have statutes or regulations prohibiting the practice, representing a significant increase since the 2003 GAO report.

- **Voluntary Placements**: About half of states use voluntary placement agreements (VPAs) for the specific purpose of preventing transfer of custody solely for mental health care. Through VPAs, children can enter the child welfare system to receive out-of-home mental health treatment, while parents retain legal custody and involvement in decisions about their child’s life.

- **Policies, Guidance, and Training**: 69 percent of states have executive orders, formal policies, and/or guidance to prevent custody relinquishment for treatment; 76 percent provide training for staff and providers on how to avoid this practice.

- **Diversion**: 78 percent of states reported some type of strategy to divert children with mental health needs from entering the child welfare or juvenile justice system to obtain treatment, such as specific diversion protocols or programs.
State Strategies to Increase the Availability of HCBS

- **System of Care (SOC) Strategies:** 94 percent of the states reported developing SOCs as a strategy to increase HCBS. The SOC approach calls for a broad array of effective HCBS for children with serious mental health conditions and their families (Stroul, Blau, and Friedman, 2010; Pires, 2010). SOC implementation and expansion have been supported by federal grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) Children’s Mental Health Initiative (CMHI) (U.S. Department of Health and Human Services, 2017).

- **Medicaid Strategies:** Medicaid has played a pivotal role in financing HCBS, with 90 percent of states indicating that they have used one or more Medicaid strategies, such as the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, expanding eligibility, and various types of Medicaid waivers, options, and state plan amendments.

- **Cross-System Strategies:** Most states (83 percent) reported using resources that are provided by various federal and state child-serving systems to build capacity to provide HCBS. SAMHSA Mental Health and Substance Abuse Block Grants, state agency resources, and child welfare Title IV-E Waivers were the most frequently cited strategies.

Effective Strategies

A comparison of the strategies used by states reporting that custody relinquishment never occurs with those reporting that it occurs frequently shows some differences:

- States with frequent relinquishment have no mandates (statutes or regulations) or policies, while the majority of states reporting no relinquishment have mandates in place, suggesting that some type of requirement and/or explicit, formalized policy can have an impact.

- Greater monitoring was reported in states indicating no occurrence.

- The strategies used by both groups to build HCBS are fairly consistent, with SOC, Medicaid, Block Grant, and state mental health and other state funds used most frequently by both groups.

Child welfare agency, mental health agency, and FRO interviewees all emphasized that an effective approach to eliminating this practice requires multiple strategies in each of these areas and that it is the synergistic effect of strategies in combination that has the largest impact.

Recommendations

Despite progress in reducing custody relinquishment as a means to access and finance services, the scan and follow-up discussions found that custody relinquishment still occurs in some states. Recommendations for eliminating the practice of trading custody for care are summarized below to both directly address the practice and to increase HCBS that can avert the need for relinquishment. As noted, neither of these alone is sufficient to eliminate the practice. It is only when they are combined that custody relinquishment can be removed as an option if the need for mental health care is the only purpose, while at the same time meeting the child’s and family’s needs with a full range of intensive treatment and support services, including residential treatment when indicated.
Strategies to Prevent Custody Relinquishment

- Implement mandates that prohibit custody relinquishment solely to obtain mental health services for children
- Develop diversion processes for responding to situations with a risk of custody relinquishment for mental health services
- Provide training on strategies for eliminating custody relinquishment for key constituencies, including child-serving agencies, judges, Medicaid agencies, families, etc.
- Create voluntary placement options
- Prevent families from being penalized when VPAs are used or when custody relinquishment does occur
- Collect data on the extent and reasons for custody relinquishment for mental health services and use it to develop solutions
- Work with psychiatric hospitals to connect them with intensive HCBS
- Involve family members and youth in problem solving

Strategies to Increase HCBS

- Implement comprehensive SOCs that provide intensive HCBS throughout states, communities, tribes, and territories
- Maximize the use of existing financing streams to provide mental health services
- Identify payment sources for services and supports
- Work with commercial insurers to increase coverage for HCBS
- Involve family members and youth in planning, implementing, and financing HCBS

Respondents to the scan identified a number of areas in which technical assistance could be helpful to address custody relinquishment for mental health services, including additional information on effective state strategies, assistance and resources on implementing and financing specific HCBS and supports, and guidance on collecting and using data to track and eliminate this practice.

As noted by Seltzer (2004), “Custody relinquishment is not a rational choice — and it is no choice at all for families.” The strategies identified through this project are having an impact in reducing custody relinquishment for the sole purpose of obtaining mental health services. Although this is occurring less frequently than in the past, if it does occur, it remains a tragedy. It is hoped that the strategies identified through this project will assist states, communities, tribes, and territories in eliminating this practice completely.
Relinquishing Custody for Mental Health Services: Progress and Challenges

By Beth A. Stroul, MEd

Custody Relinquishment Revisited

Custody relinquishment for mental health services refers to situations in which parents transfer legal and physical custody of their child to the state in order to access services that the child could not obtain otherwise. In these cases, no maltreatment (abuse or neglect) is alleged; rather, parents who are unable to obtain appropriate mental health treatment for their child agree to give up custody to receive mental health services, often residential interventions (Cannon, 2012; Friesen, Giliberti, Katz-Leavy, Osher, and Pullman, 2003; Giliberti, 2005). In their desperation, they are forced to “trade custody for care,” a practice that has been referred to as “tragic” and “inhumane” (Bazelon Center, 2000 and 2003; Gruttadaro, 2005; Maryland Coalition of Families, 2002; Mental Health America, 2015; NAMI Ohio, 2005).1

Although national analyses were undertaken in 2000 and 2003, there was little recent information about custody relinquishment solely to obtain needed treatment beyond anecdotes and stories. As a result, an analysis was undertaken to revisit the problem nationwide. Conducted by The Institute for Innovation and Implementation at the University of Maryland School of Social Work, the intent was to obtain up-to-date information about the practice of custody relinquishment for mental health treatment across states to inform efforts by child welfare and mental health agencies to eliminate this practice. The project explored the extent to which custody relinquishment continues, progress that has been achieved in reducing its occurrence, approaches used by states to prevent the practice, and strategies to increase the availability of home- and community-based services (HCBS)2 that might mitigate the need to relinquish custody. A 2019 issue brief summarizes the results; detailed findings are presented in this document (Stroul, 2019).

Methodology

This project included the following components:

- A literature review of both peer-reviewed and gray literature to identify previous explorations of this practice and available information on strategies to prevent it.

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1 Custody relinquishment occurs for different reasons, including the incarceration of a parent. Although those other reasons are devastating as well, they were not the focus of this project, which was limited to custody relinquishment for mental health services.

2 HCBS refers to both formal and informal services and supports delivered while children are in their own homes or family-based settings.
An informational scan to obtain the most recent information on the extent of custody relinquishment across states, the reasons that it continues to occur, and how states are trying to reduce this practice. The scan was sent to child welfare directors and children’s mental health directors in all states and territories. Responses were obtained from child welfare agencies in 17 states and children’s mental health agencies in 41 states. Overall, information was provided by all 50 states and three territories. The scan was also sent to family-run organizations (FROs), and responses were obtained from 18 FROs in 18 different states.

Telephone discussions with leaders in the child welfare and mental health systems in selected states, as well as leaders of FROs, to obtain more in-depth descriptions of effective strategies and lessons learned in reducing the practice.

An analysis conducted by the National Indian Child Welfare Association (NICWA) of tribal issues in custody relinquishment to meet the mental health needs of American Indian/Alaska Native children is included as Appendix C (Cross, Simmons, Stanley, and Becenti, 2018).

This report details the findings from this analysis and recommendations for preventing custody relinquishment for mental health care. Appendix A provides examples of strategies used by states, and Appendix B reports on the analysis of custody relinquishment in tribal communities.

Previous Analyses

Both national and state-specific analyses have explored this problem, most notably those conducted by the Bazelon Center for Mental Health Law (2000) and the U.S. Government Accountability Office (GAO, 2003). The President’s New Freedom Commission on Mental Health (2003) also cited custody relinquishment to obtain mental health services as a serious concern. Despite attention to the practice and identification of potential solutions, custody relinquishment to receive mental health services persists in some states.

The problem of custody relinquishment was raised as early as 1978, when Knitzer reported that parents were told that they must place their children with disabilities in out-of-home care and even give up legal custody in order to obtain services. In her 1982 landmark report, Unclaimed Children, Knitzer stated that “coercive custody relinquishment” to obtain services was widespread, and that parents were frequently told that this was only way to access residential treatment for children with mental health challenges.

Examinations of the practice have shown that, in the majority of cases, it is the state child welfare system that assumes custody and has even been referred to as the “default mental health provider” for children (Simmons, 2008). However, the juvenile justice system may assume custody if the child’s behavior is defined as “delinquent.” Courts may then order services that parents were unable to obtain previously (Disability Law Center, 2007). Parents may be advised to have their child arrested, even for minor infractions, in order to have their child placed in a secure setting where they hope mental health services will be provided (Cannon, 2012). As noted by the GAO, neither the child welfare nor the juvenile justice system is designed to take care of children solely because of their mental health treatment needs (GAO, 2003).

Some families reach a breaking point and, as a last resort, they refuse to allow their children to come home from psychiatric hospitals or similar locations, hoping that the state will then take custody and their child will receive additional treatment – a practice that has become known as “psychiatric lockouts” (The Family Defense Center, 2012; Herman, 2018). In some instances, parents who attempt to access services through lockout are treated as abusive or neglectful and ultimately lose custody of their child. The GAO (2003) noted that some teachers and mental health providers have encouraged parents to refuse to bring their child home.
from a hospital or other type of supervised placement so that they could obtain services from state agencies. Parents feeling that they had no choice have followed this advice, even knowing that they could be charged with abandonment and risk arrest or loss of custody. Similarly, children may become “stuck” in hospital emergency rooms for extensive periods of time awaiting placement when their families do not feel that they can safely take them home, which also creates a risk for custody relinquishment (Chedekel, 2017; Goldberg, 2008; Schoenberg, 2017).

A significant number of children adopted from foster care have mental health conditions, and they and their families are at a higher risk for disruption or dissolution of custody (Faulkner, Adkins, Fong, Rolock, 2016; North American Council on Adoptable Children, 2007). If post-adoption mental health services and supports are not provided, situations may escalate to the point that adoptive parents are faced with the prospect of ending their relationship with their child and transferring custody back to the child welfare system to obtain services.

Previous national analyses include the following:

- **Portland State University**: One of the first studies to call attention to this issue was conducted in 1989 by the Research and Training Center on Family Support and Children’s Mental Health at Portland State University. Findings indicated that 25 percent of approximately 1,000 families surveyed had received suggestions that they give up custody to obtain care (Friesen and Koroloff, 1989; McManus and Friesen, 1989).

- **National Alliance on Mental Illness (NAMI)**: Ten years later, NAMI published a study with similar findings. Of the families surveyed, 23 percent reported being told that they would have to relinquish custody to access services for their child, and 20 percent said that they actually did give up custody to obtain treatment for their child’s mental health condition (NAMI, 1999).

- **Commonwealth Institute for Child and Family Studies**: A 1991 survey of states conducted by the Commonwealth Institute found that at least one agency in 62 percent of states used custody relinquishment as a mechanism to access and finance services for children with serious mental health conditions (Cohen, Harris, Gottlieb, and Best, 1991).

- **Bazelon Center for Mental Health Law**: A Bazelon Center study found that the practice was common in at least half of the states. Its report, Relinquishing Custody, The Tragic Result of Failure to Meet Children’s Mental Health Needs, identified states with statutes and other mechanisms to address custody relinquishment and profiled the approaches used in two states. However, the Bazelon Center found that custody relinquishment was occurring even in states with statutes and policies intended to eliminate this, and reached the conclusion that custody relinquishment remained a national problem (Bazelon Center, 2000).

- **GAO**: Based on an investigation, the GAO (2003) reported that thousands of families were forced to relinquish custody to obtain services for their children with mental health conditions. At least 12,700 instances were found in fiscal year 2001 alone in which children were placed in the child welfare or juvenile justice system solely to access mental health care. The GAO acknowledged that these figures understated the problem nationally, since the study included child welfare directors in only 19 states and county juvenile justice officials in only 30 counties. The GAO noted that news articles in over 30 states reported the difficulty that parents had when trying to access services for their children with severe mental health needs, and, as a result, many of these parents gave up custody to obtain care. The GAO also found that there were no formal federal or state systems to track the number of families relinquishing custody of their child to secure mental health services.
• **George Washington University (GWU):** The National Health Policy Forum at GWU explored this problem from the perspective of the juvenile justice system and cited reports suggesting a direct connection between the lack of access to mental health treatment and entry into the juvenile justice system. This may occur when families cannot find or afford mental health treatment and the child’s behavior becomes disruptive to the point that supervised care is needed. Once in the juvenile justice system, the courts may order mental health care, and services such as residential or inpatient treatment can be accessed and paid for (*Koppeliman*, 2005).

Concern about custody relinquishment led to studies and analyses in states that have been conducted by state legislatures, law centers, and FROs. For example, the Maryland Coalition of Families for Children’s Mental Health found that 27 percent of parents surveyed were advised to relinquish custody and/or to refuse to bring their children home from hospitals, and that this occurred in order to qualify for Medicaid or other child-serving agency resources to pay for costly services including residential treatment. Additionally, it occurred when families felt that they could no longer manage their child at home and could only obtain out-of-home treatment by transferring custody to the state (*Maryland Coalition of Families*, 2002). In 2004, the Virginia General Assembly ordered the formation of a state executive council to investi‌gate the reasons for custody relinquishment solely to obtain mental health services and to recommend policy options to abolish this practice. The primary conclusion was that “this problem is a direct result of inadequate access to and availability of prevention, intervention, and intensive mental health and substance abuse treatment for children and adolescents,” and changes in code, regulation, policy, and practice were deemed necessary (*Virginia General Assembly, 2004; 2005; 2007*). Analyses were also conducted in Utah, Texas, and Ohio (*Disability Law Center, 2007; Faulkner, Gerlach, Marra, Gomez, and Schwab, 2014; NAMI Ohio, 2005*). (See Appendix A for additional information.)

**Consequences of Custody Relinquishment**

These analyses identified devastating consequences resulting from relinquishing custody for mental health services. The Bazelon Center stated that despite the negative consequences for families, children, and service systems, custody relinquishment continued to be used as a “passport to services” for decades (*Bazelon Center, 2003*).

- **Consequences for Children and Families:** Relinquishing custody is traumatic for families, leading to feelings that they have failed as parents in meeting their child’s needs and that they are abandoning them. By giving up legal custody, they lose the authority to make or participate in decisions about their children. They have no control over their child’s medical or mental health treatment, education, living situation, or even religious observance (*Bazelon Center and Federation of Families for Children’s Mental Health, 1999; Bazelon Center, 2007; Giliberti, 2005; NAMI, 2003*).

  “Parents are forced to make an ‘unthinkable’ choice between retaining their responsibility for and relationship with their child, or giving over decision-making authority and control to a state agency to get the help their child desperately needs. ... Children feel abandoned by their family and the bond between the child and family is often irreparably damaged.” (*Bazelon Center, 2007*)

The process for relinquishing custody itself is difficult for families in that it typically involves an investigation by the child welfare system and a court proceeding of some type. Working with the child welfare system and the courts can be threatening, intimidating, and stigmatizing for families, particularly since entry into the child welfare system involves an implication or actual determination of child abuse or neglect (*Simmons*, 2008). In one state, children entered the child welfare system under a disposition of “refusal to accept parental responsibility,” even though the only reason for relinquishment was to access and pay for mental health treatment (*Faulkner et al., 2014*). Parents who see no other option and refuse
to take their child home from hospitals or other placements may be faced with charges of abandonment (Maryland Coalition of Families, 2002). Some reports indicated that, as a result of these proceedings, their names may be placed on a child abuse registry, which may preclude employment in fields such as teaching, law enforcement, nursing, or social work. In essence, parents are being penalized for making the difficult decision to relinquish custody to get help for their child (Horton, 2014). Further, regaining custody may not be easy. In many states, parents must petition the court and receive the approval of a judge in order for custody to be reinstated (Cannon, 2012). Although they don’t have legal or physical custody, some states require parents to pay child support to offset some portion of their child’s care and treatment (Cancian, Cook, Seki, and Wimer, 2017).

Relinquishing custody is also traumatic for children. They feel abandoned, unwanted, and displaced when separated from their families (Bazelon Center, 2003). They may not be able to maintain contact with their families through visits at treatment facilities, home visits, or even phone calls. Placement in treatment facilities far from their homes and communities weakens their ties with their families further. Because of their histories and attachment problems, children who are adopted are likely to experience this trauma perhaps more acutely (Faulkner, Adkins, Fong, and Rollock, 2016; North American Council on Adoptable Children, 2007). Those youth who are placed in juvenile correctional facilities may feel that they are being punished based on their mental health treatment needs. The multiple placements that often result from custody relinquishment further compromise children’s stability and feelings of abandonment.

- **Consequences for Service Systems:** Assuming legal custody of children results in considerable expense for state agencies in providing treatment, as well as for supervision, legal proceedings, and compliance with other system requirements and regulations. There is broad agreement that providing and financing intensive HCBS can divert children from costly residential treatment and from custody relinquishment. Data on return on investment (ROI) in systems of care (SOCs) for children with mental health conditions document cost savings from investing in HCBS (Stroul, Pires, Boyce, Krivelyova, and Walrath, 2014). The SOC approach, first introduced in the mid-1980s, calls for a broad array of effective HCBS for children with serious mental health conditions and their families (Stroul, Blau, and Friedman, 2010; Pires, 2010). In addition to cost considerations, outcomes can be improved with the services and supports provided within SOCs (Stroul, Goldman, Pires, and Manteufel, 2012; U.S. Department of Health and Human Services, 2015).

Most service systems now adhere to the principle of services provided in the least restrictive setting, which is a basic tenet of the SOC approach (Stroul, Blau, and Friedman, 2010). The GAO (2003) noted that there are both federal and state laws and policies supporting the right of children to receive services in their homes and communities, unless there is a compelling reason for residential placements for treatment. However, service systems may not have the capacity to provide an array of intensive HCBS, leading them to rely, perhaps unnecessarily, on costly residential treatment. As a result, services systems and taxpayers incur costs related to custody, as well as uncertain outcomes for children and families. Currently, lengths of stay in residential treatment tend to be shorter based on multiple factors such as treatment goals, costs, and managed care. Thus, service systems must still be prepared to provide intensive HCBS to children and their families upon discharge.
Relinquishing Custody for Behavioral Health Services: Progress and Challenges

Current Status of Custody Relinquishment

How Often Does It Occur?

Availability of Data
Most of the previous explorations attempted to determine how often parents relinquish custody of their children solely to obtain needed mental health services. A challenge, however, was that states typically did not collect data on children entering custody for this reason rather than for reasons of maltreatment. The frequency of occurrence of this practice cited in these analyses, therefore, were rough estimates, often relying on anecdotal information from states, communities, and families. The lack of systematic data collection is a problem that continues, as the informational scan found that nearly two-thirds of states do not collect data on custody relinquishment for the express purpose of obtaining mental health treatment, although there may be data indicating that mental health conditions are one of the characteristics of many children entering care.

Frequency and Progress
On the whole, the responses of both states and FROs support the conclusion that custody relinquishment for mental health services is occurring less frequently than it was in the past. In many cases, the reports of frequency are not based on systematically collected data and, therefore, rely on estimates.

Table 1 shows that most states (64 percent) reported that it now occurs rarely. No states indicated that it occurs extensively, and six (13 percent) reported that it never occurs. The FROs that responded to the scan presented a slightly less positive picture, reporting on average that the practice occurs sometimes.

The scan also explored progress that has been achieved in reducing the practice since the Bazelon Center report in 2000, and significant progress was reported (Table 2). The majority of states (74 percent) indicated that substantial or extensive progress has been achieved. On a scale of 1-10, the mean rating across states was 7.4. Although the responding FROs did not report the extent of progress conveyed by states, they did signal positive movement toward addressing this problem.
When and Why Does It Occur?

According to state officials and family leaders, custody relinquishment may occur when mental health conditions are so severe that children or adolescents are judged to be dangerous to themselves or others and require intensive services. They may have engaged in serious self-injurious, suicidal, or violent behavior; caused harm to or threatened their parents or siblings; or are perceived as a threat in their schools or other community settings. Respondents described “extreme” behaviors resulting from complex conditions that may include co-occurring disorders such as intellectual or developmental disabilities and mental health disorders. Their need for high levels of supervision may also make it difficult for parents to meet the needs of their other children, and parents report often feeling exhausted, overwhelmed, hopeless, and fearful for the safety of family members.

In these situations, three primary factors may set the stage for possible custody relinquishment: 1) intensive HCBS are not available, accessible, or have not met the child’s and family’s needs; 2) financing is not available to cover the costs of residential interventions and/or intensive HCBS; and 3) courts order youth into state custody for treatment, particularly residential treatment. Each is discussed below.

Causes Related to HCBS

Determination of where care should occur for children with serious and complex mental health conditions is complicated by a historic overreliance on residential treatment and a belief among practitioners and parents that residential placements are the best options for ensuring the safety of the child, family, and community. Growing evidence and an accompanying culture shift have led to the recognition that, in many cases, intensive HCBS can provide treatment and support to these children and their families so that they can remain at home safely (Barbot et al, 2016; Kamradt, Gilberston, and Jefferson, 2008; Stroul, Goldman, Pires, and Manteufel, 2012; Stroul, Pires, Boyce, Krivelyova, and Walrath, 2014). Ideally, these services would be available, but, as determined through responses to the informational scan and follow-up discussions, intensive HCBS may not be uniformly available or accessible to all children and families. Further, both states and FROs described situations in which HCBS have been available and tried but have not been successful in keeping the child in the home and community.

Previous analyses contended that custody relinquishment is a symptom of this much larger problem — lack of available, affordable, and effective mental health services for children and their families (Seltzer, 2004). Even though state agencies may believe that HCBS are preferable, the lack of availability and accessibility of intensive services and supports are significant impediments to keeping children in their homes and communities safely. Adequate funding for these
services is not available in some states, leading to limited capacity to provide the level and intensity of care needed by children with the most serious and complex conditions.

Both states and FROs reported that issues related to the availability and accessibility of intensive HCBS can be reasons for custody relinquishment (Table 3). *Forty percent of states reported that a lack of these services is somewhat or very common as a contributing cause; about half (49 percent) indicated that lack of accessibility is a problem.* Most FROs indicated that both lack of availability (81 percent) and lack of accessibility (90 percent) are somewhat or very common.

- **Lack of Availability of HCBS:** Some states have taken advantage of available opportunities and strategies to build a broad array of intensive HCBS for children and youth with serious and complex mental health conditions. These include resources provided through the federal CMHI for the development and expansion of SOCs, and various types of Medicaid and child welfare waivers, among others. These investments have been supported by data documenting the effectiveness of HCBS in maintaining children and youth in their homes and communities, as well as cost savings by shifting resources to HCBS in lieu of residential treatment and psychiatric hospitalization (Stroul, Goldman, Pires, and Manteuffel, 2012; Stroul, Pires, Boyce, Krivelyova, and Walrath, 2014). Respondents in other states reported that there have not been substantial investments of resources in the development of intensive HCBS so that they are not widely available, and in many states, budgetary pressures have led to cuts in services. Even where HCBS are available, they often lack sufficient capacity to meet the need and may have waiting lists. There was consensus across both state and FRO respondents that without intensive HCBS that provide treatment and support to youth and families and keep them safe, residential treatment may be seen as the only available option.

- **Variable Accessibility of HCBS:** Intensive HCBS vary in accessibility across areas in states. There may be pockets of availability, typically in more heavily populated areas. However, in more rural or frontier regions, there are significant gaps in these services, making them difficult for children and families to access. This is compounded by shortages of mental health professionals, particularly child psychiatrists, a problem that is more pronounced in rural and frontier areas. Services also may not be accessible due to stringent eligibility requirements, medical necessity criteria, long wait lists, lack of payment sources, or little use of telehealth and other technologies to increase access. Again, without accessible intensive HCBS, both families and providers may feel that residential interventions are the best recourse.

Respondents indicated that in some situations, HCBS are obtained, but do not adequately meet the needs of the child and family. When all available HCBS options have been exhausted, and when the family still feels that the child poses a threat to him or herself, to siblings, parents, or others, then parents and providers may seek treatment in a secure setting, such as a psychiatric residential treatment facility (PRTF) or another type of residential treatment center (RTC). Custody relinquishment may come into play in such cases.

**Causes Related to Payment Mechanisms for High-Cost Services**

Previous analyses noted that existing payment systems should cover the services and supports needed by children with serious mental health needs — private insurance, public insurance (e.g., Medicaid),

“Parents are victims of an irrational and wholly inadequate system of insurance coverage. ... Private insurance may cover only outpatient therapy and acute hospital care, but the intensive HCBS required by many children with serious disorders are typically beyond the reach of private insurance. As a consequence, working families who cannot pay out of pocket for such services must forego essential care for their child, often with dire consequences, or relinquish custody to the state so that the child will become eligible for public insurance, typically Medicaid [or other state funds].” (Bazelon Center)
and special education under the Individuals with Disabilities Education Act (IDEA). These three payment mechanisms were explored through the scan and subsequent discussions.

- **Private Insurance**: Among issues related to paying for high-cost services, private insurance was ranked by both state officials and FROs as the most problematic. As shown on Table 4, private insurance plans were reported to have inadequate coverage, both for intensive HCBS and residential treatment for mental health conditions. If some of these services are covered, the level of coverage is often inadequate, such that families exhaust their insurance coverage before adequate treatment can be provided.

  Two-thirds of state respondents (67 percent) reported that inadequate coverage of mental health services is very common or somewhat common as a reason for custody relinquishment. FROs (88 percent) similarly reported inadequate coverage of mental health services by private insurance. Exhausting private insurance benefits was reportedly not as common as inadequate coverage.

  These findings are consistent with other analyses, which found that private insurance did not cover the costs of mental health care for children (Bazelon Center, 1999; GAO, 2003). The Mental Health Parity and Addiction Equity Act of 2008 requiring that mental health services are not subject to limitations that are not applied to physical health services was intended to rectify this. Still, data from a national survey of children with special health care needs found that 27 percent of parents who had children covered under a private health insurance plan reported that their child’s mental health needs went unmet because the services were too expensive, compared with only about 12 percent of parents with children covered under public insurance programs such as Medicaid (DeRigne, 2010).

  Gaps in coverage, as well as high deductibles and co-pays, are barriers to accessing care. This finding is echoed in the literature: “Often, the only insurer that provides coverage for the intensive level of care needed for these youth is Medicaid” (Graaf and Snowden, 2017, p.272).

  A result is that parents may be forced to give up custody to the state in order for their children to become eligible for Medicaid and qualify for the typically richer benefit package for mental health services, or for state or county child welfare funds that may cover the cost of services. Middle-class families may be at greater risk for custody relinquishment, since they are more likely to have private insurance and cannot afford to pay the high costs for services not covered under their insurance plans or the high deductibles and co-pays for services that are covered, including both intensive HCBS and residential treatment (DeRigne, 2010).

- **Public Insurance**: Public insurance was rated lowest among payment issues by both state agencies and FROs as a cause of custody relinquishment. Table 5 shows that the majority of state officials (67 percent) think that inadequate coverage for mental health services is not common in either Medicaid or the Children’s Health Insurance Program (CHIP). Still, about one-third of states did cite public insurance
issues, as did two-thirds of FROs. State Medicaid programs tend to have more robust benefits than private insurance plans, but coverage varies across states as do management approaches. Some states do not cover the comprehensive array of intensive HCBS that could avert the need for residential treatment.

Additionally, the increasing use of managed care strategies in state Medicaid programs could limit the scope and duration of services that are covered due to stringent medical necessity criteria coupled with restrictive prior authorization and utilization review processes. If services are denied, custody relinquishment may be seen as the only way to access services using state funds other than Medicaid. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program under Medicaid is intended to allow states to provide any services indicated for children after regular screenings. However, EPSDT screens often do not include sufficient assessments of mental health problems and treatment needs (Gruttadaro, 2005). CHIP expands public insurance coverage to additional children, but based on the model each state has adopted, may have more limited coverage of mental health services. Most states (83 percent) also think that ineligibility for Medicaid or CHIP is not a common problem, although there are still families whose income is above the eligibility threshold established in their states, and they may not have private insurance. The FROs reported coverage and eligibility problems to a greater extent than state agency respondents, but still considered public insurance to be less problematic than the other payment-related issues. As noted, giving up custody in some cases is done for the primary reason of allowing children to qualify for Medicaid benefits that will pay for HCBS and/or residential treatment.

**IDEA**: IDEA requires that children with disabilities receive a free public education, with special education and “related services” to maximize their learning and success in schools. A problem has been that children with serious emotional disturbances (SED) often are not identified by school systems as eligible for special education and related services (Bazelon Center, 2000; GAO, 2003; Gruttadaro, 2005; Simmons, 2008). According to U.S. Department of Education data, the numbers of children identified as SED by school systems has been steadily declining (National Center for Educational Statistics, 2018). Many children are being given plans related to Section 504 of the Rehabilitation Act, which prohibits discrimination based upon disability. However, that act does not entitle them to additional services such as HCBS, only to accommodations in schools (U.S. Department of Education, 2020). Table 6 shows that

<table>
<thead>
<tr>
<th>States</th>
<th>FROs</th>
</tr>
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<tbody>
<tr>
<td>Very Common</td>
<td>44%</td>
</tr>
<tr>
<td>Somewhat Common</td>
<td>22%</td>
</tr>
<tr>
<td>Not Common</td>
<td>5%</td>
</tr>
<tr>
<td>Inadequate Coverage in Medicaid</td>
<td></td>
</tr>
<tr>
<td>Very Common</td>
<td>71%</td>
</tr>
<tr>
<td>Somewhat Common</td>
<td>31%</td>
</tr>
<tr>
<td>Not Common</td>
<td>2%</td>
</tr>
<tr>
<td>Inadequate Coverage in CHIP</td>
<td></td>
</tr>
<tr>
<td>Very Common</td>
<td>83%</td>
</tr>
<tr>
<td>Somewhat Common</td>
<td>44%</td>
</tr>
<tr>
<td>Not Common</td>
<td>0%</td>
</tr>
</tbody>
</table>
40 percent of states reported that underidentification of children with SED under IDEA is either somewhat or very common.

Even if identified, school systems have varying definitions as to what services and supports meet the criteria for related services to meet their needs, and there often is inadequate funding for needed mental health services. Inadequate funding for mental health services under IDEA was reported to be either somewhat or very common indicated by 51 percent of states. Similar to other areas, FROs rated this issue as more common than state agencies did.

- **Juvenile Courts:** The GAO (2003) noted that after an arrest, parents or providers may request mental health services as part of a disposition. The court may then order these services and place the child in state custody in order to receive and finance them, particularly residential treatment. Table 7 shows that about half of states (49 percent) reported court-ordered residential treatment to be somewhat or very common as a cause for custody relinquishment. FROs judged this is to be a more significant cause, with 79 percent reporting this to be somewhat or very common. A concern is that courts may order residential treatment or other services, even in specific facilities, without the input of mental health professionals or providers of intensive HCBS in the area. Judges may believe that the only way to ensure that children receive the treatment they need is by entering the custody of the state.
Table 8 shows the mean ratings across all of the categories of reasons for custody relinquishment. Although FROs rated all of them as more problematic than state agency respondents, their rank order of the various reasons is similar, with issues related to private insurance as the top reasons and issues related to public insurance being the lowest rated reasons for custody relinquishment.

These factors are similar to those identified in previous analyses. Although they may continue to set the stage for custody relinquishment today, this analysis found that they currently occur to a lesser degree. This is attributed to state efforts to eliminate this practice and to provide and finance needed services without resorting to custody transfer, as discussed in the following section.
Strategies to Prevent Custody Relinquishment

What Types of Strategies Are Needed?

As indicated by the scan, states have made progress in preventing custody relinquishment for mental health services. They have accomplished this by implementing strategies designed to address this, as well as strategies to increase the availability of the intensive HCBS more generally that can reduce the need for relinquishment. Both types of interventions are needed since, as noted by Stine, “just banning the practice closes one door to services without opening another” (Bazelon Center News, 2003). Although many states have implemented multiple strategies in each category to prevent custody relinquishment, they underscored the difficulties in eliminating the practice completely and the need for continuing efforts to address this complex challenge. Both types of strategies are described below, and Appendix A includes specific examples of strategies that were derived from the discussions with representatives from selected states.

What Strategies Are States Using to Prevent Custody Relinquishment?

Overall, nearly all states (90 percent) reported using at least one strategy to directly address the problem of relinquishing custody for mental health services (Table 9). These strategies can be grouped into four categories: 1) mandates or requirements that prohibit custody relinquishment for mental health services and their enforcement; 2) voluntary agreements that temporarily allow the state to provide care while parents retain legal custody; 3) policies, guidelines, and related training; and 4) diversion.

Mandates and Enforcement Strategies

In 2003, the GAO identified 13 states that had enacted legislation to prohibit state agencies from requiring parents to relinquish custody in order to obtain mental health services for their child. The informational scan indicated that today, about half of the states (26) have statutes specifically prohibiting this practice. An additional eight states reported having regulations that prohibit custody relinquishment, so that two-thirds (67 percent) of the states have statutes or regulations or both.

Voluntary Placement Agreements

A comparative analysis across states found that most states have statutes and/or regulatory policies allowing voluntary placements in child welfare without relinquishing legal custody (Jones, Kim, Hill, and Diebold, 2018; Hill, 2017). In this information scan, 52 percent of states reported using voluntary placement agreements (VPAs) for the specific purpose of preventing custody relinquishment solely for mental health services. Through VPAs, children enter the child welfare system to receive out-of-home treatment, but parents retain legal custody and typically remain involved in decisions about treatment, education, and other areas of their child’s life. The use of VPAs is considered preferable to transferring custody, since children can be served without severing legal ties with their families. However, these agreements still require entry into the child welfare system and an out-of-home placement. In some cases, the use of VPAs is required, and in others it is an option available to state agencies when there is no other recourse. Some states reported a requirement to exhaust all HCBS before a VPA can be considered. VPAs often require parents to provide financial support for the child’s care (including medical and dental health services) based on their income and insurance or other benefits they may receive for the child.

“At the same time that statutes, policy, or regulatory measures are developed, strategies are needed at the state level to implement the array of HCBS needed to reduce the need for custody relinquishment, and at the federal level to provide financing, TA, and other incentives and support for addressing custody relinquishment and implementing SOCs with intensive community-based services.” (GAO, 2003)
Policies, Guidance, and Training Strategies

Policies and guidance are tools to prevent custody relinquishment for services. Sixty-nine percent of states reported using executive orders, policy manuals, and guidelines with specific procedures to follow. These are often accompanied by training for staff and providers on how to avoid this practice, reported by 76 percent of states.

Diversion Strategies

The majority of states (78 percent) reported some type of strategy to divert children with mental health needs from entering the child welfare or juvenile justice system solely to obtain treatment, such as diversion protocols or programs and differential response.

- **Diversion Procedures and Protocols:** Some states have developed specific protocols to use in situations with a risk for custody relinquishment to obtain mental health services. Multi-agency teams were reported that review cases with a risk for custody relinquishment, or even for VPAs, and work to resolve system barriers and provide individualized HCBS that may avert the need for an out-of-home placement. Plans may include intensive care coordination, in-home mental health treatment, mobile crisis response and stabilization, parent and youth peer support, respite, and others. Other states have created specific programs to divert children from potential custody relinquishment while providing the services they need.

- **Differential Response:** Differential response is an approach based on the recognition that families coming into contact with the child welfare system have different needs and strengths, and therefore require tailored approaches to address their unique needs. Differential response (sometimes referred to as alternative, multitrack, or dual-track response) can be a vehicle for providing treatment and supports to children and families without transferring custody, whether or not investigations substantiate abuse or neglect (Administration for Children and Families, 2017).
What Strategies Are Being Used to Expand and Finance HCBS?

As noted, legislative, regulatory, and policy actions prohibiting the practice, and mechanisms such as VPAs are essential, but comprise only one piece of the puzzle in eliminating custody relinquishment to obtain mental health services. It is also critical to address the underlying issues that lead to custody relinquishment — the need for greater access to intensive HCBS. Thus, prevention strategies must be accompanied by efforts to expand the capacity to provide, and ensure payment mechanisms for, intensive HCBS that may keep children safely in their homes and communities while receiving needed treatment and supports.

A range of potential state strategies were included in the informational scan, and respondents indicated which they have used to help them build and finance an array of HCBS. It is important to note that, when HCBS cannot provide the treatment and safety needed in some cases, payment mechanisms are also needed to cover the costs of residential interventions to avert the need for custody relinquishment. The state strategies fall into four categories — SOC, Medicaid, cross-system, and local strategies. As shown in Table 11, the two categories used most frequently by states to expand the availability and accessibility of HCBS are SOC strategies and Medicaid strategies.

System of Care Strategies
The SOC approach was developed to address the many documented problems in serving children with serious and complex mental health conditions. The SOC approach calls for a broad array of effective services and supports for children with serious mental health conditions and their families that are grounded in the core values of community-based, family- and youth-driven, and culturally and linguistically competent services (Stroul, Blau, and Friedman, 2010; Pires, 2010). SOCs typically provide services including intensive care coordination using Wraparound, intensive in-home mental health treatment, mobile crisis response and stabilization, parent and youth peer support, and others cited in a joint bulletin issued by the Centers for Medicaid and Medicare Services (CMS) and SAMHSA in 2013. Both improved outcomes, and positive returns on investment have been documented for SOCs (Stroul, Goldman, Pires, and Manteufel, 2012; Stroul, Pires, Boyce, Krivelyova, and Walrath, 2014; U.S. Department of Health and Human Services, 2015). SOC implementation has been supported by federal grants through SAMHSA’s Children’s Mental Health Initiative.
As shown on Table 11, nearly all states (94 percent) reported developing SOCs as a strategy to increase HCBS. The vast majority have received SOC funding from SAMHSA at the state level, in local communities, and/or in tribes for this purpose, and many states have implemented and financed their own SOC development initiatives.

**Medicaid Strategies**

Previous analyses have emphasized the importance of Medicaid in preventing custody relinquishment (Bazelon Center, 2002). This scan also found that Medicaid has played a pivotal role in expanding HCBS, with 90 percent of states indicating that they have used one or more Medicaid strategies (Table 13). The EPSDT program in Medicaid was reported to be the most cited Medicaid strategy. It requires regular screening to identify health problems among children and mandates the provision of all Medicaid-covered treatment services listed in Section 1905(a) of the Social Security Act (U.S. Department of Health and Human Services, 2014), even if they are not included in the individual state’s Medicaid plan. Although EPSDT screening for mental health problems is variable across states and communities, 71 percent of states indicated that this authority has been used to increase availability and access to HCBS.

Various types of Medicaid waivers, options, and state plan amendments have also allowed states to develop and finance HCBS as alternatives to treatment in costly and restrictive service settings. Some types of new service delivery structures, such as health homes, were reported by nearly half of the states. The TEFRA (Tax Equity and Fiscal Responsibility Act or “Katie Becket Option”) allows states to make children with disabilities eligible for Medicaid regardless of their family’s income. However, only 13 percent of the states reported that this option is used to access the HCBS and residential treatment covered by Medicaid. In addition to the Medicaid strategies explored through the scan, all states have used the Rehabilitation Option to expand coverage of HCBS, and nearly all states have used Targeted Case Management as a vehicle to provide care management to specific populations.
Cross-System Strategies

As shown on Table 14, 83 percent of states reported using resources that are provided by various federal and state child-serving systems to build HCBS capacity. Most frequently used for this purpose are the SAMHSA Mental Health and Substance Abuse Block Grants received by states. These noncompetitive grants are allocated based on the population at risk, the cost of services, and the fiscal capacity of states to pay for services. A previous analysis similarly found that 89 percent of states allocated some Block Grant funds to children, and that the funds most commonly were used to fund services that were not covered by Medicaid or other sources and/or to fund services to children who were uninsured (Stroul and Le, 2013). State agency initiatives (mental health and others) were cited by 69 percent of the states, and the use of Title IV-E Waivers in child welfare by 63 percent. Education system strategies were reportedly used least frequently to build HCBS.

Which Appear to be Effective Strategies?

A comparison of the strategies used by states reporting that custody relinquishment never occurs, versus those reporting that the practice occurs frequently shows some differences (Table 15). The most significant is that the states with frequent relinquishment (6 percent of states) have no mandates (statutes or regulations) or policies, while the majority of states indicating no relinquishment (13 percent of states) have these provisions in place. This suggests that some type of requirement and/or explicit, formalized policy can have an impact. In addition, greater monitoring was reported in states indicating no occurrence.

As shown on Table 16, the strategies used by both groups to build HCBS are fairly consistent, with SOC, Medicaid, Block Grant, and state mental health and other state funds reported to be the strategies used most frequently by both groups. A difference between groups is that child welfare strategies are used in half of states with no occurrence, and not at all in states with frequent occurrence. However, given the small number of states in each category, it is difficult to reach definitive conclusions.

Child welfare agency, mental health agency, and FRO interviewees all emphasized that an effective approach to eliminating this practice requires multiple strategies in each of these areas, and that it is the synergistic effect of strategies in combination that has the greatest impact.
Relinquishing Custody for Behavioral Health Services: Progress and Challenges

Table: 15 Custody Prevention Strategies in States with No vs. Frequent Occurrence

<table>
<thead>
<tr>
<th>Strategy</th>
<th>No Occurs (N=6)</th>
<th>Frequent Occurs (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandates</td>
<td>0%</td>
<td>67%</td>
</tr>
<tr>
<td>Policies</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Training</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>VPAs</td>
<td>33%</td>
<td>83%</td>
</tr>
<tr>
<td>Diversion</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Monitoring</td>
<td>100%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table: 16 HCBS Strategies in States with No vs. Frequent Occurrence

<table>
<thead>
<tr>
<th>Strategy</th>
<th>No Occurs (N=6)</th>
<th>Frequent Occurs (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>System of Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Block Grant</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Child Welfare</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>BH/Other State</td>
<td>0%</td>
<td>33%</td>
</tr>
<tr>
<td>Education</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Local</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>50%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Recommendations and Technical Assistance Needs

Despite progress and a reduction in relinquishing custody as a means to access and finance services, the information obtained, along with follow-up discussions, found that custody relinquishment still occurs. Recommendations for addressing this follow.

Recommendations

The recommendations for preventing the practice of trading custody for care include strategies to both directly address the practice and strategies to increase the availability, accessibility, and financing of intensive HCBS that can avert the need for relinquishment to obtain care. Neither of these alone is sufficient to eliminate the practice. It is only when they are combined that custody relinquishment can be removed as an option when the need for mental health care is the only purpose, while at the same time meeting the child’s and family’s needs with a full range of intensive treatment and support services, including residential interventions when indicated.

Strategies to Directly Address Custody Relinquishment

1. **Implement Mandates:** Implement requirements in the form of statutes or regulations that prohibit custody relinquishment solely to obtain mental health services and supports and that prohibit making access to and/or public funding for services (particularly residential treatment) contingent on being in state custody. Accompany these requirements with monitoring to ensure that state and local agencies comply.

2. **Implement Specific Diversion Processes:** Implement processes for responding to situations with a risk of custody relinquishment for mental health services to identify alternatives and remove barriers to care to divert children from entering the child welfare or juvenile justice system, e.g., protocols, review teams, consultation to juvenile courts about treatment options, diversion to mental health courts, etc.

3. **Provide Training:** Conduct training for key constituencies on requirements, policies, and protocols that address custody relinquishment for mental health services, including training for mental health, child welfare, and juvenile justice staff; judges; Medicaid agencies; and inpatient psychiatric staff. Conduct training for family and youth organizations and leaders on their rights and options available to them to avoid custody relinquishment.

4. **Create Voluntary Placement Options:** Create a voluntary agreement option that allows the state to provide and finance services temporarily without transfer of legal custody and with parents or legal guardians remaining involved in decisions about treatment, education, and other areas of their child’s life. While not ideal, VPAs offer a preferable alternative to transfer of custody.

5. **Prevent Families from Being Penalized:** When VPAs are used, or in instances in which custody relinquishment does occur solely for treatment, ensure that parents are not charged with abandonment, placed on child abuse and neglect registries in the absence of maltreatment, or are subject to any other types of penalties.

6. **Collect and Review Data on Custody Relinquishment:** Systematically track the frequency of custody relinquishment solely for mental health services (and other maltreatment reasons), why it occurred, and what strategies or services could have prevented it from happening. Review the data with an oversight body to better understand the extent and reasons for relinquishment and to develop and implement solutions.

7. **Work with Psychiatric Hospitals:** Implement procedures to work with inpatient psychiatric hospitals and units to connect them with intensive HCBS post-discharge to reduce both referrals for residential treatment and parents being charged with abandonment by refusing to take their children home.
8. **Involve Family Members and Youth in Problem Solving:** Involve family and youth organizations and leaders in identifying the circumstances that lead to custody relinquishment and what measures and strategies they recommend for eliminating the practice.

**Strategies to Increase Availability, Access, and Financing of Intensive HCBS**

1. **Implement Comprehensive SOCs:** Provide resources to implement SOCs broadly across states, communities, tribes, and territories that provide intensive HCBS, such as intensive care coordination using the Wraparound process, intensive in-home mental health treatment services, mobile response and stabilization, parent and youth peer support, respite, etc. This may include redirecting resources currently being spent by child-serving systems on high-cost, out-of-home services to lower-cost HCBS and identifying new resources to expand SOCs. Ensure that residential interventions are available to children who meet the clinical criteria for these services, that it is used to achieve specific short-term treatment goals, and that it is linked to intensive HCBS in SOCs for ongoing treatment.

2. **Use Existing Financing Streams:** Maximize the use of existing financing streams to ensure access and payment for needed mental health services, such as the Medicaid EPSDT program to screen for mental health conditions and provide needed services, and resources available under IDEA.

3. **Identify Payment Sources for Services:** Ensure that payment sources are available to cover the costs of intensive HCBS and residential interventions when indicated, so that children and families receive services based on clinical need. This may include: 1) ensuring that these services are covered under Medicaid through state plans, waivers, options, state plan amendments, and other authorities; 2) expanding eligibility for Medicaid and CHIP; 3) ensuring that medical necessity criteria do not inappropriately restrict payment for intensive mental health services; 4) allocating state agency funds to pay for services not in the benefit packages of Medicaid or commercial insurance; 5) allocating state agency funds for services to children who do not qualify for Medicaid; and 6) blending funds among partner agencies to provide match for increased federal funds to invest in HCBS. Collect data on effectiveness and ROI in intensive HCBS across child-serving agencies to support the allocation of funds.

4. **Work with Commercial Insurers:** Reach out to commercial insurers to encourage coverage for intensive HCBS under private insurance plans. Provide data on effectiveness and ROI in intensive HCBS.

5. **Involve Family Members and Youth:** Involve family and youth organizations and leaders in planning, implementing, and financing HCBS to determine their needs; barriers to accessing and financing care; and the effectiveness of strategies to increase availability, access, and payment for services.

**Technical Assistance Needs**

Child welfare, children’s mental health, and FRO respondents identified a number of areas in which technical assistance (TA) could be helpful to address custody relinquishment for mental health services. Examples include information, strategies, and assistance in the following areas:

- **Best Practices:** Identifying effective strategies used by states to avoid custody relinquishment, including examples of statutes, rules, regulations, and guidelines; diversion protocols for mental health, child welfare, and juvenile justice systems; and training approaches.

- **Cross-System Process:** Convening groups of key partners to strategize about eliminating custody relinquishment solely to receive mental health services.

- **Data Collection:** Identifying and collecting data on custody relinquishment for mental health services and the reasons the practice occurs and using data to develop solutions.

- **Intensive HCBS:** Implementing specific HCBS, including mobile response and stabilization services, intensive care coordination using Wraparound, intensive in-home mental health treatment, parent and youth peer support, short-term residential interventions, etc.
Financing HCBS: Financing HCBS, working with commercial insurers to cover HCBS, financing residential interventions, financing services for children and families not covered by Medicaid, financing services not covered by Medicaid, etc.

Training for Families and Youth: Educating and training family and youth organizations and leaders about VPA and their rights and options other than custody relinquishment, and on how to provide information and peer support to other families in this situation.

As noted by Seltzer (2004), “custody relinquishment is not a rational choice — and it is no choice at all for families.” The strategies identified by states through this project are having an impact in reducing custody relinquishment for the sole purpose of obtaining mental health services. Although this is occurring less frequently, if it does occur, it remains a tragedy. It is hoped that these strategies identified through this project will assist states, tribes, and territories to eliminate this practice completely.

“The practice of requiring parents, who have exhausted all other resources, to relinquish custody in order to obtain essential mental health services for their children must cease. ... Families must have ongoing access to a wide range of assistance, including HCBS, culturally relevant spiritual healing, as well as traditional clinical mental health treatments and appropriate special education services necessary for a child to remain in their neighborhood and live with the family that will love and care for them as no one else ever
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Appendix A: State Strategies to Address Custody Relinquishment

State-Specific Analyses

Concern about custody relinquishment led to studies and analyses in states that have been conducted by state legislatures, law centers, and FROs to determine the extent and causes of the problem and to recommend solutions:

- **Maryland Coalition of Families for Children’s Mental Health**: The Maryland Coalition conducted a study and found that many families were told that they could access needed services by relinquishing custody. A total of 27 percent of parents surveyed were advised to relinquish custody and/or to refuse to bring their children home from hospitals. This advice came from professionals such as social services staff, therapists, and hospital staff, as well as from advocates, relatives, and friends. The Coalition found that custody relinquishment occurred primarily in two types of situations — in order to qualify for Medicaid or other child-serving agency resources to pay for costly services including residential treatment, and when families felt that they could no longer manage their child at home and could only obtain out-of-home treatment by transferring custody to the state. The came to conclusions that likely applied to other states: 1) families do not want to give up custody and try to seek help, but are exhausted and hopeless; 2) children in this situation have serious and complex mental health conditions; 3) caring for these children can be financially devastating for families that must pay for intensive services that they cannot afford and that are not covered by insurance; 4) advising families to relinquish custody is a common practice; and 5) custody relinquishment for this purpose is a major policy issue that warrants a high priority (Maryland Coalition of Families, 2002).

- **Virginia Legislature**: In 2004, the Virginia General Assembly ordered the formation of a state executive council to investigate the reasons for custody relinquishment solely to obtain mental health services and to recommend policy options to abolish this practice. The primary conclusion was that “this problem is a direct result of inadequate access to and availability of prevention, intervention, and intensive mental health and substance abuse treatment for children and adolescents” (Virginia General Assembly, 2004; 2005). The council found that: 1) for a significant number of families, custody relinquishment was the only way to obtain services; 2) negative consequences for families, children, and communities were severe and devastating; 3) primary reasons are related to lack of funding or inadequate insurance coverage for mental health treatment; and 4) adequately funding the state’s service system would significantly improve access to treatment and eliminate the need for custody relinquishment. Changes in code, regulation, policy, and practice were deemed necessary to improve access to mental health services and reduce the effects of custody relinquishment. Recommendations included: working with the state Bureau of Insurance to include coverage for intensive HCBS in private insurance; developing a method to track the incidence of this problem; developing a full continuum of mental health treatment services; training localities on the use of voluntary agreements; and expanding financing for mental health services. A follow-up report found that some communities were still requiring parents to relinquish custody to obtain mental health services, primarily to obtain residential or longer-term treatment services than those offered in the community. Non-custodial VPAs were an option rather than relinquishment of legal custody, but this vehicle was not being used in some communities. These reports have led to measures to ensure greater access to services without relinquishing custody (Virginia General Assembly, 2007).

- **Utah Disability Law Center**: In Utah, the Disability Law Center interviewed parents and staff from state agencies to explore situations in which families were told that their only option to obtain services was to relinquish custody. The frequent crises experienced by their children with serious mental health conditions were cited as a contributor, as well as the inability of families to pay the significant costs incurred for
mental health services. Custody relinquishment was seen as the only way for the child to qualify for Medicaid and access the array of services covered through the state’s Medicaid program. It was determined that many families were facing this decision, and at that time, state agencies were not collecting data to track the extent of the problem (Disability Law Center, 2007).

- Texas Legislature: The Texas legislature required an assessment to examine this problem and to develop recommendations to prevent parents from relinquishing custody of their children with serious mental health conditions. The study found that cost was the primary barrier to families in accessing services, along with other difficulties in obtaining help and navigating systems. The report noted that families that relinquished custody for the purpose of receiving mental health treatment were then placed on the state’s child abuse registry, which had significant implications for their lives, particularly for their employment. The assessment concluded that the treatment of SED is a public health issue rather than a child protection issue, and that families should be able to access the services and supports that are most useful to them, such as Wraparound, care management, psychiatric services, in-home care, and emergency services (Faulkner, Gerlach, Marra, Gomez, and Schwab, 2014).

- NAMI Ohio: A 2005 report indicated that over 1,000 families in Ohio relinquished custody of their children to the state to obtain mental health treatment. Several reasons for this were cited: 1) private insurance does not cover intensive services or imposes limits on the type and duration of services; 2) publicly funded services are not available or are insufficient, and 3) intensive treatment is expensive — whether provided in homes, hospitals, or residential treatment centers (RTCs). It was concluded that HCBS be expanded, while at the same time prohibiting agencies from requiring parents and caregivers to relinquish custody solely to obtain needed mental health services and supports.

Strategy Examples

Mandates and Enforcement Strategies

<table>
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<th>Illinois</th>
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<td>A Custody Relinquishment Prevention Act went into effect in Illinois in 2015 to establish a pathway for families to obtain services for their child’s serious mental illness (SMI) or SED through the appropriate child-serving agency without relinquishment of parental custody. The act required the child-serving agencies (child welfare, mental health, juvenile justice, public health, Medicaid, and education) to enter into an intergovernmental agreement to prevent children who are not abused or neglected from entering state custody solely for the purpose of receiving treatment. The agreement required the agencies to establish an interagency clinical team to review cases of children and youth who are at risk of relinquishment and connect them and their families with services, treatment, and support to stabilize the child’s or youth’s SMI or SED and prevent custody relinquishment, including a crisis stabilization assessment and plan of care, intensive community-based services, or a short-term residential placement. An annual report was required to provide, among other data, the number of children who were relinquished to the state for purposes of receiving treatment for their SMI or SED, the number of children who were intercepted, and the services they were connected with to prevent custody relinquishment and to stabilize the child. (<a href="https://www.illinoislegislature.com/History/Statutes/2015-16/FullText/House/098/0808.aspx">Public Act 098-0808)</a></td>
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<th>Connecticut</th>
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<td>The state’s Department of Children and Families has a statutory mandate specific to children’s behavioral health. Regulations prohibit transfer of custody to the state for children requiring community-based services or temporary placement in residential services, thereby preventing them from entering state custody as neglected, uncared for, or dependent. This is designed to “encourage the preservation and enhancement of family relationships and the continuing rights and responsibilities of parents” whose financial resources prevent them from obtaining treatment for the child. A 2013 statute states that the agency is not required to seek custody of any child or youth with mental illness, emotional disturbance, a behavioral disorder, or a developmental or physical disability for the purpose of accessing an</td>
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out-of-home placement or intensive outpatient services, including residential treatment programs, therapeutic foster care programs, and extended day treatment programs, and that commitment to the agency cannot be a condition for receipt of services delivered or funded by the department. (Gen Stat 17a-129)

**Indiana**

A statute enacted in 2001 specified that the child welfare agency “may not initiate a court proceeding to terminate parental rights or transfer legal custody, or require a parent to agree to the termination of parental rights or transfer of custody” as a condition for receiving services delivered or funded by the agency.” The bill addressed the needs of children with severe emotional, behavioral, or mental disorders whose parents were financially unable to access needed treatment — whether treatment is in a residential treatment facility or in the community. VPAs were also authorized. ([Indiana Code 31-34-1-16](https://www.leg.mt.gov/Laws/Code/31/31-34/c31.34.1.16.html))

**North Dakota**

A 2015 statute requires a program to provide out-of-home treatment services for Medicaid-eligible children with a serious emotional disorder and states that “the department may not require a parent or legal guardian to transfer legal custody of the child in order to have the child placed in an out-of-home treatment program when the sole reason for the placement is the need to obtain services for the child’s emotional or behavioral problems. With departmental approval, a parent with legal and physical custody of the child may obtain services for the child through the program.” An application is submitted, typically by a care manager, and if approved, the child is eligible for state funds to pay for a placement for treatment purposes. ([North Dakota Code 50-06-06.13](https://legis.nd.gov/statutes/50-06-06.13.html))

**Voluntary Placement Agreements**

**Minnesota**

In Minnesota, VPAs (referred to as “Voluntary Foster Care Agreements”) were created by statute in 2008 to provide out-of-home treatment without custody relinquishment. The law distinguishes placements necessary to access treatment from child protection placements. The purpose of the law and accompanying policy is to: 1) ensure that a child with a disability is provided with the services necessary to treat or improve the symptoms of their disability; 2) preserve and strengthen a child’s family ties; 3) approve a child’s placement away from their parents only when their need for care or treatment requires it and he/she cannot be maintained in the home of the parents; and 4) ensure that a child’s parents retain their rights and responsibilities during placement, including actively planning with the agency to make treatment decisions. When county or tribal social service agencies and parents agree that placement is needed for a child, the parents and agency sign a VPA agreeing that the child needs residential treatment based on a level of care determination. Agencies are required to make reasonable efforts to ensure that children’s treatment needs cannot be met through home-based care. The VPA gives the agency the authority to place children for treatment, and parents retain legal custody and associated decision-making authority while their child is in care. Agencies, parents, and children jointly develop out-of-home placement plans. A detailed “Notice to Parents Considering Voluntary Foster Care for Treatment” outlines the rights and responsibilities of the parents, including actively participating in: 1) developing an out-of-home placement and treatment plan; 2) providing educational, medical, and dental services; 3) ensuring contact and visitation to maintain the child’s connection to the family; and 4) supporting the child financially based on any income, benefits, insurance, or child support that the child or family receives. A specific agreement has been developed for American Indian children in voluntary care for treatment. Court reviews of voluntary placements occur when children have been in placement for 165 days, and permanency reviews are required when children have been in voluntary care for 13 months, with annual reviews thereafter. When the court finds that the agency and parents are planning together to meet the child’s need for safety, stability and permanency, the voluntary placement is continued. Parents or the agency may end voluntary placement for treatment with written notice. Parents of American Indian children may end voluntary placements on demand. ([2019 Minnesota Statutes 260c.277](https://www.revisor.mn.gov/statutes/cite/260c.277.html))
Oregon

Parents or legal guardians can enter into an agreement to place a child with the state to obtain care or services without relinquishing custody. Under the VPA, the parent or legal guardian retains legal authority over the child and continues to exercise and perform all parental authority and legal responsibilities, except those specifically designated to the state in the VPA. A VPA must be used in all cases in which the sole purpose for placing the child in a foster care, group home, or institutional setting is to obtain services for the child’s emotional, behavioral, or mental disorder or developmental or physical disability. Parents must agree to provide information about insurance and other financial resources to meet the child’s medical, dental, and mental health needs; cooperate fully in making decisions for the child based on the child’s identified needs; and visit and financially support the child to the fullest extent possible. A family support services case plan is developed that guides the services provided while the VPA is in effect. If the child remains in placement for more than 180 days, the juvenile court reviews the case to determine if the placement is in the best interests of the child, and a permanency hearing is required after 14 months and every 12 months thereafter. Either the Department or a parent who signed the VPA may terminate the agreement by providing 48 hours’ written notice. If the child is an American Indian child who is an enrolled or eligible member of an Indian tribe, each parent or Indian custodian who has legal custody of the child must sign the VPA in a hearing before a judge of a court with appropriate jurisdiction. (Oregon Administrative Code, 413-020-1030 et seq.)

Connecticut

A Voluntary Services Program provides services for children or youth requiring community-based treatment or temporary residential or other out-of-home placement who might otherwise be committed as neglected, uncared for, or dependent to obtain services from the state. The program is designed to encourage the preservation and enhancement of family relationships and the continuing rights and responsibilities of parents, even though limited financial resources prevent them from providing the required care and treatment for their child. In order to be eligible, the child must: 1) have an emotional, behavioral, or substance use disorder, and the alleviation of this disorder is the primary purpose of the request for voluntary services; 2) the child’s treatment needs cannot be met through services currently available to the parent or guardian; and 3) the disorder can be treated within the resources available to the department. In addition, the department must determine that out-of-home placement is the least restrictive alternative for treatment, the parent or guardian will be an active participant in all aspects of the planning and treatment process, and there is a reasonable expectation that the child or youth will return to the parent or guardian when the service plan is completed. Following an assessment and development of a case plan, services are provided by the department, including public or private community services and/or placement in a resource or facility. Parents or legal guardians are expected to be active participants in the case plan, with the goal of maintaining the child in the home or reunifying the child with the family; meet regularly with staff and service providers to monitor progress; attend therapy or treatment sessions as appropriate; attend court hearings; provide transportation for the child to service providers or leaves from residential facilities; and make financial contributions toward the costs of services if determined capable. Court review must occur within 180 days of admission into the program and on an annual basis thereafter.
**Policies, Guidance, and Training Strategies**

**Maryland**
In 2003, the governor signed an executive order establishing a Council on Parental Relinquishment of Custody to Obtain Health Services that was charged with identifying alternatives to the practice of relinquishing custody of children who have significant and complex mental health needs and/or developmental disabilities for the purpose of accessing needed services (Executive Order 01.01.2003.02). Legislation also was passed in 2007 implementing VPAs and requiring that the local departments of social services review all VPA requests and make reasonable efforts to prevent placement. The state also prohibited families from being placed on the Child Abuse and Neglect Central Registry when they refuse to take a child home from a psychiatric hospital or other facility because of a reasonable fear for the safety of their child or other family members. Regulations, policies, and trainings have followed. ([COMAR 07.02.11.06](https://www.maryland.gov/Regulations/COMAR) and [MD Code, Family Law, § 5-524 et seq](https:// LegiFile.laws.maryland.gov/))

**North Dakota**
A manual ([Mental Health Services Voluntary Out-of-Home Treatment Program](https://www.mentalhealth.org)) was published in 2006 with protocols and procedures for voluntary out-of-home treatment for children with SED. The guidelines are intended to provide parents with an option for accessing out-of-home treatment for their children without relinquishing legal custody. The program is administered collaboratively by the child welfare and mental health agencies and pays for the maintenance costs of the treatment episode while Medicaid pays for the treatment costs. Through these protocols, parents or legal guardians retain legal authority and are obligated to perform all parental duties and legal responsibilities. The parents are required to remain involved and work with the agency to develop and implement a plan for the return of the child to their home with appropriate supports in place, including intensive care coordination/case management. The policy requires the agency to form a team to review applications for the program that includes, at minimum, a member experienced in child protection services and an experienced mental health professional. The behavioral health agency provides training, TA, and case consultation to prevent out-of-home placements, out-of-state placements, and custody relinquishment.

**Diversion Protocols and Differential Response Strategies**

**Missouri**
A [Custody Diversion Protocol](https://www.childwelfare.gov) was developed to divert youth from entering or remaining in state custody solely to access behavioral health services. It was developed jointly by the child welfare and mental health agencies, the courts, and family members. It was implemented statewide in 2005 and revised in 2015, and a current revision is in process. The protocol includes a flow chart and step-by-step process for diversion, and extensive training was provided to ensure that appropriate services from the mental health system are provided to avoid relinquishment. The protocol is not applicable if there is a recent child abuse or neglect allegation and the child’s safety cannot be assured, or if the allegation is likely to be substantiated.

A VPA was also implemented that can only be used in conjunction with the Custody Diversion Protocol. The VPA allows state funding of out-of-home placements for 180 days without relinquishing custody if an assessment determines that this level of care is needed. The mental health provider is responsible for locating and monitoring an appropriate out-of-home placement. As of the end of 2006, 90 percent of children assessed were diverted from state custody. Of those diverted, 51 percent were served in their homes with community-based services, and 49 percent received out-of-home services. It was concluded that children can be diverted from state custody if there is effective communication across child-serving agencies and sufficient resources to respond to families’ needs. In addition, an interagency group was convened to develop a protocol for transferring custody to parents of children already in state custody. It was found that with interagency collaboration, children in state custody can be returned to their parents’ custody while still receiving the mental health services they need. Local interagency teams and extensive staff training were considered critical to the success of these efforts.
Texas
In 2014, a pilot program (referred to as the Residential Treatment Center (RTC) Relinquishment Avoidance Project) was implemented whereby the state can procure and fund beds in RTCs without transfer of legal custody. Funding for the program initially supported 10 beds per year and, by 2017, increased to finance 30 beds to serve approximately 60 children per year for lengths of stay of up to six months, with the flexibility to extend if a child requires a longer stay. The state contracts with multiple private RTCs to provide this service. Referrals to the program can only come from the child welfare system. Abuse or neglect must be ruled out, and referrals must be reviewed by a mental health professional and include an assessment using the Child and Adolescent Needs and Strengths (CANS) to determine if the child meets the criteria for residential treatment. Further, if it is determined that the child and family have not yet received intensive HCBS, they may be referred for HCB interventions prior to pursuing residential treatment, if appropriate. Parents must agree to participate in treatment, such as weekly family therapy, as well as agreeing that the child will come home following treatment. The local mental health authority remains involved during treatment through regular contact between the care coordinator and the facility to discuss treatment needs, progress, and discharge plans. In addition, the local mental health authority assigns a family partner to the family to provide peer support. Between the inception of the program in January 2014 and July 2016, 89 percent of referred children were diverted from custody relinquishment. Training is provided to both child welfare and mental health staff on the referral process for these services, as well as the services and supports needed when children are discharged and returned to their families.

Indiana
A Children's Mental Health Initiative was implemented in Indiana with a primary objective of allowing families to access needed services so that children do not enter the child welfare or juvenile probation system for the sole purpose of accessing services. Other objectives are to ensure that children with SEDs receive services from the appropriate system and to construct a multiagency approach for children within communities to achieve the best outcomes. The service array includes Wraparound services, skill building, therapeutic services, clinic-based services, and residential services when indicated.

Connecticut
In 2012, Connecticut implemented a Differential Response System (Family Assessment Response) that is a strength-based, family-centered approach based on partnerships and collaboration between families, the child welfare system, and other community providers. Following a safety assessment and determination that the children in the home are safe, the intervention shifts to identifying strengths, needs, and formal and informal services and supports. Families are given access to and linked with a broad array of services and resources in their communities to address their identified needs, including flexible funding. The Family Assessment Response shares many of the same principles of a traditional investigation (e.g., focus on safety and well-being of the child), but the model allows services to be provided without a determination of abuse or neglect. By allowing services without a determination of maltreatment, and by offering individualized services, the differential response approach can be used to meet children’s treatment needs without relinquishment of custody.
Statewide System of Care Strategy

**New Jersey**

New Jersey has combined SOC, Medicaid, and cross-agency collaboration and financing strategies to create a statewide SOC (Children’s System of Care - CSOC) that provides comprehensive behavioral health services to children and their families. In the past, residential treatment could only be accessed through the child welfare system, and custody relinquishment was common in order to obtain and pay for these services. By creating the SOC, the state moved behavioral health services out of the child welfare system, and one of the premises of the state’s SOC is that custody relinquishment to obtain services should never occur. A 2000 concept paper, developed with family members, led to the development of the SOC approach involving care management organizations in each county that manage care for children with serious and complex conditions and their families. The SOC was sequentially implemented in the state over a period of approximately five years. The SOC provides intensive HCBS to any child who needs them, regardless of ability to pay or payment source. Services are provided based solely on clinical need, not ability to pay. The system has been described as “payment blind,” in that those with private insurance, Medicaid, or no coverage at all have access to the same services and receive needed care. A comprehensive array of HCBS is provided, including residential treatment when indicated based on clinical necessity, mobile crisis response and stabilization services that are available to all children, and intensive care coordination. Mobile response and high-fidelity Wraparound are considered the drivers used to assist families to keep their children at home safely. Through the SOC, 89 percent of children are served in their own homes, and the use of residential treatment and length of stay in RTCs have both been reduced by half. By creating the statewide SOC, the child welfare system no longer needs to be involved in providing behavioral health services, allowing it to focus on its mission of abuse, neglect, and permanency. The SOC has evolved since its implementation and now includes children and youth with developmental disabilities and substance use disorders.
Appendix B: Tribal Issues in Custody Relinquishment to Meet the Mental Health Needs of American Indian/Alaska Native Children

By Terry Cross, MSW; David Simmons, MSW; Rosella Stanley, MSW; and Adam Becenti, MPP

The practice of families relinquishing custody solely for the purpose of obtaining mental health services for their children has been studied by such organizations as the Bazelon Center for Mental Health Law (2000) and the U.S. General Accounting Office [GAO] (2003). None of the previous analyses of this practice addressed tribal issues, and no systematic examination of custody relinquishment for mental health services has been conducted in Indian Country. The National Indian Child Welfare Association (NICWA) conducted a special analysis to explore custody relinquishment by families and/or tribes for treatment. The analysis was undertaken in conjunction with a national analysis to systematically obtain current information about the practice that was conducted by the Institute for Innovation and Implementation at the University of Maryland School of Social Work (Stroul, 2019; Stroul, 2020).

For American Indian and Alaska Native (AI/AN) families, custody relinquishment for mental health services is considered especially troubling and more challenging to address due to the complexities of federal Indian policy, jurisdictional issues, tribal-state relations, federal laws governing the custody of AI/AN children, and funding for mental health services in states and tribes. To elucidate these issues, this explored the reasons for custody relinquishment of AI/AN children and the implementation of strategies to prevent this practice in tribes. This document summarizes the findings and offers recommendations.

Reasons for Custody Relinquishment of AI/AN Children

Similar to findings in the national analysis, the reasons for custody relinquishment in tribes are primarily the lack of home- and community-based services and supports (HCBS) and the lack of payment mechanisms for intensive services, including residential treatment.

- **HCBS Issues**: Tribes have had few opportunities to develop HCBS, and the lack of availability and accessibility of these services contributes to the risk for custody relinquishment. Systems of care (SOCs) offer an approach that reduces the need for custody relinquishment by providing intensive HCBS. Since the 1990s, the Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded grants to states, communities, tribes, and territories to develop SOCs through its Children’s Mental Health Initiative (CMHI) and has invested in helping tribal grantees overcome significant obstacles to the development of culturally appropriate SOCs. Additionally, the Bureau of Indian Affairs (BIA) launched the Tiwahe Initiative designed to help tribes integrate services including child welfare, and bring more HCBS to Indian Country. However, HCBS are the exception rather than the rule, and lack of access to such services in Indian Country is a significant factor contributing to parental loss of custody.

- **Private Insurance Coverage Issues**: Some American families may experience a loss of custody when their private insurance has inadequate coverage for HCBS; however, AI/AN families are unlikely to have insurance at all. Studies have found that 34 percent to 50 percent of AI/AN individuals are uninsured (Kaiser Family Foundation, 2013; U.S. Department of Health and Human Services, 2014). Although many people may think that AI/AN populations receive free health care that is responsive to a broad range of needs through the Indian Health Service (IHS), there are barriers to receiving these services. First, IHS services are provided only at IHS facilities, which may not be accessible to all families. Additionally, the agency’s website explains that IHS is not an insurance program, does not provide a benefits package, cannot guarantee funds, and covers only an estimated 60 percent of health care needs. As a result, only the most severe conditions are treated, and mental health has been a low priority (Indian Health Service, 2020). IHS also states that it is the provider of last resort, such that IHS resources can be accessed only after all
other sources have been exhausted. Thus, the low rate of private insurance among AI/AN children, coupled with inadequate funding through the IHS, results in their families being especially vulnerable to losing custody.

• **Tribes and IDEA**: IDEA was signed in 1975 to ensure that students with disabilities (including AI/AN children) receive a free and appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living. However, access to services under IDEA for AI/AN children with mental health conditions varies across the nation. Educational structures for AI/AN children (e.g., school districts, funding mechanisms, and governance) are not consistent and are dependent on a number of complex jurisdictional and historical policy issues. AI/AN students may attend non-Indian schools near the reservation, federally funded and operated schools, or tribally operated schools. Resources, governance structures, funding streams, policy, and local relationships all contribute to the extent of implementation of IDEA in Indian Country. Thus, local variability in access to HCBS through IDEA likely contributes to custody relinquishment for AI/AN families.

• **Coverage of Behavioral Health Services under Medicaid and the Children’s Health Insurance Program (CHIP)**: Medicaid can be billed as an insurance company by IHS and tribal health facilities. Additionally, having Medicaid or CHIP coverage provides AI/AN individuals with more options and flexibility for accessing health care, as they can use this coverage for health care services provided outside of IHS or tribal facilities. However, tribes are dependent on the applicable state’s Medicaid plan, which specified what services are covered. If residential treatment and/or intensive HCBS are not approved under the state Medicaid plan, a tribal program cannot be reimbursed for the cost. The risk for custody relinquishment increases under these circumstances.

• **Jurisdictional Issues in Commitment of Children to Custody**: Child custody is a civil regulatory matter, and tribes retain original jurisdiction over civil regulatory matters. However, this is complicated by jurisdictional issues that determine which courts and judges can or cannot commit children into custody. About two-thirds of tribes in the United States have tribal courts; those that do not relinquish jurisdiction to the state by default. Further, [Public Law 280](http://example.com) (a federal statute on jurisdiction with respect to tribes) gives state courts concurrent jurisdiction over child custody, unless the tribe has assumed exclusive jurisdiction. Therefore, depending on the jurisdiction, the judge making the decision regarding custody relinquishment may be tribal or state. In some cases, where a tribe has custody (as in a child welfare placement or guardianship), the tribe may have to transfer custody to the state in order to secure funding for residential placements. These jurisdictional issues are major factors in custody relinquishment for AI/AN families and are highly variable across tribes based on specific jurisdictional law and individual judges.

**Strategies to Prevent Custody Relinquishment**

The national scan explored strategies used by states to directly address custody relinquishment and to expand HCBS. For the most part, there is little or no evidence of their application in tribes or that the unique circumstances of tribes have been considered in their development or implementation. The use of these strategies by tribes is discussed below.
Mandates:
There is no evidence that tribes have developed rules, regulations, or statutory codes regarding custody relinquishment to obtain mental health services. Child welfare representatives in the two states explored for this analysis (Oregon and South Dakota) indicated that there are no state rules/regulations that specifically prevent relinquishment of custody of AI/AN children in their respective states. Based on Oregon’s experience, tribal children appear to benefit when the state in which they reside has clear rules and regulations regarding custody relinquishment.

Voluntary Placement Agreements (VPAs):
Voluntary placement appears to be the primary method used for tribal children to avert relinquishing custody for the purpose of receiving mental health services. However, the implementation of voluntary placement is challenging in the context of the Indian Child Welfare Act (ICWA) requirements, which are discussed below. In Oregon, when tribal youth need intensive services, their parents or guardians can use a state hotline to reach the Oregon Department of Human Services (DHS). If a need for services such as residential treatment is identified, the parents/guardians can sign a voluntary agreement with DHS to place the youth in temporary state custody. Children receive the services, and parents/guardians are not billed for them. Parents/guardians can revoke or terminate this agreement at any point at which they feel uncomfortable, but mental health services will then not be funded by the state. If parents/guardians decide not to transfer custody of their youth, DHS can still wrap services around the youth and family, but these may not meet the level of need or be available in the family’s area.

Policies/Guidance/Training:
There is no evidence that tribes have developed written policies or guidelines regarding custody relinquishment for mental health services or that tribes are receiving any training or technical assistance (TA) on strategies to prevent custody relinquishment. Some state policies governing custody may consider tribes. For example, in Oregon, when a tribal family attempts to access state mental health services, the Oregon DHS administers a family support assessment to gather information. If it is discovered that the family is a tribal member, DHS notifies the appropriate tribal child welfare office within 24 hours, and the state will not proceed with the child welfare case until consent is obtained from the tribe.

Diversion:
Specific protocols to divert children from entering custody to receive mental health services were not identified in tribes. The national scan found that some states have differential response programs in their child welfare systems that use a screening process to direct families to appropriate services, without their children entering state custody (Administration for Children and Families [ACF], 2017). Many tribes use in-home service models to prevent placement, but few, if any, have structured differential response or other programs directed at providing mental health services without custody relinquishment.

Strategies to Expand and Finance HCBS
SOC Strategies:
- **Federal SOC Grants**: Through its CMHI, SAMHSA has funded tribal entities to plan and implement culturally competent SOCs. While these grants have been received by a modest share of the 567 federally recognized tribes, the approach has demonstrated that a holistic and collaborative SOC approach is effective for tribal children and families. The tribal SOCs provide HCBS that may include clinic or school-based counseling, intensive care coordination using the Wraparound process, intensive in-home services, mobile crisis and stabilization services, respite care, and others. A significant barrier is that few tribes have the resources to finance these services, and many have not been able to sustain their SOCs beyond the period of federal funding, unless they have been able to leverage Medicaid and other financing streams.
• **SOC-Related Policies and Statutes:** No tribes have been identified that have statutes related to the SOCs; however, several tribes with current or previous SAMHSA grants have SOC policies to increase access to HCBS that may reduce the need for custody relinquishment.

**Medicaid Strategies:**

• **Medicaid in Tribes:** Tribes are not currently eligible to operate Medicaid programs. In states with positive tribal state relationships, tribes have gained access to Medicaid financing, but the Medicaid plans in their respective states determine what services can be financed. In these states, tribes may benefit from waivers, option, state plan amendments, and other opportunities to support the delivery of HCBS. In states where tribal-state relations are strained or where historic distrust and bias operate, tribes have a difficulty accessing Medicaid.

• **Early and Period Screening Diagnosis and Treatment (EPSDT):** The EPSDT program in Medicaid requires states to screen children for health problems and provide a comprehensive array of prevention, diagnostic, and treatment services, regardless of whether these are included in the state’s Medicaid plan. For Medicaid-eligible children, EPSDT provides a vehicle for covering intensive HCBS, or even residential treatment, without custody relinquishment and can be used in tribes that have access to Medicaid financing.

• **Tax Equity and Fiscal Responsibility Act (TEFRA):** The TEFRA option offers Medicaid coverage irrespective of the family’s income for children who are disabled, living at home, do not qualify for Supplemental Security Income (SSI) due to family income, and meet stringent disability requirements. For example, Massachusetts uses TEFRA to allow children with disabilities who would not be eligible due to their family’s income being above guidelines to receive medical assistance benefits, thereby increasing access to needed services. Massachusetts has two federally recognized tribes, and AI/AN children may be eligible for Medicaid through this vehicle. AI/AN children could qualify for Medicaid as citizens of other states, but their families may not be aware of this potential resource.

• **Health Homes:** Health homes are an option for states under Medicaid to integrate primary care with mental health care. They are required to provide a range of HCBS, and could impact custody relinquishment by better meeting children’s mental health treatment needs. Future examination would be helpful to determine the extent to which tribal children and families participate in health homes.

**Cross-System Strategies**

• **Mental Health and Substance Abuse Block Grant Funds:** Tribes are not currently eligible for the Mental Health and Substance Abuse Block Grants. These funds go to states and are relatively modest. There is considerable variability across states in the amount of Block Grant funds that are allocated to children’s mental health and how they are used (Stroul and Le, 2013). To date, the use of these funds for tribes has not been systematically explored. One example of the use of Block Grant funds for tribes is in Oregon, where Block Grant funds have been awarded to the Yellowhawk Tribal Health Center, the Native American Rehabilitation Association, and the Northwest Portland Area Indian Health Board for Suicide Prevention.

• **State Mental Health and Other State Agency Initiatives and Funds:** Tribal access to state agency initiatives is dependent on factors including P.L. 280 (which changed the division of legal authority among tribal, federal, and state governments), the quality of tribal-state relations, and the priorities of the state. The extent to which tribes can access state-funded initiatives that can impact loss of custody to obtain mental health services has yet to be determined.

• **Child Welfare Strategies and Funds:** Child welfare strategies center around Title IV-E of the Social Security Act and Title IV-E Waivers. Tribes gained access to Title IV-E via the Fostering Connections Act in 2008, but, as of 2017, only nine tribes were approved to operate Title IV-E programs (Children’s Bureau, 2014). The Fostering Connections Act enhanced the possibility of tribes entering into IV-E agreements with states. For example, six Oregon tribes have agreements with the Oregon DHS for Title IV-E funding (Legislative
Commission on Indian Services, 2015). In states with IV-E waivers, it is possible for tribes to enter into funding agreements for services that the state has included in its waiver. Under a IV-E waiver, Oregon assists families to access HCBS that could help to prevent residential treatment and provide services including peer parent mentoring, relationship-based visitation, and family navigator services. In 2011, tribes became eligible to apply for IV-E waivers that offer potential resources for HCBS, such as intensive in-home services or Wraparound (James Bell Associates, 2013), but as of 2017, only one tribe was approved (Casey Family Programs, 2017).

- **Juvenile Justice/Court Strategies and Funds:** Currently, few tribes receive funding for juvenile justice alternatives. For example, discretionary grants from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) support fewer than five tribes to demonstrate alternatives to incarceration.

- **Education Strategies and Funds:** A youth in need of intensive mental health services may be able to access services and funding through IDEA, provided the youth has an existing IEP or a documented disability. This could decrease the need for custody relinquishment by providing needed services and supports in school and at home. At least one tribal program in South Dakota has successfully worked with the local school district to avoid residential placements by providing HCBS, as well as to access residential treatment for its tribal youth in need of such treatment.

- **Local Agency Initiatives and Funds:** Very few tribes have funds available to increase HCBS, and there are many competing priorities for tribal resources that are available. As a result, local (i.e., tribal) funding is not viable for expanding availability and funding of HCBS.

- **Contract Health Services (CHS):** CHS is administered by IHS and has the potential to increase access to HCBS for eligible AI/AN youth. CHS pays community health care providers when there is not an existing tribal or IHS health care facility, the available facility does not provide the needed services or is overcapacity, or when emergency services are necessary. In reality, CHS has not been a successful strategy for expanding HCBS. Typically, only the highest priority or level 1 health services (Emergency/Acutely Urgent Care Services) receive funding, and non-life-threatening mental health issues are not considered level 1 (Levinson, 2011). CHS, like all IHS services, is a payer of last resort, and when CHS funds are depleted, payments cannot be authorized.

### ICWA Requirements and Voluntary Custody Relinquishment

ICWA (25 USC §1901 et. seq.) was enacted into law in 1978 after several years of hearings in Congress and testimony revealing that 25 percent to 35 percent of all AI/AN children had been removed from their homes and placed in out-of-home care by public and private agencies, and that approximately 85 percent of them were placed in non-Indian homes (Senate Committee on Interior and Insular Affairs, 1974). These abusive practices left many smaller tribes teetering on the brink of extinction and created widespread trauma for AI/AN communities and families throughout the United States. Fortunately, these practices have subsided significantly since ICWA’s passage, but the continued need for ICWA is evidenced by the current disproportionate placement of AI/AN children in state foster care and disparate treatment by public and private agencies (Hill, 2007).

ICWA contains requirements for public and private agencies and state courts that are involved in child custody proceedings involving AI/AN children and families. The federal requirements address both voluntary and involuntary proceedings and are closely aligned with standards of excellence in child welfare practice for all children. Statutory requirements in ICWA, along with accompanying regulations, have significant implications for situations in which custody is relinquished so that AI/AN children can obtain needed mental health services.

- **Process for Voluntary Placement:** A voluntary proceeding under ICWA is defined as a proceeding whereby a parent or parents or Indian custodian has, of their own free will and without threat of removal by a state agency, consented that the Indian child be placed (25 CFR § 23.2). These provisions apply to a placement
for the purpose of mental health or substance abuse treatment. The statute includes requirements on how voluntary consent to a placement by a parent or Indian custodian must be given — it must be executed in writing, recorded before a judge, and accompanied by the judge’s certificate that the terms and consequences of the consent were fully explained in detail and were fully understood by the parent or Indian custodian (25 USC § 1913(a)). The parent or Indian custodian may also withdraw consent at any time, and upon such withdrawal, the child must be returned to the parent or Indian custodian. Additionally, the voluntary placement must meet ICWA’s placement preferences, unless the court finds good cause to deviate from them. The placement preferences require that the child be placed in the least restrictive setting that most approximates a family and in which his/her special needs, if any, may be met. It is further required that the child be placed within reasonable proximity to his or her home, taking into account the child’s special needs. ICWA regulations issued in 2016 specify that in a voluntary proceeding, the court must require the participants to state on the record whether they know, or have a reason to know, if the child is an Indian child (25 CFR § 23.124(a)). If the child meets the criteria, regulations stipulate that the court must explain to the parent or Indian custodian the terms and consequences of the consent in detail, and that they may withdraw consent for any reason, at any time, and have the child returned (25 CFR § 23.125(b)(2)(i)).

- **Tribal Role**: ICWA provides that the Indian child’s tribe may intervene at any time in voluntary or involuntary proceedings for foster care in state court (25 USC § 1911(c)). With such intervention, the tribe has all of the rights of other legal parties, including access to court reports and other information filed with the court. Although ICWA only requires notice to the child’s tribe of involuntary proceedings, several states have state laws that require notice to the child’s tribe in voluntary proceedings as well.

Overall, individuals and agencies facilitating placements of Indian children must make diligent efforts to follow ICWA’s statutory requirements. The additional protections under ICWA add complexity to the placement process, including both custody relinquishment for mental health treatment and voluntary placements for obtaining services without transfer of legal custody.

**Custody Relinquishment in Tribes in Oregon and South Dakota**

In order to understand custody relinquishment in tribes and the issues specific to AI/AN children and families, informal telephone discussions were held with tribal child welfare and children’s mental health representatives in South Dakota and Oregon. Three tribes in South Dakota and four tribes in Oregon participated in this process. These two states were chosen for several reasons. In the national scan, Oregon reported using all of the listed strategies to avoid custody relinquishment by families seeking treatment for their children. Conversely, South Dakota did not report specific strategies to address this practice. Additionally, Oregon is a “P.L. 280” state and South Dakota is not. In P.L. 280 states, the state shares jurisdiction with the tribes regarding civil regulatory matters such as custody, and these states have assumed responsibility for serving tribal members in their mental health systems. Thus, an Indian child in Oregon is eligible for state mental health services like any other citizen of the state. In contrast, the federal government retains jurisdiction over such matters in South Dakota, and thus, IHS or the tribe (under contract or compact with IHS) is the primary provider of services. The intent of the discussions with tribes was to determine how tribal children and families experience custody relinquishment in these very different policy environments.

- **South Dakota**: Of the three South Dakota tribes, one tribe’s child welfare agency is experienced in seeking funds from the state to pay for residential treatment if the child comes from a single-parent or extremely low-income family. If the state does not pay, the tribal agency has a successful process for receiving BIA funding so that the family does not have to relinquish custody to access residential treatment for the child. A second tribe has successfully used home-based (Wraparound) services to keep youth out of residential treatment. When necessary, IDEA funds are used to pay for residential treatment through agreements with
the local school district on a case-by-case basis. This has been made possible through the development of a SOC approach in which the schools are partners. In the third South Dakota tribe, it was reported that families have to relinquish custody frequently, because the residential treatment programs are costly and located in faraway states. A child welfare worker in that tribe explained that families relinquish custody to the BIA after the tribal court petitions the BIA for the funding. Gaining custody back from the BIA is not always successful, especially if the youth continues to manifest mental health challenges. Discussions with only three of the many tribes in South Dakota revealed three different approaches, inconsistent policies, and family experiences that are highly dependent on local relationships, access to HCBS, and jurisdiction.

- **Oregon**: Of the four tribal agencies interviewed in Oregon, two reported that they have never had a family relinquish custody to receive mental health services. One cited a commitment from both the Oregon Department of Children and Family Services (DCFS) and community partners to work proactively to provide services to children and families to avoid custody relinquishment. Another agency reported that there were one or two VPAs per year for this purpose. The interviewees described a process by which the parents voluntarily give physical custody of the youth to the state without relinquishing parental rights, so that the state will pay for residential treatment. Reportedly, there are no difficulties transferring placement back to the family when the youth has completed treatment. Representatives of another of the tribal agencies in Oregon indicated that they knew of only two cases in which the family relinquished custody so that the youth could receive mental health services in residential treatment facilities. The tribal court facilitated VPAs in both cases. The agreements lasted for three months, at which point the agreement was revisited. When the youth entered the aftercare phase of treatment, the families regained custody. In Oregon’s case, families reportedly experience custody relinquishment less frequently, and the policy approaches appear better defined. It appears that AI/AN families in Oregon tribes are benefiting from the full range of strategies for addressing custody relinquishment that are applied to all families in that state.

The discussions with tribes in Oregon and South Dakota offer a glimpse into the experience of AI/AN families in two states with regard to relinquishing custody for mental health services. In Oregon, HCBS backed up by voluntary placement strategies appear to be the predominant choice. The state appears to have a well-defined strategy to avoid custody relinquishment for this purpose that extends to the AI/AN population. South Dakota does not have a statewide policy to address custody relinquishment. However, individual tribes have addressed the problem by implementing HCBS and collaborative SOC approaches.
Recommendations

This preliminary exploration of the issue of custody relinquishment to obtain mental health services in Indian Country suggests that tribal children can benefit from efforts in states to reduce the practice. However, AI/AN children and their families face a number of unique issues that impact custody relinquishment, including the variable availability and financing of treatment in different states and tribes. The analysis indicates that there is a need to learn more about the experience of AI/AN children and families with respect to custody relinquishment. The following recommendations are offered:

1. Conduct a more systematic exploration of this issue with tribes. Focus groups at a national conference and a scan of tribes in selected states known to have effective strategies would help to identify, articulate, and highlight best practices for AI/AN children and families.
2. Disseminate this analysis broadly to tribes to raise awareness of this practice and foster a dialogue between tribes and states to prevent it.
3. Conduct a workshop at NICWA’s national conference on this issue to raise awareness and to assess training and TA needs.
4. Conduct a dialogue with state children’s mental health directors to discuss this issue as it relates to tribal citizens and to begin to develop strategies that consider tribes.
5. Provide TA to tribes seeking to change policy and practice, or that are interested in working more closely with states on custody relinquishment for mental health care.
6. Provide TA to tribes on how to access resources to increase availability and access to HCBS.
7. Provide information to tribal and state children’s mental health directors and service providers on ICWA and its implications for voluntary placements.
8. Conduct a more thorough examination of the relationships between current funding streams and custody relinquishment to determine which financing strategies are effective in supporting services for tribal children and families.
9. Enhance the capacity of states and tribes to collect data regarding custody relinquishment for mental health treatment.

Although there are efforts in states to prevent custody relinquishment solely to obtain mental health services, there have been few such specific efforts in tribes. Implementation of effective strategies to prevent this should be encouraged throughout Indian Country.

References


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