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ISSUE BRIEF

Relinquishing Custody for Mental Health Services: Progress and Challenges

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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; 2003*; *Gruttadaro, 2005; Maryland Coalition of Families, 2002; Mental Health America, 2015; NAMI Ohio, 2005*).[1]

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*

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

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 also creates 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 in 2000 and the U.S. General Accounting Office (GAO) in 2003. These analyses found extensive use of custody relinquishment for services and cited devastating consequences for families, including feeling that they have failed as parents, risking being charged with child abandonment and being placed on child abuse and neglect registries, and facing daunting obstacles to reinstating custody. Some parents have been required to pay child support to offset the costs of their child's care and treatment (*Cancian, Cook, Seki, and Wimer, 2017*). The analyses also found that children experienced the trauma of family separation, including feeling abandoned, unwanted, punished, and displaced. Despite these negative consequences, it was concluded that custody relinquishment continued to be used as a "passport to services" by families and states struggling to meet the mental health needs of a child (*Bazelon Center, 2003*).

Purpose and Methodology

Unfortunately, beyond anecdotes and stories, there was little recent information about custody relinquishment solely to obtain needed mental health treatment. 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 intent of the project 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.

The methodology included:

- 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;
- An informational scan sent to state child welfare directors and children's mental health directors, as well as to family-run organizations (FROs) focusing on children's mental health;
- 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; and
- An analysis conducted by the National Indian Child Welfare Association of tribal issues in custody relinquishment to meet the mental health needs of American Indian/Alaska Native children (*Cross, Simmons, Stanley, and Becenti, 2020*).

Informational scans were returned by child welfare and/or mental health agencies in all 50 states and three territories, as well as by 18 FROs in 18 different states.

The complete results are detailed in a report that includes descriptions of strategies used by specific states and the analysis of tribal custody relinquishment issues (*Stroul, 2020*). This issue brief provides a summary of the overall findings on the current status of custody relinquishment for mental health services and on strategies for preventing this practice.

2. HCBS refers to both formal and informal services and supports delivered while children are in their own homes or family-based settings.

Current Status of Custody Relinquishment

How Often Does Custody Relinquishment Occur?

- According to state officials and FROs, custody relinquishment for mental health services is occurring less frequently than in the past, with most states (64 percent) reporting that it now occurs rarely. No states indicated that the practice occurs extensively, and six reported that it never occurs.
- Significant progress was noted 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) indicated that substantial or extensive progress has been achieved.
- Similar to findings in previous analyses, two-thirds of states do not systematically 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.

When and Why Does It Occur?

State officials and FRO leaders 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. They may have engaged in serious self-injurious, suicidal, or violent behavior; caused harm to or threatened their parents or siblings; and/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 make it difficult for parents to meet the needs of their other children, and the parents report often feeling exhausted, overwhelmed, hopeless, and fearful for the safety of family members.

In these situations, three primary factors may lead to custody relinquishment:

- **Lack of availability or accessibility of intensive HCBS:** Without intensive HCBS, residential interventions may be seen as the only option for accessing necessary treatment and ensuring safety. Despite data documenting the effectiveness of HCBS in maintaining children and youth in their homes and communities (*Barbot et al, 2016; Graaf and Snowden, 2017; Stroul, Goldman, Pires, and Manteuffel, 2012; U.S. Department of Health and Human Services, 2015*), 40 percent of states reported that a lack of these services is somewhat or very common as a contributing cause of custody relinquishment. Half of respondents indicated that variable accessibility across geographic areas in states also is somewhat or very common. Respondents noted that, in some situations, HCBS are obtained but do not adequately meet the needs of the child and family.
- **Lack of payment mechanisms for high-cost services, including intensive HCBS and residential interventions:** Private insurance was ranked as the most problematic among payment concerns. Even if some of the mental health services are covered, the level of coverage often is 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 by private insurance is very common or somewhat common as a reason for custody relinquishment, a finding that 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*). Although causes related to public insurance — i.e., Medicaid and the State Children's Health Insurance Program (CHIP) — were ranked lower, inadequate coverage of a comprehensive array of HCBS in both Medicaid and CHIP were cited as somewhat or very common by approximately 30 percent of states. In addition, states reported issues with financing services

through the Individuals with Disabilities Education Act (IDEA), noting that children with mental health disorders often are not identified as eligible for special education and related services (reported to be somewhat or very common by 40 percent) and that, even if identified, there is inadequate funding for needed mental health services (reported to be somewhat or very common by 51 percent) (*National Center for Education Statistics; Simmons, 2008; GAO, 2003; Gruttadero, 2005; Bazelon Center, 2000*).

- **Courts order youth into state custody for treatment, particularly residential treatment:** 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. A common concern is that these decisions may be made without the input of mental health professionals or providers of intensive HCBS in the area. About half of the states (49 percent) reported court-ordered residential treatment to be somewhat or very common as a cause 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 below.

Strategies to Prevent Custody Relinquishment

What Types of Strategies Are Needed?

States reported that they 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 more generally, which 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*).

What Strategies Are States Using to Prevent Custody Relinquishment?

Overall, nearly all states (90 percent) reported using at least one strategy to eliminate the problem of relinquishing custody for mental health services. 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 procedures.

Some states are highlighted below under a specific category as an example of how strategies have been designed and implemented. Although these states and many others have implemented multiple strategies to prevent custody relinquishment, they underscored the difficulties in eliminating the practice completely and the need for continuing efforts to address this complex challenge.

- **Mandates prohibiting custody relinquishment to obtain mental health services:** In 2003, the GAO identified 13 states that had enacted legislation to prohibit state agencies from requiring parents to relinquish custody to obtain mental health services for their children. The informational scan indicated that, in 2018, about half of states (26) have statutes specifically prohibiting this practice. An additional eight states reported having regulations that prohibit custody relinquishment, for a combined two-thirds (67 percent) of the states with statutes and/or regulations.

ILLINOIS: A 2015 Custody Relinquishment Prevention Act went into effect to establish a pathway for families to obtain services for their child's serious mental illness or serious emotional disturbance 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, and to establish an interagency clinical review team to review cases of children who are at risk of relinquishment and connect them and their families with treatment, services, and supports to prevent custody relinquishment. (*Public Act 098-0808*)

CONNECTICUT: A 2013 statute states that the agency is not required to seek custody of any child or youth with mental illness, emotional disturbance, behavioral disorder, or developmental or physical disability for the purpose of accessing an out-of-home placement or intensive outpatient services, including residential treatment programs, therapeutic foster care, and extended day treatment, 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 bill 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. (*Indiana Code 31-34-1-16*)

- **Voluntary Placements:** A comparative analysis across states found that most states have statutes and/or regulatory policies allowing voluntary placements in child welfare (*Jones, Kim, Hill, and Diebold, 2018; Hill, 2017*). In the informational 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 services, 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, and parents are not charged with abuse or neglect. However, these agreements still require entry into the child welfare system and an out-of-home placement. VPAs often require parents to provide financial support for the child's care (including medical, dental, and mental health services) based on their income and any insurance or other benefits they may receive for the child. Some states reported a requirement to exhaust all HCBS before a VPA can be considered.

MINNESOTA: VPAs were created in 2008 as a way to provide out-of-home treatment without custody relinquishment. The purpose of the law and accompanying policy is to distinguish placements necessary to access treatment from child protection placements; ensure that children are provided with the services necessary to treat or improve the symptoms of their disability; preserve and strengthen their family ties; and place children out of home only when their need for care or treatment requires it, and they cannot be maintained in the homes of their parents. 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. The rights and responsibilities of parents include actively participating in: 1) developing an out-of-home placement and treatment plan jointly with agencies and children; 2) providing educational, medical, and dental services; 3) ensuring contact and visitation to maintain the child's connection to the family; 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. Parents or the agency may end voluntary placement for treatment with written notice; parents of American Indian children may end voluntary placements on demand. (*MN Stat. 260c.277*).

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. 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 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 413-020-0130 et seq.*)

- **Policies, Guidance, and Training:** Executive orders, policy manuals, and guidelines with specific procedures to follow are strategies that states use to prevent custody relinquishment, often accompanied by training for staff and providers on implementation. Most states (69 percent) reported using executive orders, formal policies, and/or guidance to prevent custody relinquishment for treatment, and 76 percent provide training on how to avoid this practice.

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).*

NORTH DAKOTA: A manual (Mental Health Services Voluntary Out-of-Home Treatment Program) was published in 2006 with protocols and procedures 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, except those delegated to the state through a signed agreement. 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. The mental health agency provides training, technical assistance, and case consultation to prevent out-of-home placements, out-of-state placements, and custody relinquishment.

- **Diversion:** 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. Some states reported specific diversion protocols or programs to divert children from potential custody relinquishment while providing the services they need. Others reported using multi-agency teams to resolve system barriers and provide individualized HCBS that may avert the need for an out-of-home placement. Differential response is another approach reportedly used by 63 percent of states as a vehicle for child welfare systems to provide individualized treatment and support services to children and families without transferring custody, whether or not investigations substantiate abuse or neglect.

MISSOURI: A Custody Diversion Protocol was developed to divert youth from entering or remaining in state custody solely to access mental health services. It was developed jointly by the child welfare and mental health agencies, the courts, and family members, and 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. A VPA also was implemented that can only be used in conjunction with the Custody Diversion Protocol if an assessment determines that out-of-home treatment is needed. The mental health provider is responsible for locating and monitoring an appropriate out-of-home placement. A review at the end of 2006 showed that 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, along with sufficient resources to respond to families' needs.

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. By 2017, the program was serving approximately 60 children per year for lengths of stay of up to six months, with the flexibility to extend if a child required a longer stay. The state contracts with multiple private RTCs to provide this service. 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 before 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 after 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 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.

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 among families, the child welfare system, and other community providers. After a safety assessment and determination that the children in the home are safe, the intervention shifts to identifying strengths and needs and providing a broad array of services to families in their communities, including flexible funding. The Family Assessment Response shares many of the same principles of a traditional investigation (e.g., focus on the safety and well-being of the child), but the model allows individualized services to be provided without a determination of abuse or neglect and can be used to meet children's treatment needs without relinquishment of custody.

What Strategies Are States Using to Expand and Finance HCBS?

- **System of Care (SOC) Strategies:** Nearly all states (94 percent) reported developing SOCs as a strategy to increase HCBS. 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 Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicaid and Medicare Services (CMS) 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 (*U.S. Department of Health and Human Services, 2017; 2019*). The vast majority of states 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:** Medicaid has played a pivotal role in financing HCBS, with 90 percent of states indicating that they have used one or more Medicaid strategy to cover these services. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was the most frequently 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. The use of health homes and various types of Medicaid waivers, options, and state plan amendments also were reported as strategies to expand HCBS.
- **Cross-System Strategies:** The majority of states (83 percent) reported using resources that are provided by various federal and state child and family-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, which often are used to fund services that are not financed through Medicaid or other sources and/or to fund services to children who are uninsured (*Stroul and Le, 2013*). About two-thirds of states cited state agency initiatives (mental health and others) and the use of Title IV-E waivers in child welfare. Education system strategies reportedly were used least frequently to build HCBS.

NEW JERSEY: New Jersey has combined funding from multiple systems, such as mental health, Medicaid, child welfare, and others to create a statewide SOC (Children's System of Care - CSOC) that provides comprehensive mental 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 mental 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 in partnership with family members, led to the implementation 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 and provides intensive HCBS to any child who needs them, regardless of ability to pay or payment source. 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 based solely on clinical need. A comprehensive array of HCBS is provided, including residential treatment when clinically necessary, 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 both have been reduced by half. By creating the statewide SOC, the child welfare system no longer needs to be involved in providing mental 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 intellectual/developmental disabilities and substance use disorders.

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 often shows some differences, although the comparison is based on a small number of states:

- States with more frequent relinquishments (6 percent of states) have no mandates (statutes or regulations) or policies, while the majority of states reporting no relinquishments (13 percent of states) 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 respondents 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.

Recommendations

Despite progress in reducing custody relinquishment as a means to access and finance services, the information obtained, along with follow-up discussions, found that custody relinquishment still occurs. Recommendations for eliminating the practice of trading custody for care are summarized below and include strategies to prevent the practice and to increase HCBS that can avert the need for relinquishment. As noted, none 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 interventions when indicated.

State Strategies to Prevent Custody Relinquishment	
Implement Mandates Prohibiting Custody Relinquishment to Obtain Services	Implement requirements in the form of statutes or regulations that prohibit custody relinquishment solely to obtain mental health services, and that prohibit making access to, or public funding for, services contingent on being in custody. Accompany mandates with monitoring for compliance.
Develop Specific Diversion Processes	Implement protocols 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.
Provide Training	Conduct training for key constituencies on requirements, policies, and protocols that address custody relinquishment for mental health services, including 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 avoid custody relinquishment.
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.
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, or are subject to any other types of penalties.
Collect and Review Data on Custody Relinquishment	Systematically track the frequency of custody relinquishment solely for mental health services, why it occurred, and what strategies or services could have prevented the practice from happening. Use these data to better understand the extent to which the practice is being used, for what reasons, and potential solutions. Identify an oversight body to review the data and make recommendations for quality improvement.
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.
Involve Family Members and Youth in Problem Solving	Involve family and youth organizations and leaders in identifying the circumstances that lead to custody relinquishment and what measures and strategies they recommend to eliminate the practice.

State Strategies to Increase Availability, Access, and Financing of Intensive HCBS	
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 crisis response and stabilization, parent and youth peer support, respite, etc. SOCs should ensure that residential interventions are available to children who meet the clinical criteria for this service, that it is used to achieve specific short-term treatment goals, and that it is linked to intensive HCBS for ongoing treatment.
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.
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 ensuring that these services are covered under Medicaid; expanding eligibility for Medicaid and CHIP; ensuring that medical necessity criteria do not inappropriately restrict payment for intensive mental health services; and allocating state agency funds to pay for services not in the benefit packages of Medicaid or commercial insurance, and to serve children who do not qualify for Medicaid.
Work with Commercial Insurers	Work with commercial insurers to encourage coverage for intensive HCBS under private insurance plans. Provide data on the effectiveness and return on investment in intensive HCBS.
Involve Family Members and Youth in Planning, Implementing, and Financing HCBS	Involve family and youth organizations and leaders in planning, implementing, and financing HCBS to determine their needs; identify barriers to accessing and financing care; and assess the effectiveness of strategies to increase availability, access, and payment for services.

Technical Assistance (TA) Needs

Child welfare, children's mental health, and FRO respondents identified a number of areas in which 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, 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 on 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 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 the strategies identified through this project will assist states, communities, tribes, and territories in eliminating this practice completely.

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