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Report to Congressional Requesters

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MENTAL HEALTH SERVICES

Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown

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Abbreviations

ACF	Administration for Children and Families
CMS	Centers for Medicare & Medicaid Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ERISA	Employee Retirement Income Security Act of 1974
FEMA	Federal Emergency Management Agency
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
MHPA	Mental Health Parity Act of 1996
OVC	Office for Victims of Crime
POS	point of service
PPO	preferred provider organization
PTSD	posttraumatic stress disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SED	serious emotional disturbance
SMI	severe mental illness
VOCA	Victims of Crime Act

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United States General Accounting Office
Washington, D.C. 20548

August 22, 2002

The Honorable Richard J. Durbin
The Honorable Edward M. Kennedy
The Honorable Paul Wellstone
United States Senate

One-time traumatic events like natural disasters, terrorist incidents, and school shootings as well as ongoing exposure to trauma such as family and community violence can have serious psychological, emotional, and developmental repercussions for children. In the short term, children's lives can be radically disrupted, and longer-term effects can include difficulties in school, work, and personal relationships. If children who have experienced trauma do not receive the care they need, these problems can continue into adulthood.

Large numbers of children are at risk for trauma-related mental health problems. The Department of Justice reported in 1997 that almost 9 million children aged 12 to 17 had witnessed serious violence during their lifetimes; Justice has also reported that during the period of 1993 through 1998, children under the age of 12 resided in 43 percent of households where intimate partner violence was known to have occurred. Further, the Department of Health and Human Services (HHS) reported that about 826,000 children and adolescents were found to be victims of abuse and neglect in 1999.

In response to your request for information on the ability of children who have experienced trauma to obtain mental health services, this report addresses (1) the extent to which private health insurance and the primary public programs that insure children—Medicaid and the State Children's Health Insurance Program (SCHIP)—cover mental health services needed by children exposed to traumatic events and (2) other federal programs that help children who have experienced trauma receive needed mental health services.[1] As requested, we are also providing national data that are available through federal agency sources on the incidence of child abuse and neglect, sexual assault, rape, intimate partner violence, and children's witnessing such violence. (See app. II.)

[1] In this report the term children encompasses both younger children and adolescents.

To determine the extent of private and public insurance coverage of mental health services for children, we reviewed available employer survey data; reviewed the benefit design of health plans provided by 13 insurers in the individual market as well as state Medicaid programs and SCHIP programs; and interviewed representatives of private insurers and public officials in California, Georgia, Illinois, Massachusetts, Minnesota, and Utah. We selected these states on the basis of variation in the number of beneficiaries covered, in geographic location, in the extent to which the insurance market is regulated, and in the design of the SCHIP program. To describe other federal programs that can help pay for mental health services for children who have experienced trauma or that try to ensure that these children receive needed services, we reviewed grant program documents obtained from officials of federal agencies, such as HHS, Justice, the Department of Education, and the Federal Emergency Management Agency (FEMA), and interviewed agency officials and representatives of national health care and child advocacy organizations. To gather information on services provided to children and on problems in obtaining needed services, we reviewed the relevant literature and contacted state and local mental health agencies, state crime victim compensation and assistance agencies, child welfare and protective service agencies, and other organizations receiving federal grants in California and Massachusetts, as well as additional service providers with federal grants in Colorado, Illinois, Minnesota, and Oregon. The programs and efforts we discuss in this report do not represent an exhaustive list of all federally funded programs that can address the mental health needs of children exposed to traumatic events; they highlight a range of programs that target varied populations, services, and systems that come into contact with this population. In addition, we obtained data on child abuse and neglect, intimate partner violence, and sexual assault that were collected and analyzed by HHS's Administration for Children and Families (ACF) and Justice's Bureau of Justice Statistics, National Institute of Justice, and Federal Bureau of Investigation. We did not verify the accuracy of these data. (For additional information on our methodology, see app. I.)

We conducted our work from September 2001 through August 2002 in accordance with generally accepted government auditing standards.

Results in Brief

Eighty-eight percent of children nationwide, or over 67 million, have private or public health insurance that, to varying degrees, covers mental health services, including those that may be needed to help children recover from traumatic events. Despite the widespread prevalence of

health insurance coverage for children, depending on their type of insurance coverage and where they live, children may face certain limitations in coverage or other barriers that could affect their access to needed services. Employer-sponsored health plans cover nearly two-thirds of children nationwide, or over 50 million, and federal law requires plans that cover more than 50 employees and include mental health benefits to cover mental health services to the same extent as other services in terms of annual or lifetime dollar limits. However, the federal law does not preclude these employer-sponsored plans from including other features, such as day or visit limits, that are more restrictive for mental health services. In addition, the 4 percent of children, or over 3 million, covered by private-sector individual health insurance may face even greater coverage restrictions. For example, insurers in the individual market may offer only limited mental health coverage, such as a lifetime limit of $10,000 on mental health benefits; exclude specific disorders from coverage, such as posttraumatic stress disorder (PTSD); or offer no mental health coverage at all.

The 16 percent of children, or over 12 million, who are enrolled in Medicaid and SCHIP public insurance programs generally have coverage for a wide range of mental health benefits, and those enrolled in Medicaid are not subject to day or visit restrictions. In addition to any mental health services that states explicitly cover in their Medicaid programs, federal law requires states to provide all children enrolled in Medicaid with any service necessary to treat physical and mental conditions detected through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings. Because EPSDT is not a mandatory component of SCHIP, however, states have more discretion in how they design their SCHIP programs, including the extent to which they cover mental health services. In states that model their SCHIP programs on private insurance plans rather than Medicaid, children may face day or visit limits, as in California and Utah. In addition, certain other factors, such as the availability of providers willing to participate in the Medicaid program or cost-sharing requirements of SCHIP, could also constrain the ability of some children to obtain needed services. The extent to which children enrolled in Medicaid and SCHIP receive covered mental health services is not fully known, but available evidence suggests that enrolled children in some states may not be obtaining services they need.

Beyond providing insurance that can give children access to mental health services, a range of federal programs can help children who have experienced trauma obtain needed services. We identified over 50

programs—primarily in HHS, Justice, FEMA, and Education—that can be used by grantees to provide mental health and other needed services to children who have experienced trauma, although many of these programs have a broader focus and were not designed specifically for this purpose. Some federal programs pay for crisis counseling, such as the Crisis Counseling Assistance and Training Program to assist victims of disasters, which is administered by FEMA in collaboration with HHS's Substance Abuse and Mental Health Services Administration (SAMHSA). Justice's Victims of Crime Act (VOCA) Crime Victim Compensation grants to states are an important federal source of funding for mental health services for victims of crimes. However, children's access to benefits may be constrained by states' eligibility requirements or program limitations, such as caps on mental health services. In addition, other factors may also hamper some child victims' ability to obtain financial assistance for needed mental health services. These include families' lack of knowledge about state victim compensation programs and state program requirements such as filing a police report within 72 hours of a crime. Several federal grant programs encourage coordination among mental health and other service systems—such as child welfare, health care, and justice—so that children who have experienced trauma and their families can more easily gain access to the full range of services they need. Furthermore, some federal grants, such as Justice's VOCA Crime Victim Assistance grants to states, can improve service providers' ability to meet the needs of children who have experienced trauma by providing access to services, such as case management, that may not be covered by insurance.

While federal grant programs expand the number of children whose mental health services may be reimbursed or help increase the available services in a community, some children who need services may not benefit from such programs. For example, some grants are awarded to a relatively small number of communities and expire after a defined period. Moreover, little is known about the effectiveness of federal programs that can help children who have experienced trauma to obtain mental health services or about gaps in access to needed services. SAMHSA's National Child Traumatic Stress Initiative, which is specifically designed to take a coordinated approach to improving mental health care for children who have experienced various kinds of trauma, plans to evaluate both its overall program and individual components. If carefully implemented, the SAMHSA evaluations have the potential to provide information on ways to effectively provide mental health services to children who have experienced trauma. Some key programs have not conducted evaluations to assess their effectiveness in helping traumatized children obtain needed

mental health services, and others have lagged in establishing their evaluation frameworks. For example, FEMA and SAMHSA have not evaluated the effectiveness of the disaster crisis counseling program. Without evaluations of the effectiveness of federal programs that have a clear goal of helping children who experienced trauma obtain mental health services, federal managers and policymakers lack information that would help them assess which federal efforts are successful; determine which programs could be improved, expanded, or replicated; and effectively allocate resources to identify and meet additional service needs.

We are recommending that the Director of FEMA work with the Administrator of SAMHSA to evaluate the effectiveness of the disaster crisis counseling program. We provided a draft of this report to four departments and agencies for their review. FEMA and HHS concurred with our discussion of the Crisis Counseling Assistance and Training Program, agreed that evaluation of this program is needed to ensure program effectiveness, and stated that they have initiated additional evaluation activities. However, the activities they described do not constitute the programwide effectiveness evaluation we are recommending and FEMA did not indicate whether it intends to implement our recommendation to coordinate with SAMHSA to conduct such an evaluation. Both HHS and Education suggested that the report more fully address their concerns that the mental health workforce does not include enough appropriately trained providers to meet the service needs of children who have experienced trauma. We included additional information on this subject, but a detailed discussion of this issue is outside the scope of this report. HHS also suggested that the report treat in greater depth several other topics, including the role of stigma associated with mental health problems. We modified the report to acknowledge the role of stigma, but although we agree that this and other subjects are important, detailed discussion of them is outside the scope of this report. Justice provided technical comments.

Background

Many children across the country have been victims of, or witnesses to, violence in their homes, schools, or communities. In 1999, according to the most recent edition of a joint Justice and Education report, students aged 12 through 18 were victims of about 186,000 violent crimes at school and about 476,000 violent crimes away from school.[2] In addition, thousands of children have been exposed to natural disasters or terrorist acts such as those that occurred on September 11, 2001, placing them at risk for mental health problems. While many children respond to these situations with resilience, others suffer acute and chronic effects. Children's reactions to trauma may appear immediately after the traumatic event or may appear days, weeks, months, or even years later. Researchers report that children who experience traumatic events show a wide range of reactions, and their nature and intensity vary on the basis of factors such as the type and frequency of trauma, whether a child knew the offender or victim, the strength of the family support system, and a child's sex and age. For example, children age 5 and younger typically react to traumatic events with crying, screaming, and fear of being separated from a parent, while adolescents tend to have reactions similar to adults, such as flashbacks, nightmares, and suicidal thoughts.[3] A child's reactions to traumatic events, including disasters, may also vary based on how well their parents cope with the situation and on whether a child or parent has a preexisting mental disorder. Some children have a special vulnerability to the impact of traumatic events. Studies indicate that the impact is likely to be greatest for a child who had previously been victimized or already had a mental health problem.[4]

Certain psychiatric diagnoses are associated with exposure to traumatic events, including acute stress disorder, PTSD, depression, and conduct disorder. Children with acute stress disorder can display multiple symptoms, including reexperiencing of the event, avoidance of situations that remind them of the traumatic event, sleep disturbances, poor concentration, and regressive behavior. The disorder is of short duration, with symptoms beginning within 4 weeks of a traumatic experience and

[2] Phillip Kaufman et al., *Indicators of School Crime and Safety: 2001* (Washington, D.C.: U.S. Departments of Education and Justice, 2001).

[3] See, for example, Joy Osofsky, *The Impact of Violence on Children* (Los Altos, Calif.: The David and Lucile Packard Foundation, Winter 1999).

[4] See, for example, Betty Pfefferbaum, "Posttraumatic Stress Disorder," *Child and Adolescent Psychiatry*, 3rd ed. (forthcoming).

lasting from 2 days to 4 weeks. If symptoms continue, the diagnosis may be reevaluated and changed to PTSD. PTSD is similar to acute stress disorder and shares many of the same symptoms, but lasts longer. It is diagnosed when symptoms persist more than a month, although the disorder may develop either immediately after a traumatic event or several months later. Exposure to traumatic events may also result in depression, which is generally characterized by changes in appetite, sleep disturbances, constant sadness, and irritability. Conduct disorder may also develop after experiencing a traumatic event. The disorder is identified by a persistent pattern of behavior that violates major age-appropriate societal norms, such as aggression toward people and animals or destruction of property.

The prevalence of different diagnoses varies based on factors such as age and sex. For example, a preliminary report on how the September 11, 2001, attack affected New York City public school students found that children in grades 4 and 5 were more likely than children in grades 6 to 12 to experience PTSD and other disorders involving intense fear and avoidance of usual activities, while the older children were more likely to have conduct disorder or depression. Similarly, girls had higher rates of PTSD, depression, and generalized anxiety than boys, who had higher rates of conduct disorder.[5]

Depending on the nature and severity of a traumatized child's condition, a variety of mental health treatment options and service settings may be recommended. These include outpatient individual, family, or group therapy; inpatient hospital care; and residential care. A range of service providers, including psychiatrists, psychologists, psychiatric nurses, counselors, and clinical social workers, may treat children who have experienced trauma. Optimal care of these children often requires participation by a variety of service systems, such as mental health and social services.

[5] Applied Research and Consulting, Columbia University Mailman School of Public Health, and the New York State Psychiatric Institute, *Effects of the World Trade Center Attack on NYC Public School Students: Initial Report to the New York City Board of Education*, for the New York City Board of Education (New York, N.Y.: May 2002).

The Surgeon General has reported that there are not enough mental health professionals trained to work with children.[6] Moreover, trauma experts report that even professionals who are trained to work with children may not have specialized training or experience in working with children who have experienced trauma. Children whose families do not speak English can have a particularly difficult time finding providers who can assist them.

Because the types of trauma that children experience vary considerably, numerous pathways can lead to the identification, referral, assessment, and treatment of traumatized children needing mental health services. These pathways include families; schools; day care; primary health care; and the law enforcement, juvenile justice, and child protective services systems. However, the professionals working in these systems may not be trained to identify children with trauma-related mental health problems. For example, a recent report by the Surgeon General noted that primary care providers often have little training on mental health services and vary in their capacity to recognize and diagnose disorders and to coordinate with mental health providers.[7] In addition, the Institute of Medicine recently concluded that health professionals are not sufficiently educated about family violence.[8] Further, not all teachers are aware of the connection between academic or behavioral problems and the possibility that they are related to a child's exposure to violence. Justice has also reported that law enforcement personnel are generally not sufficiently aware of the psychological effects that witnessing violence can have on children.[9]

[6] HHS, SAMHSA, Center for Mental Health Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md.: 1999); HHS, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (Washington, D.C.: 2000); HHS, SAMHSA, Center for Mental Health Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, Md.: 2001).

[7] HHS, Public Health Service, Office of the Surgeon General, *The Integration of Mental Health Services and Primary Health Care: Report of a Surgeon General's working meeting on the integration of mental health services and primary health care, November 30-December 1, 2000, Atlanta, Georgia* (Rockville, Md.: 2001).

[8] Institute of Medicine, *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence* (Washington, D.C.: 2001).

[9] See, for example, Steve Marans and Miriam Berkman, *Community Development—Community Policing: Partnership in a Climate of Violence* (Washington, D.C.: Department of Justice, Mar. 1997).

At the national level, few data are available on the number of children who need mental health services as a result of exposure to trauma and the number who receive services. For example, there are no nationwide data on the number of children in foster care and the juvenile justice system—populations likely to have been exposed to trauma—who need mental health care, or on the number who have received treatment.[10]

Private and Public Health Insurance Coverage for Children

Access to health care services, including mental health services, is highly correlated to having health insurance coverage. According to March 2001 Current Population Survey data, over 67 million children nationwide have health insurance coverage. More than two-thirds of children under age 19—almost 54 million—obtain health insurance privately, either as a dependent under a parent's or guardian's employer-sponsored health plan or through the individual insurance market. In addition, almost 14 million children are enrolled in public programs such as Medicaid, SCHIP, or other federal insurance programs. Although most children have insurance coverage, over 9 million remain uninsured. (See table 1.)

Table 1: Type of Insurance Coverage for Children under Age 19 in 2000

Type of insurance		Percentage of children under 19[a]
Private	Employer-sponsored	65.9
	Private/Individual	4.1
Public	Medicaid (including SCHIP)	16.3
	Medicare[b]	0.5
	TRICARE[c]	1.2
Uninsured		12.0

[a]Some people may receive coverage from several sources. To avoid double counting, we assigned an individual reporting coverage from two or more sources to one source, based on a hierarchy in the following order: employer-sponsored, Medicare, Medicaid, TRICARE, private/individual, and uninsured. Therefore, percentages for specific sources of coverage, such as Medicaid, may be underestimated.

[b]Children with a disability or End-Stage Renal Disease may be eligible for Medicare.

[10] See, for example, Bradley Stein et al., "Violence Exposure Among School-Age Children in Foster Care: Relationship to Distress Symptoms," *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 40, no. 5 (2001).

[c]TRICARE is a program administered by the Department of Defense for families of active duty, retired, and deceased service members.

Source: GAO analyses of March 2001 Current Population Survey.

Despite widespread health insurance coverage of children, private health insurance plans historically included greater restrictions on mental health benefits than on benefits for other health services. Consequently, federal and state laws have attempted to partially equalize benefit levels. The federal Mental Health Parity Act of 1996 (MHPA) prohibits certain group health plans sponsored by employers with more than 50 employees from imposing annual or lifetime dollar limits on mental health benefits that are more restrictive than those imposed on other benefits.[11] As of March 2000, more than half of the states had also passed laws that exceeded the federal law by requiring that certain health insurers not only have parity in dollar limits, but also in service limits and cost-sharing provisions. However, these state mental health parity provisions do not affect employers who pay their employees' health expenses directly rather than by purchasing insurance. Federal law permits states to regulate insurance, but employers' self-funded health plans, which covered almost half of all employees enrolled in employer-sponsored plans in 1999, are not affected by such state insurance regulations.[12]

Medicaid operates as a joint federal-state program to finance health care coverage for certain categories of low-income individuals. Within guidelines established by federal law, states have considerable flexibility in how they structure their programs, including determining eligibility levels and what benefits to cover. For example, federal law requires states to offer Medicaid coverage to children age 5 and under if their family incomes are at or below 133 percent of the federal poverty level and to children ages 6 to 18 if their family incomes are at or below the federal poverty level.[13] To

[11] 29 U.S.C. § 1185a (2000). However, MHPA does not require these group health plans to offer mental health benefits.

[12] The Employee Retirement Income Security Act of 1974 (ERISA) generally preempts states from regulating employee health plans, although state governments maintain the ability to regulate health insurance sold in their states. 29 U.S.C. § 1144 (2000).

[13] In 2002, the federal poverty level was $18,100 for a family of four. Medicaid eligibility is mandatory for all children born after September 30, 1983 whose family incomes are less than or equal to the federal poverty level. By September 2002, mandatory Medicaid eligibility will apply to all children (under age 19) who meet the income requirements. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VII), (*l*)(1)(D) and (*l*)(2)(C).

offer coverage to additional children, many states have set family income eligibility thresholds beyond these minimum federal levels.

Benefits covered by state Medicaid programs are either mandatory or optional. For example, states are required to cover EPSDT services, which include comprehensive, periodic health and developmental evaluations or screenings. A state must cover any services necessary to treat physical and mental conditions detected through these screenings, regardless of whether the services are covered by the state's Medicaid program.[14] We have previously reported that the extent to which children actually receive EPSDT services is not fully known, largely because no reliable, national utilization data exist for these services.[15] States also have the option to provide beneficiaries with a number of other services, such as inpatient psychiatric and psychological services. HHS's Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid and SCHIP programs, does not have current data that comprehensively summarize the extent to which states cover mental health services; however, other available sources suggest that the majority of states provide some level of mental health coverage as an optional benefit.[16]

In 1997, the Congress enacted SCHIP to provide health care coverage to low-income children living in families whose incomes exceed the eligibility limits for Medicaid.[17] Although SCHIP is generally targeted to families with incomes at or below 200 percent of the federal poverty level, each state may set its own income eligibility limits within certain guidelines. As a result, SCHIP maximum income eligibility levels vary considerably among

[14] 42 U.S.C § 1396(r)(5).

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

[16] For example, see Bazelon Center for Mental Health Law, *Recovery in the Community: Funding Mental Health Approaches for Rehabilitative Approaches Under Medicaid* (Washington, D.C.: Nov. 2001) and Commerce Clearing House Incorporated, *Medicaid and Medicare Guide Volume 4, Medicaid State Plans, Medicare and Medicaid Laws* (Chicago, Ill.: Nov. 1996). However, these sources do not fully capture the extent to which states cover mental health services for children. Since states report their provision of mental health services to CMS differently, summary information of state coverage of these services is difficult to compile. For example, a state may report these services as psychological services, rehabilitation services, clinical services, or as part of its managed care program.

[17] The Balanced Budget Act of 1997 (Pub. L. No. 105-33) established SCHIP as Title XXI of the Social Security Act. SCHIP is set out at 42 U.S.C. § 1397aa et seq.

states, ranging from 100 to 350 percent of the federal poverty level. States have three options in designing SCHIP: expand their Medicaid programs, develop separate child health programs that function independently of the Medicaid programs, or do a combination of both. States that implement SCHIP by expanding Medicaid must use Medicaid's enrollment structures and benefit packages (including EPSDT services); in contrast, separate SCHIP programs may depart from Medicaid requirements for benefits and for the plans, providers, and delivery systems available. (See app. III for a state summary of SCHIP programs.)

Federal Agencies with Responsibility for Assisting Children Who Have Experienced Trauma

Several federal departments and agencies have responsibility for addressing the mental health needs of children who have experienced trauma. For example, HHS agencies have responsibility for improving the accessibility and delivery of mental health services, conducting research on children's mental health issues, disseminating information on promising approaches for improving children's mental health, and promoting the well-being of children. In addition to CMS, these agencies include ACF, the Health Resources and Services Administration (HRSA), the Indian Health Service, and SAMHSA. In addition, the National Institutes of Health, the Centers for Disease Control and Prevention, and the Agency for Health Care Research and Quality fund research on a range of topics related to child victims and trauma, including the effects of trauma on children and interventions to assist children who have experienced trauma. HHS's Office of Public Health and Sciences coordinates programs across agencies and supports crosscutting initiatives involving children's mental health.

FEMA is charged with providing financial and technical assistance to states and federally recognized Indian tribes for crisis counseling and other services to children and adults affected by presidentially declared disasters, which can include earthquakes, fires, floods, hurricanes, and terrorism. Justice seeks to mitigate the effects of violence on children, including by paying for mental health services for children who are victims of, or witnesses to, violent crimes. Offices within Justice that focus on this population include the Office of Juvenile Justice and Delinquency Prevention, the Violence Against Women Office, and the Office for Victims of Crime (OVC), all within the Office of Justice Programs. In addition, Education, through its Office of Elementary and Secondary Education, oversees programs that can help students obtain services to ensure that mental health problems do not interfere with their ability to learn.

Most Children Have Health Insurance Coverage, But Mental Health Coverage May Have Limits and Not Guarantee Access

Private health insurance plans, such as employer-sponsored or individually purchased plans, and public programs, such as Medicaid or SCHIP, provide health insurance coverage to 88 percent of children. Although most children have health insurance, the level of mental health coverage available to children varies and depends largely on the type of insurance they have. While children enrolled in private insurance plans often face limitations in their mental health coverage, such as the exclusion of certain diagnoses from coverage or limits on the number of covered visits for outpatient therapy, children in Medicaid and SCHIP programs generally have coverage for a wide range of mental health services. The typically broader coverage of Medicaid programs and SCHIP programs that are Medicaid expansions is largely due to these programs being required to cover all necessary health care for problems detected through an EPSDT screening. Despite the availability of public insurance coverage, other factors, such as low Medicaid reimbursement rates that discourage provider participation or SCHIP cost-sharing requirements that may make services unaffordable for some families, could affect children's access to services. Although little is known nationwide about the extent to which children in public insurance programs receive mental health services, available evidence suggests that children in some states may not be receiving services they need.

Coverage Limitations in Private Health Insurance Plans Could Affect Children's Ability to Obtain Mental Health Services

The extent to which private health insurance plans cover mental health services varies. Most employer-sponsored health plans cover inpatient and outpatient mental health services, as do individual insurers, although to a lesser extent. However, private insurance plans often contain coverage or other restrictions, which may limit the availability of mental health services to enrollees, including children who have been exposed to trauma. For example, private plans may impose day or visit limits on mental health treatment, exclude certain diagnoses or benefits from coverage, or not offer mental health coverage at all.

Employer-Sponsored Group Health Plans

Employer-sponsored group health plans, which cover over 50 million children, or 66 percent, typically include mental health benefits that children who have experienced trauma may need. However, many of these plans impose more restrictive limits, such as day or visit limits, on mental health benefits than on other benefits. For example, in a prior survey of nearly 900 employers, we found that 87 percent of employer plans complied with the dollar parity requirements of the MHPA but set other limits that were not prohibited by MHPA, such as the number of allowable outpatient visits or inpatient days for mental health treatment.[18] In contrast, few plans imposed limits on hospital days or office visits for health conditions not related to mental health. In addition, a survey conducted by Mercer/Foster Higgins of 2,813 employers that sponsor health plans found that at least 73 percent of preferred provider organization (PPO), point of service (POS), and health maintenance organization (HMO) health plans offered by employers with more than 500 employees imposed annual limits on mental health services.[19] These plans most commonly imposed day and visit limits on mental health services, with median limits of 30 inpatient days and 30 outpatient visits per year.[20] (See table 2.) Although for some children these service levels are sufficient, these limits may not provide adequate coverage for some traumatized children who require long-term mental health treatment.

[18] U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, GAO/HEHS-00-95 (Washington, D.C.: May 10, 2000).

[19] Mercer/Foster Higgins, *National Survey of Employer-Sponsored Health Plans 2001: Report on Survey Findings* (New York, N.Y.: 2002). The Mercer/Foster Higgins survey is representative of all employers in the United States with at least 10 employees, and results are often reported separately for employers with 500 or more employees.

[20] Another employer benefit survey by the Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey*, (Menlo Park, Calif. and Chicago, Ill.: 2001), found similar benefit limits among workers enrolled in employer-sponsored health plans it surveyed. Nearly half of employees enrolled in surveyed health plans were limited to mental health services of 30 or fewer inpatient days or outpatient visits. Eighty-seven percent lacked coverage for unlimited, annual outpatient mental health visits, while 84 percent lacked coverage for unlimited inpatient days for mental health treatment.

Table 2: Percentage of Health Plans Offered by Employers with More Than 500 Employees That Limited Inpatient and Outpatient Mental Health Services in 2001

	Percentage of health plans		
	PPO	HMO	POS
Plans with annual inpatient day limits	78	77	78
Plans with annual outpatient visit limits	78	77	73

Note: Data for indemnity (fee-for-service) health plans were not reported in 2001 because sufficient data for these plans were not available. According to Mercer/Foster Higgins, only 6 percent of employees of large employers were enrolled in indemnity plans in 2001.

Source: Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2001.

Individual Health Insurance Market

Limitations in mental health coverage are more pronounced for the over 3 million children covered by individual insurance plans. Unless precluded by state law, mental health benefits in the individual market can be more restrictive than other benefits in such areas as annual or lifetime dollar limits on what the plan will pay and service limits, such as fewer covered hospital days or outpatient office visits. The individual market may also have higher cost-sharing, such as deductibles, copayments, or coinsurance. We found such limitations among individual health plans we reviewed. For example, one insurer imposed a lifetime limit of $10,000 on mental health benefits, while another insurer that sells individual health plans in nearly 40 states includes mental health coverage only if required by state law. Another insurer limited annual mental health coverage to $1,500 for each member. (See app. IV for a summary of differences in individual market health plan coverage for certain mental health treatments available to children in six states.) In addition, few states require insurers in the individual market to guarantee access to health insurance coverage for people with mental disorders, leaving some children unable to obtain any health insurance. We recently reported that in several states, applicants for individual health insurance who had certain conditions, such as PTSD, would likely be denied coverage by five of the seven insurers reviewed.[21]

State Responses to Limitations in Private Health Insurance Plans

To address these and other limitations in mental health coverage, many states have passed laws that exceed the requirements of MHPA.[22] Among the six states we reviewed, three—California, Massachusetts, and Minnesota—mandated that health plans offer mental health benefits at the

[21] See, U.S. General Accounting Office, *Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders*, GAO-02-339 (Washington, D.C.: Feb. 28, 2002). Some states do not allow insurers in the individual market to deny coverage to applicants. We reported that 11 states required individual market carriers to guarantee applicants access to health insurance coverage, and certain carriers guaranteed access voluntarily in an additional 5 states and the District of Columbia. In the remaining 34 states, carriers may deny coverage to high-risk individuals. However, 27 of these 34 states have high-risk pools, which are typically state-created, not-for-profit associations that offer comprehensive health insurance benefits to high-risk individuals and families who have been or would likely be denied coverage. High-risk pool coverage typically costs 125 to 200 percent of standard rates for healthy individuals.

[22] In May 2000, we reported that 43 states and the District of Columbia had laws that addressed mental health coverage in employer-sponsored group plans; 29 were more comprehensive than the federal law, requiring parity not only in dollar limits but also in service limits or cost-sharing provisions. Ten states required that mental health benefits be on par with other benefits for all coverage sold in the individual market. See U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, GAO/HEHS-00-95 (Washington, D.C.: May 10, 2000).

same level as other benefits. The other three states—Georgia, Illinois, and Utah—took varied approaches to requirements on mental health coverage. Laws in these states apply only to certain types of health plans or do not require health plans to include mental health coverage. However, self-funded employer group plans, which covered close to half of all private sector employees in group health plans in 1999, are beyond the purview of state regulation and thus exempt from these reforms. (See app. V for a summary of selected laws related to mental health insurance coverage in these states.)

State Medicaid and SCHIP Programs Typically Cover a Wide Array of Mental Health Benefits, but Children May Encounter Difficulties Obtaining Covered Services

The 16 percent of children enrolled in Medicaid and SCHIP typically have coverage for a wide range of mental health benefits. However, coverage limitations and other factors, such as Medicaid reimbursement rates to providers and SCHIP cost-sharing requirements, could affect children's access to services and available data suggest that some enrolled children are not receiving mental health services they need.

Medicaid Program

With few exceptions, the Medicaid programs in the six states we reviewed provided children with coverage for a wide range of mental health services. For example, all six states provided children with coverage for diagnostic assessments, outpatient therapy, medication management, and mental health treatment in residential care facilities, and did not impose day or visit limits or cost-sharing requirements.[23] In addition to specified mental health services, Medicaid requires states to cover all necessary health treatment services when a health problem that could affect a child's development is detected during an EPSDT screening, regardless of whether the condition or treatment is explicitly covered by the state's Medicaid program. A required element of an EPSDT screening is a comprehensive history, which is supposed to include an assessment of a child's mental health needs. Although many states have developed recommended screening protocols for health care providers to complete on specified schedules, CMS defines screenings very broadly and considers any encounter with a health care provider to be a screening sufficient to identify and require the provision of needed services.

[23] A residential treatment center is a licensed 24-hour facility that offers mental health treatment.

One mental health service that can be important to families of children who have experienced trauma is respite care. Although respite care is not a mandatory Medicaid service, states may use flexibility available under the Medicaid statute to cover respite services, such as child care and weekend group home services, in order to provide some relief for an eligible child's parent, guardian, or primary caregiver.[24] By providing a temporary period of time apart for parents and their children, respite care services can decrease stress in the family and increase the likelihood that a child with a mental illness can continue to live at home and avoid placement in an institution. However, only one of the six state Medicaid programs we reviewed—Minnesota—explicitly covered respite services for some children with mental illness.[25]

[24] Under section 1915 (c) of the Social Security Act, 42 U.S.C. §1396n(1) (2000), states may request waivers of certain federal requirements in order to develop Medicaid-financed, community-based services, including respite care.

[25] Minnesota has a waiver that provides coverage for home and community-based services, including respite care for some persons with disabilities. However, according to a CMS official, only a small group of children—those with mental illness who are at risk of being placed in a nursing facility—are eligible for these waiver services. Although the Medicaid programs in the remaining five states we reviewed do not explicitly cover respite care, providers in these states may rely on other sources of funding to provide these services to Medicaid enrollees. For example, according to a Utah official, the state provides community mental health centers with funds specifically earmarked for respite services.

Despite having mental health coverage, children enrolled in Medicaid may face constraints when they attempt to obtain covered services. For example, children may have difficulty finding providers to treat their mental health needs. Officials in the six states we reviewed said that their states had shortages of mental health providers, especially child psychiatrists, and that these shortages were particularly acute in rural areas. In addition, some providers said that low Medicaid reimbursement rates, coupled with delayed payments from states, discourage providers from participating in Medicaid. Although not specifically focused on mental health services, studies have compared Medicaid fee-for-service reimbursement rates to Medicare and have shown that Medicaid rates are significantly lower.[26] For example, in the six states we reviewed, Medicaid reimbursed physicians for a psychiatric diagnostic interview at rates that ranged from 28 to 78 percent of the average national rate Medicare pays for the same service.[27]

[26] See, American Academy of Pediatrics, Division of Health Policy Research, Department of Practice and Research, *Medicaid Reimbursement Survey, 2001- 50 States and the District of Columbia* (Elk Grove Village, Ill.: 2001), and the Lewin Group, *Comparing Physician and Dentist Fees Among Medicaid Programs, June 2001*, a special report prepared at the request of the Medi-Cal Policy Institute (Oakland, Calif.: 2001).

[27] These rates do not apply to mental health services provided through capitated, managed care plans. To varying degrees, four of the six states we reviewed—California, Massachusetts, Minnesota, and Utah—provide mental health services to Medicaid or SCHIP children through a managed care plan that is prospectively paid a capitated per-member per-month rate or through other risk arrangements.

SCHIP

The SCHIP programs in the six states we reviewed varied in their extent of mental health service coverage and the extent to which they have instituted cost-sharing requirements for covered beneficiaries. Four of the six SCHIP programs we reviewed covered generally the same extensive mental health benefits as Medicaid programs in their states. For example, SCHIP beneficiaries in Minnesota have coverage for the same unlimited mental health benefits as Medicaid beneficiaries and are not responsible for any out-of-pocket costs. Similarly, the SCHIP benefits of Illinois, Georgia, and Massachusetts generally mirror the benefits available under their state Medicaid programs, albeit with limited cost-sharing that Medicaid does not require. For example, Georgia families must pay a premium of $7.50 per month for each child over age six, with a monthly limit of $15 per family. Similarly, families in Illinois with incomes over 150 percent of the federal poverty level must pay $5 for each outpatient or inpatient mental health visit and a monthly premium of $15 for one child, $25 for two children, and $30 for three children.[28]

[28] The maximum annual copayment for outpatient or inpatient mental health visits in Illinois is $100 per family.

In contrast to these four states, SCHIP beneficiaries in California and Utah generally have coverage for fewer benefits than Medicaid beneficiaries and may face limits on treatment days and visits. Unlike their state Medicaid programs, the SCHIP programs in each of these states are modeled after the private insurance plan available to public employees in the state.[29] These SCHIP plans are not required to cover residential care or targeted case management services and are not required to provide all enrolled children with EPSDT screenings or coverage for services these screenings identify as necessary.[30, 31] (See fig. 1.) Also, children in Utah's SCHIP program are allotted a maximum of 30 outpatient visits and 30 days of inpatient care per year and are not covered for family therapy visits.[32] Similarly, California SCHIP allows participating health plans to limit children to 20 outpatient visits and 30 days of inpatient care per year. Some health plans have chosen not to impose these limits; health plans that do impose limits told us that children rarely reach them. In addition, these limits do not apply to children in California who are diagnosed with a serious emotional disturbance (SED) or one of nine severe mental illnesses (SMI).[33] These children are eligible to receive unlimited mental health services. Whether limits in California and Utah SCHIP plans prevent children from obtaining needed services is unknown; however, these limits

[29] California's SCHIP program has two components: a separate, stand-alone child health program that functions independently of the state Medicaid program and an expansion of the state Medicaid program. According to data provided by the state, most California SCHIP children—over 506,000 in January 2002-–were enrolled in the separate, stand-alone component of the program, while about 33,000 children were enrolled in the Medicaid expansion component in June 2001.

[30] SCHIP children in California diagnosed with severe emotional disturbance are eligible for these services through the county mental health departments.

[31] Unlike California and Utah, whose SCHIP programs are largely modeled after private insurance plans, states that elect to expand their Medicaid programs, such as Minnesota, must offer the same comprehensive benefit package, including EPSDT services, to SCHIP beneficiaries as they do to Medicaid beneficiaries. Officials in three other states we reviewed—Georgia, Illinois, and Massachusetts—told us they also make EPSDT services available to SCHIP enrollees, although these services are not required.

[32] A Utah state official said that by creating a separate SCHIP plan with certain benefit limitations (rather than expanding the state Medicaid program), the state was able to offer SCHIP coverage to significantly more children.

[33] California law defines severe mental illness as (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder (manic-depressive illness), (4) major depressive disorders, (5) panic disorder, (6) obsessive-compulsive disorder, (7) pervasive developmental disorder or autism, (8) anorexia nervosa, or (9) bulimia nervosa.

may not provide sufficient coverage to some traumatized children who require long-term mental health treatment.

Figure 1: Comparison of State Medicaid and SCHIP Coverage for Selected Mental Health Treatments in California and Utah

	California		Utah	
	Medicaid	SCHIP [a]	Medicaid	SCHIP
Diagnostic assessment	●	◑[b]	●	◑[c]
Individual therapy	●	◑	●	◑
Group therapy	●	◑	●	◑
Family therapy	●	◑	●	○
Medication management	●	◑	●	●
Inpatient care	●	◑[d]	●	◑[e]
Residential care [f]	●	○	●	○
Targeted case management	●	○	●	○
Nonemergency transportation	●	○	●	○

Key: ● = service covered; ◑ = service covered with limitations; and ○ = service not covered.

[a]SCHIP children in California who are diagnosed with SED have coverage for all of these services without limitations through the county mental health departments. In addition, day and visit limits do not apply to SCHIP children diagnosed with SMI.

[b]Health plans may limit outpatient care for non-SED/non-SMI children to 20 visits per year.

[c]Health plans limit enrollees to a maximum of 30 visits per year.

[d]Health plans may limit inpatient care for non-SED/non-SMI children to 30 days per year.

[e]Health plans limit enrollees to a maximum of 30 days per year and 60 days in a 3-year period.

[f]The Medicaid programs in both states cover mental health services provided to enrollees in residential care facilities but not the cost of room and board.

Source: State Medicaid and SCHIP health plans.

In addition to inpatient day and outpatient visit limits, children in California and Utah are also subject to cost-sharing requirements through SCHIP that may make mental health services unaffordable for some families. For example, depending upon the level of their income, families in California must pay $5 for each outpatient visit and must also pay a monthly premium of $4 to $9 for each child enrolled in the program, with a monthly limit of $27 per family.[34] Although Utah's SCHIP program does not charge monthly premiums, it requires families with incomes from 100 to 150 percent of the federal poverty level to pay a $5 copayment for each outpatient visit, and families with incomes from 151 to 200 percent of the federal poverty level to pay for half of the total cost of the outpatient service.[35]

Utilization of Mental Health Services

Little is known about the extent to which traumatized children with public insurance utilize mental health services, largely because no reliable, national utilization data exist for mental health services covered by Medicaid or SCHIP. While states are required by law to submit annual reports on the utilization of EPSDT services, CMS's efforts to assemble reliable information about EPSDT participation in each state have been unsuccessful, despite 1999 revisions to the annual report that sought to clarify and simplify reporting requirements. State-reported data are often untimely or inaccurate, particularly in states where children receive services through managed care plans that are prospectively paid on a capitated basis, meaning the plans receive a flat payment per member, regardless of the cost of treating the patient.[36] Moreover, states are not required to report mental health services provided under the EPSDT program. Limitations in other CMS data reporting requirements also make it difficult for the agency to determine the extent to which children are receiving mental health services. For example, periodic reports on health care utilization and expenditures that CMS requires states to submit do not collect consistent data on mental health services covered by Medicaid and SCHIP.

[34] The annual copayment amount in California is limited to a maximum of $250 per family for each benefit year. Copayments are not required for services provided to SED children at county mental health centers.

[35] Annual copayment amounts in Utah are limited to a maximum of $500 for families with incomes from 100 to 150 percent of the federal poverty level and $800 for families with incomes from 151 to 200 percent of the federal poverty level.

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

Although national data regarding publicly insured children's use of mental health services are not available, numerous lawsuits alleging shortcomings in the provision of EPSDT services, coupled with individual state utilization data that were available from most of the states we reviewed, indicate that children enrolled in Medicaid or SCHIP may not be obtaining needed services. According to the National Health Law Program, a national public interest law firm, as of September 1, 2001, 49 court opinions had been rendered on challenges alleging a state's failure to properly implement EPSDT or to provide access to necessary services. In several of these cases, courts have found that a state violated EPSDT requirements by not providing all necessary mental health services to children.[37] For example, in response to a class action lawsuit alleging that children were not being provided with access to mental health services, the court approved a consent decree by the parties under which West Virginia agreed to ensure that all EPSDT screens and subsequent treatments include behavioral and mental health services.[38]

[37] See Emily Q. v. Belshe, No. CV-98-4181-WDK, C.D., Cal., May 5, 1999 (court held that therapeutic behavioral services were required to be provided under EPSDT); French v. Concannon, No. 97-CV-24-B-C, D. Me., July 16, 1998 (in response to lawsuit challenging state's failure to provide notice of mental health services availability, state agreed to modify its EPSDT materials to include specific information about mental health screening and treatment).

[38] See Sanders v. Lewis, No. 2:92-0353, S.D.W.Va., March 1, 1995.

In addition, statewide utilization data collected by four of the six states we reviewed—California, Illinois, Minnesota, and Utah—indicated that a small percentage of children enrolled in the state's Medicaid and SCHIP programs, ranging from 0.7 percent of children in Illinois to 6 percent of children in Minnesota, used mental health services.[39] Utilization data collected by Massachusetts, however, indicated that close to 16 percent of the children enrolled in its Medicaid and SCHIP managed care program were using available mental health services.[40] Based on their experience and their reviews of research, officials in California and Utah told us they would expect the proportion of children needing mental health services to be higher. State officials and providers told us that various factors, such as the difficulty associated with identifying children with mental illness, lack of parental awareness of mental illness, and the stigma associated with mental illnesses, could contribute to lower than expected utilization of services.

Type of Insurance Coverage and State of Residence Affect Mental Health Service Coverage and Costs

A child's type of health insurance and state of residence generally determine the extent of mental health coverage available. To demonstrate the variation between public and private insurance programs in the availability and cost of mental health services for children, as well as variation among states, the following example outlines the covered benefits and annual benefit limitations of various types of insurance available to a hypothetical 5 year-old child who has experienced trauma and resides in either California or Illinois. Depending on the recommended treatment, which may include individual, group, or family therapy; inpatient hospitalization; or care in a residential facility, the services available and their cost to the child's family could vary considerably. (See fig. 2.)

[39] In states that provided mental health services to Medicaid or SCHIP children through both prepaid managed care plans and traditional fee-for-service arrangements, utilization data provided were the most recent available (all were from state fiscal years 2000 or 2001) and were for the delivery system that covered the majority of children. For Illinois and Minnesota, the data included children in both Medicaid and SCHIP. Medicaid utilization rates in California and Utah were approximately 5 percent. Utilization data were not available from Georgia.

[40] In Massachusetts, at least 85 percent of children in the Medicaid and SCHIP programs are covered through a managed care program. Utilization data provided were from fiscal year 2001.

For example, if enrolled in Medicaid, the child in California would have coverage for all these services at no cost; if enrolled in SCHIP, the child may not have coverage for residential care or transportation and could face limits on the number of inpatient days and outpatient visits allowed.[41] In addition, the family of the SCHIP-enrolled child would be responsible for a $5 copayment for each outpatient visit. This child would experience similar differences among types of coverage in Illinois. Under Illinois' Medicaid and SCHIP programs, the child would have coverage for all these services without limitations. However, the family of the child enrolled in SCHIP would also have to pay a copayment for each outpatient visit, and depending on the family's income, could be responsible for a monthly premium as well. In comparison, a child in Illinois who relied on coverage from the individual insurer specified would not have coverage for residential care and would be limited to 10 inpatient days and 20 outpatient visits each year.

[41] The California Medicaid program covers mental health services provided to enrollees in residential care facilities but not the cost of room and board.

Figure 2: Public and Private Insurance Coverage Options in California and Illinois for a Hypothetical 5-Year Old Child Who Has Experienced Trauma

	Extent of coverage						Monthly premium in dollars	Other costs to the child's family	
	Individual, group, and family therapy	Number of visits per year	Inpatient hospitalization	Number of inpatient days per year	Residential treatment [a]	Transportation		Inpatient	Outpatient
California									
Medicaid	●	Unlimited	●	Unlimited	●	●	$0	$0	$0
SCHIP [b]	◑	Maximum 20 visits	◑	Maximum 30 days	○	○	$4-9 [c]	$0	$5/visit [d]
Employer sponsored group insurance [e]	◑	Maximum 30 visits	◑	Maximum 30 days	N/A	N/A	$191 (employee share of family premium)	10% of charges	$15/visit and 20% of charges
Individual insurance [f]	◑	Maximum 20 visits	◑	Maximum 30 days	○	○	$79	-Physician all but $25/visit -Hospital all but $175/day	Physician all but $25/visit
Illinois									
Medicaid	●	Unlimited	●	Unlimited	●	●	$0	$0	$0
SCHIP	●	Unlimited	●	Unlimited	●	●	$15 [g]	$0	$2-5/visit [h]
Employer sponsored group insurance [i]	◑	Maximum 30 visits	◑	Maximum 30 days	N/A	N/A	$172 (employee share of family premium)	$0	$11/visit
Individual insurance [j]	◑	Maximum 20 visits with family therapy equal to 2 visits	◑	Maximum 10 days	○	◑ [k]	$113	20% of costs	20% of costs

Key: ● = service covered; ◑ = service covered with limitations; ○ = service not covered; and N/A = information was not available.

[a]The Medicaid programs in both states cover mental health services provided to enrollees in residential care facilities but not the cost of room and board.

[b]Some health plans in California do not choose to impose these limits on services. In addition, children in California who are diagnosed with SED have coverage for all the services included in figure 2, without limitations, through county mental health departments. Also, day and visit limits do not apply to SCHIP children diagnosed with SMI.

[c]Maximum of $27 premium per family per month.

[d]Maximum family copayment of $250 per year. However, copayments are not required for services provided to SED children in county mental health centers.

[e]These data represent conditions and in-network costs for a sample of PPO plans of employers with 500 or more employees; these plans had a median family deductible of $600. The data represent the most common day and visit limitations and other costs, and the average employee premium portion for family coverage.

[f]Data are from a PPO that is one of the most popular health plans sold in the individual insurance market in California and has a $1,000 deductible per person (maximum of $2,000 per family). Children who are diagnosed with a SED or one of nine SMI are eligible for unlimited benefits and pay 25 percent of service fees.

[g]This applies only to a child in a family whose income exceeds 150 percent of the federal poverty level. For two children, the premium is $25; for three, the premium is $30.

[h]Maximum copayment per year per family is $100.

[i]This example represents conditions for a sample of HMO plans of employers with 500 or more employees. The data represent the most common day and visit limitations, and the average employee premium portion for family coverage and outpatient copayment costs.

[j]Data are from an HMO that is one of the most popular plans sold in the individual health insurance market in Illinois.

[k]A health plan official told us that this service is available to members who meet the plan's medical necessity criteria.

Sources: State Medicaid and SCHIP health plans, Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001, and individual insurers in California and Illinois.

Federal Programs Can Help Children Who Have Experienced Trauma to Obtain Mental Health Services, But Extent of Assistance Is Largely Unknown and Little Evaluation Has Occurred

Beyond insurance, a range of federal programs—including over 50 grant programs we identified—can help children who have experienced trauma obtain needed mental health services. (See app. VI for descriptions of selected federal grant programs.) Some federal programs pay for crisis counseling, such as the crisis counseling program for victims of disasters, which is administered by FEMA in collaboration with SAMHSA. Justice's VOCA Crime Victim Compensation grants and Crime Victim Assistance grants to states help pay for mental health treatment needed by crime victims. However, factors such as state eligibility requirements and mental health service caps, as well as families' lack of knowledge about the programs, may limit some child victims' ability to benefit from these programs. Several federal grant programs encourage coordination among mental health and other service systems—such as social services, health care, and justice—so that children who have experienced trauma and their families can more easily gain access to the full range of services they need. One such program is SAMHSA's National Child Traumatic Stress Initiative, a recent effort specifically designed to take a coordinated approach to

improving mental health care for children who have experienced various kinds of trauma. Some federal programs have a broader focus, such as general mental health, or are targeted to specific populations, such as children in foster care, but grantees can elect to use program funds to provide mental health and other needed services to children who have experienced trauma and their families. Little is known about the extent to which these broader programs assist these children. Moreover, little is known about the effectiveness of federal programs that help children who have experienced trauma to obtain mental health services. For example, FEMA and SAMHSA have not evaluated the effectiveness of the disaster crisis counseling program.

Federal Disaster Grants Provide Some Mental Health Services to Children

Federal agencies provide financial and technical assistance to states and localities to meet crisis-related mental health needs of children and adults who are victims of natural disasters and mass violence. FEMA collaborates with SAMHSA's Center for Mental Health Services to provide financial and technical assistance to states and federally recognized Indian tribes that request aid for crisis counseling[42] and other services for children and adults affected by presidentially declared disasters.[43] FEMA funds the program, and SAMHSA, through an interagency agreement, provides technical assistance, program guidance, and oversight. The Crisis Counseling Assistance and Training grant funds are generally available for up to 12 months after a disaster declaration. FEMA reported that in fiscal year 2001, it had obligated about $16.2 million in crisis counseling funds.

[42] The goals of crisis counseling include helping disaster survivors understand their current situation and reactions, mitigating additional stress, developing coping strategies, providing emotional support, and encouraging links with other individuals and agencies who can help survivors return to their predisaster level of functioning. Services may be provided by mental health professionals and trained paraprofessionals.

[43] States and tribes must demonstrate that existing state and local resources are inadequate to provide for these services. Individuals are eligible to obtain crisis counseling services if they were residents of the designated disaster area or were located in the area at the time of the disaster and are experiencing mental health problems caused or aggravated by the disaster.

In addition to crisis counseling, program funds are used for such activities as training paraprofessionals to provide crisis counseling, distributing information to increase public awareness about the effect disasters can have on children, and helping identify and refer children who may need longer term mental health treatment.[44] For example, New York and Virginia were declared disaster areas after the September 11, 2001, terrorist attacks and, as of May 2002, FEMA had approved about $160.6 million in crisis counseling grants.[45] As of March 2002, New York had reported using the FEMA funds to provide free crisis counseling to approximately 10,000 children under age 18 affected by the attacks. In addition, HHS has allocated over $28 million for crisis counseling and other mental health and substance abuse services to help areas affected by the terrorist attacks, including $6.8 million that was awarded to eight states and the District of Columbia to help support crisis mental health services and to assist mental health and substance abuse systems in these locations. HHS also awarded $10 million to 33 New York City and New Jersey community health centers to support response-related services, including the provision of grief counseling and other mental health services. The Congress also appropriated $68.1 million to Justice to further meet the crisis counseling needs of victims, their families, and crisis responders. According to Justice, as of July 2002, the department had awarded more than $40 million of this amount to California, New Jersey, New York, Massachusetts, Pennsylvania, and Virginia.[46]

According to federal officials, communities have generally found the 12-month time frame sufficient for responding to all but the most serious types of disasters, and extensions of limited duration have occasionally been approved.[47] However, SAMHSA officials and trauma experts told us that there are concerns about whether the crisis counseling grant's time frame is sufficient for identifying all children who may require trauma-

[44] FEMA crisis counseling grant funds cannot be used to provide treatment for substance abuse, mental illnesses, developmental disabilities, or any preexisting mental health conditions.

[45] In addition, at the request of New York and Virginia, a portion of their crisis counseling grant funds was provided by FEMA directly to Connecticut, the District of Columbia, Massachusetts, New Jersey, and Pennsylvania.

[46] The fiscal year 2002 Defense Emergency Supplemental Appropriations Act provided funds to Justice for these additional crisis counseling grants.

[47] Most extensions have been primarily for administrative purposes and have generally been for periods of 3 months or less.

related mental health assistance as a result of a large-scale natural disaster or act of terrorism that results in mass casualties. These experts told us, for example, that in the case of the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, the time frame was not sufficient to find, assess the mental health needs of, and provide assistance to the large number of children and adults who needed help. Although FEMA extended total grant funding to about 33 months, crisis counseling services were still needed after the funds had finally expired. As a result, Justice provided an additional $264,000 to Oklahoma's Project Heartland to fund crisis counseling services needed by individuals with problems stemming from the bombing. Because there was a resurgence of mental health problems during the federal bombing trials, Justice also provided about $235,000 to help provide victims and other family members with needed crisis counseling services. According to a SAMHSA official, the September 11, 2001, attacks have led program officials to discuss whether changes are needed in the nature and duration of federal assistance available to address the special, longer-term mental health service needs that can arise from mass casualty disasters, especially those caused by terrorism.

SAMHSA is collaborating with the National Association of State Mental Health Program Directors on the association's review of states' emergency response plans to identify ways that states can better plan for the mental health care needs of disaster victims. According to trauma experts and SAMHSA officials, most states have dedicated few resources to planning for mental health needs that result from such events and most have insufficient capacity to coordinate and mobilize the mental health services needed for large-scale disasters. This could result in the loss of valuable time, duplicative efforts, and missed opportunities to identify children who could benefit from mental health assistance.

Another federal resource for crisis situations is Education's School Emergency Response to Violence program, commonly known as Project SERV. Local school districts can apply for crisis response grants for generally up to 18 months to help deal with the aftermath of violent or traumatic events, such as school shootings and acts of terrorism.[48] Education officials said school districts have used grants for children's crisis counseling, school security, transportation to safe locations, and translation services.[49] In addition, under the program, Education can send trauma and violence experts to a school district to help school personnel handle disaster situations. In fiscal year 2001, Project SERV obligated nearly $9.8 million to school districts responding to violence and disasters, with nearly 90 percent of the funds awarded to schools in communities affected by the September 11, 2001, terrorist attacks.

[48] Project SERV awards in fiscal year 2001 ranged from $50,000 to $4,225,000.

[49] By statute, Project SERV funds may not be used for medical services or drug treatment or rehabilitation, except for pupil services or referral to treatment for students who are victims of, or witnesses to, crime. 20 U.S.C. § 7164(2). Pupil services are provided by school counselors, school social workers, school psychologists, and other qualified professional personnel involved in providing assessment, diagnosis, counseling, educational, therapeutic, and other necessary services (including certain services defined in section 602 of the Individuals with Disabilities Education Act). 20 U.S.C. § 7801(36)(B). Education officials report that services have included individual, group, and family counseling.

Federal Crime Victims Fund Pays for Some Children's Mental Health Services

The federal Crime Victims Fund is an important federal funding source for meeting the mental health needs of children who are victims of violent crimes, including mass violence and terrorism. The fund is administered by Justice's OVC, and most of the funds available[50] are used to support victim compensation grants and victim assistance grants to all states, the District of Columbia, Puerto Rico, and U.S. territories.[51] Federal VOCA victim compensation grants supplement state funds to provide direct financial assistance and reimbursements to, or on behalf of, eligible crime victims or their survivors[52] for a wide range of crime-related expenses, including those for mental health services.[53] Federal victim assistance grants are provided to the states, which in turn award these funds to eligible public and private nonprofit organizations that work directly with crime victims to determine their needs and provide them with a range of free services, including mental health services. In fiscal year 2002, OVC allocated about $477 million to these two grant programs.[54]

[50] The Congress has placed a cap on the amount of money in the Crime Victims Fund available to OVC for funding crime victim-related programs and activities. In fiscal year 2001, $537.5 million of the approximately $776.5 million in the Crime Victims Fund was made available to OVC for allocation. In addition to funding its two formula grant programs, OVC is authorized to use the Crime Victims Fund allocation to fund other victim-related activities, such as providing grants to help Indian tribes improve the handling of child abuse cases, funding projects to identify ways for improving the delivery of victim services, and supporting a special compensation program for child and adult victims of international terrorism, as required by the Victims of Trafficking and Violence Prevention Act of 2000. OVC is authorized to set aside up to $50 million from Crime Victims Fund allocations for an emergency reserve fund to assist victims of terrorism or mass violence and fund the International Terrorism Victim Compensation Program.

[51] OVC provides federal Victim Compensation grants and Victim Assistance grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. OVC also provides Victim Assistance grants to American Samoa and the Northern Mariana Islands.

[52] Survivors of homicide victims are also eligible for state victim compensation.

[53] VOCA requires states, at a minimum, to award compensation for victims' medical and dental costs, mental health counseling and care, lost wages, and funeral expenses. VOCA compensation program guidelines give states flexibility to offer compensation for other crime-related expenses, such as for crime scene cleanup, forensic sexual assault examinations, and loss of support, to the extent authorized by state statute or policy.

[54] In addition, in fiscal year 2001, OVC used its emergency reserve fund to allocate $16.6 million in supplemental victim compensation grants and victim assistance grants to New York, Pennsylvania, and Virginia to assist children and adults affected by the September 11, 2001, terrorist attacks.

Victim Compensation

States use federal victim compensation grants to supplement their efforts to compensate eligible crime victims or their survivors who file claims with state victim compensation programs for their crime-related expenses.[55] In some instances, children who witness crimes may be eligible for compensation.[56] State victim compensation programs provide financial assistance and reimbursement to crime victims only to the extent that other financial resources, such as health insurance, do not cover a victim's loss. Crisis counseling, individual and group therapy, psychiatric hospital care, and prescription drugs are among the mental health services covered by states. According to OVC, state victim compensation programs reimbursed approximately $50 million in mental health expenditures to children and adults in fiscal year 2000.[57] The percentage of annual compensation expenditures that provides reimbursement for mental health services varies widely by state. For example, in fiscal year 2001, 91 percent of California's victim compensation funds that paid for services to children were for mental health services, while 14 percent of Illinois's compensation funds that paid for children's services were for mental health services.

State officials told us that the availability of victim compensation funds can be particularly helpful for uninsured children or children whose insurance does not cover all needed mental health services. For example, of the claims for children's services reimbursed by California's compensation program in fiscal year 2001, about 58 percent were for children who were uninsured, 21 percent for children with private insurance, 10 percent for children enrolled in Medicaid, and about 11 percent for children with other financial resources. Similarly, Illinois officials told us that the state's compensation program serves many children who have no insurance.

[55] Claims for child victims can be filed on their behalf by their parents or other guardians; children can also file on their own behalf when they reach the age of 18.

[56] Although providing victim compensation to children who witness violence is not specifically required by VOCA, the National Association of Crime Victim Compensation Boards told us that most states consider children who have witnessed violence to be victims of a crime and thus potentially eligible for victim compensation.

[57] OVC could not provide separate reimbursement data for children and adults. We were able to obtain selected data on some children's services in some states.

Although crime victim compensation program guidelines require states to reimburse victims for mental health expenses, states are given discretion in setting program eligibility requirements and benefits. As a result, states have different rules for who can qualify to receive compensation benefits. In addition, states' mental health benefits vary with respect to overall dollar limits, whether there are caps on mental health coverage within those limits and the amounts of those caps, the number of treatment sessions allowed, and the length of time that crime victims can receive mental health benefits through the victim compensation program. Furthermore, in most states when there are multiple victims of a crime, they typically must share the available overall maximum benefits. However, each family member or secondary victim is typically eligible for mental health counseling benefits up to specified caps, which generally apply to individuals and do not have to be shared. For example, the total maximum compensation in California for all victims of a crime is $70,000, with a $10,000 cap on mental health services for all direct victims, and Minnesota's total maximum award limit is $50,000, with a $7,500 cap on mental health services.[58] In Massachusetts and Illinois, the overall compensation ceilings are $25,000 and $27,000, respectively, with no mental health caps. New York has the most generous compensation benefit, with no overall maximum and no cap on reimbursement for victims' mental health expenses. (See app. VII for a summary of state benefit information.)

Whether state eligibility requirements and caps on mental health services are preventing some children from obtaining needed services is largely unknown. Federal and state victim compensation program officials told us that most child claimants obtain reimbursement for needed mental health services and that many do not reach their benefit limits. The state victim compensation officials, however, also told us that eligibility requirements and benefit limits may exclude some children who need assistance to pay for mental health services. OVC has not undertaken a nationwide analysis of the effect of state requirements and benefit limits on meeting the mental health needs of child crime victims. Furthermore, OVC officials told us that there are no detailed data at the national level on state compensation programs' payment for mental health services provided to children who have experienced trauma. While OVC requires states to submit annual

[58] In California, family members of homicide victims and custodial parents or primary caretakers of child victims are also subject to the $10,000 cap. However, other victims have a $3,000 cap for mental health benefits. In Minnesota, each secondary victim can obtain reimbursement for up to 20 counseling sessions.

reports on certain activities, including overall expenditures for mental health services, it does not require information on expenditures for children's mental health services and the types of mental health services provided to these children. Therefore, the number of children who have benefited from the mental health coverage available through state victim compensation programs is uncertain.

Victim Assistance

OVC's victim assistance grants to the states are another vehicle that can help children and their families obtain needed mental health services. In fiscal year 2000, these grants were combined with state victim assistance funds to award grants to about 4,300 public and private nonprofit organizations that in turn provided crime victims with free medical, mental health, social service, and criminal justice advocacy services.[59] In contrast to state victim compensation programs, which require crime victims to submit detailed applications and supporting documentation, local organizations that receive grants from state victim assistance programs typically do not require as much documentation from crime victims before providing them with needed assistance. State and local officials told us that some crime victims many obtain faster help through victim assistance programs than through filing compensation claims and waiting for reimbursement for their crime-related expenses—a process that took, on average, about 23 weeks in fiscal year 2000.

State victim assistance agencies reported allocating about $542.6 million in fiscal year 2000 to provide a range of services to about 3 million crime victims. For example, nearly 1.5 million of these victims received crisis counseling and about 230,000 received individual therapy.[60] In the four states we reviewed, children benefiting from these grants included those who had been sexually or physically abused. (See table 3.)

[59] State victim assistance agencies provide grants to such entities as mental health agencies; domestic violence shelters; rape crisis centers; child abuse programs; and victim service units in law enforcement agencies, prosecutors' offices, hospitals, and social service agencies.

[60] Data were not available on the number of children who received mental health services.

Table 3: Number of Victims in Selected Categories Served by State Victim Assistance Programs in Four States, Fiscal Year 2001

Type of victimization	California	Illinois	Massachusetts	Minnesota
Child physical abuse	4,758	646	1,291	4,769
Child sexual abuse	21,817	5,742	3,380	7,569
Adults molested as children	5,327	945	1,351	1,324

Source: Statewide Victim Assistance Performance reports.

State victim assistance programs have reported to OVC that their programs helped children who have experienced trauma and their families in varied ways. For example, California, Illinois, and Massachusetts officials reported paying for individual and group therapy in cases where children either did not have insurance or their insurance provided reimbursement for fewer sessions than were needed. In addition, California and Massachusetts officials reported that victim assistance funds had helped provide comprehensive services to children and other family members, including case management, counseling services in their native languages, translation assistance, and help in filing claims for victim compensation.

Several Factors May Limit Some Children's Use of Victim Compensation and Victim Assistance Benefits

Although many children who are crime victims obtain mental health and other services through state victim compensation programs, federal, state, and local officials told us that many victims do not file compensation claims and that program limitations can constrain access to services. It is difficult to determine the exact number of victimized children who need trauma-related mental health services and who also need the financial assistance available through state victim compensation programs to obtain such services. Many crime victims may not need to file a claim for state victim compensation because they have not incurred any crime-related expenses or they have other resources, such as insurance, to help them pay for needed services. Nonetheless, California and Illinois victim compensation officials said that based on their analyses of claimant rolls and crime victim statistics in their states, they believe that many potentially eligible victims who could benefit from the assistance their programs offer had not applied for compensation. For example, an Illinois Crime Victim Compensation office analysis comparing 2000 county-level crime statistics with compensation claims received in 2001 showed that while there were 30,630 violent crimes reported in Chicago, the state victim compensation office received only 2,796 claims from victims in that city.[61]

[61] Separate analyses were not done on children and adult crime victims.

A 2001 Justice-funded report on state victim compensation and victim assistance programs indicated that several program-related factors might impede victims' access to services supported by such programs. These factors included (1) lack of knowledge about the programs' existence, (2) lack of information on how to obtain available benefits, and (3) state eligibility requirements that might make it difficult for some victims to qualify for benefits. For example, most states stipulate that to qualify for compensation, a victim must file a report with law enforcement authorities shortly after a crime occurs, generally within 72 hours, and must cooperate with these authorities. However, victims of some crimes, such as sexual assault or domestic violence, may not report the crimes immediately and may be apprehensive about cooperating with authorities due to fear of retaliation by the offender. Other program barriers identified by state program managers surveyed for the report included (1) limited outreach and education, especially to racially and ethnically diverse populations and to rural communities, (2) lengthy and complex compensation award determination and payment processes, and (3) insufficient coordination between state victim compensation and victim assistance programs and with other agencies that work with these victims to eliminate gaps in assistance or duplicative services.[62]

Efforts to address some of these problems are under way in the states we contacted. For example, the Los Angeles County District Attorney's office placed victim advocates in county courts to inform victims of their right to benefit from the victim compensation and assistance programs and to help children and their families obtain needed services, including mental health care. In addition, California, Illinois, and Minnesota officials told us that they are now more flexible with their time frames for filing crime reports with police and will accept other official reports, such as those from child protective agencies and forensic sexual assault examinations. OVC published a report in 1998 that included a recommendation that state crime victim compensation programs reexamine their mental health benefits to ensure that they are adequate.[63]

[62] Urban Institute, *The National Evaluation of State Victims of Crime Act Compensation and Assistance Programs: Findings and Recommendations from a National Survey of State Administrators*, for the Department of Justice, National Institute of Justice (Washington, D.C.: Mar. 2001).

[63] Department of Justice, OVC, *New Directions from the Field: Victims' Rights and Services for the 21st Century* (Washington, D.C.: May 1998).

Federal Agencies Encourage Coordination to Meet the Needs of Children Who Experienced Trauma

Coordination among mental health, child welfare, education, law enforcement, and juvenile justice systems can help ensure that children who have experienced trauma and their families obtain comprehensive, timely, and appropriate services. Several federal agencies have funded grant programs to promote collaborations within and across these systems—some of which have not traditionally worked together, such as police and mental health professionals. For example, although research has documented the frequent co-occurrence of domestic violence and child abuse,[64] government officials and family violence experts report that the child welfare and domestic violence advocacy systems often fail to work together to devise safe, coordinated, and effective responses to family violence, due in part to differing missions, priorities, and perspectives. In some instances, child welfare officials want to remove a child from a home where domestic violence has allegedly occurred, while advocates for the nonoffending parent argue that taking the child out of the home would penalize that parent.

Justice awards grants to help support more than 350 Children's Advocacy Centers, which assist children who come into contact with the court system as a result of being abused.[65] The centers aim to bring together a multidisciplinary team and promote coordination among various service systems to ensure that a child's multiple needs are met, including access to mental health services for the child and other family members. Typically consisting of law enforcement representatives, child protection workers, prosecutors, victim advocates, and mental health professionals, the teams work to ensure that the child does not have to recount the traumatizing event in multiple interviews, which could result in additional trauma.

To help communities minimize the adverse impact of family and community violence on young children, Justice initiated the Safe Start Demonstration Project in 1999. The grant program, which will last about 5 years, is designed to improve access to, and the quality of, services for young children who are at high risk of exposure to violence or who have already been exposed to violence. The program's goal is to help

[64] See, for example, Jeffrey L. Edelson, *The Overlap Between Child Maltreatment and Woman Abuse* (St. Paul, Minn.: Minnesota Center Against Violence and Abuse, Apr. 1999).

[65] Through a cooperative agreement, Justice provides funds to the National Children's Alliance, a not-for-profit organization that assists communities seeking to plan, establish, and improve Children's Advocacy Centers, which in turn administers grants that fund the establishment and expansion of Children's Advocacy Centers.

communities strengthen partnerships among key service systems such as Head Start, health care, mental health care, domestic violence shelters and advocacy organizations, child welfare, and law enforcement. In fiscal year 2000, the agency awarded grants to nine communities, with each receiving $250,000 for a first-year planning phase. In addition, grantees will receive up to $670,000 annually for implementation activities.

Another way federal agencies are trying to encourage service systems to work together is the Collaborations to Address Domestic Violence and Child Maltreatment Project, which is jointly funded and administered by eight agencies and offices within HHS and Justice.[66] The one-time demonstration grant, commonly called the Greenbook Project, funds initiatives in six communities that are each receiving $350,000 annually for 3 years, starting in fiscal year 2000.[67] The project's goal is to help communities develop partnerships among three key stakeholders—the child welfare system, domestic violence groups, and juvenile and family courts—to improve the delivery of services to victims of domestic violence and their children.[68] For example, a grantee in Colorado has used program funds to hire a domestic violence advocate to work in the child welfare system to improve screening for domestic violence and assess the risk to children. The grantee has also used these funds to enhance an existing program that houses police and child protective personnel at one location, allowing them to jointly respond to domestic violence calls so they can deal with the needs of all family members, including children who have witnessed the violence.

Education, HHS, and Justice created the Safe Schools/Healthy Students demonstration project in 1999 to help schools and communities draw on

[66] HHS participants are the Office of the Secretary (Office of the Assistant Secretary for Planning and Evaluation); ACF (Children's Bureau and the Family Violence Program); and Centers for Disease Control and Prevention (National Center for Injury Prevention and Control). Justice participants are all in the Office of Justice Programs—Violence Against Women Office, OVC, Office of Juvenile Justice and Delinquency Prevention, and National Institute of Justice.

[67] The sites are located in El Paso County, Colorado; Grafton County, New Hampshire; Santa Clara County, California; Lane County, Oregon; St. Louis County, Missouri; and San Francisco County, California.

[68] The project was developed in response to recommendations presented in a report published in 1999 by the National Council of Juvenile and Family Court Judges, entitled *Effective Intervention In Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice* (Reno, Nev.: 1999).

three traditionally disparate service systems—education, mental health care, and justice—to promote the healthy development of children and address the consequences of school violence. The program, which through fiscal year 2001 had made awards totaling about $439 million, requires local education agencies to establish formal partnerships with mental health providers and local law enforcement professionals. One of the project's six core elements is the enhancement of school- and community-based mental health preventive and treatment services. In fiscal year 2001, the agencies awarded about $177 million to 97 urban, suburban, rural, and tribal community grantees.

SAMHSA's National Child Traumatic Stress Initiative is a recent initiative specifically designed to take a coordinated approach to improving mental health care for children who have experienced various kinds of trauma. Launched in October 2001, the 3-year effort is designed primarily to (1) improve the quality, effectiveness, and availability of therapeutic services for all children and adolescents who experience traumatic events, (2) develop a national network of centers, programs, and stakeholders dedicated to improving the identification, assessment, and treatment of children, and (3) reduce the frequency and severity of negative consequences of traumatic events through greater public and professional understanding of childhood trauma and greater acceptance for child trauma intervention services. SAMHSA has taken a tiered approach in structuring the $30 million initiative by establishing three grantee categories: a National Center for Child Traumatic Stress to coordinate the overall initiative; 10 Intervention Development and Evaluation Centers, which plan to develop scientifically-based improvements in treatment and service delivery; and 25 Community Treatment and Services Centers, which focus on treating victims of various types of trauma.[69] The initiative emphasizes partnerships and coordination among grantees at each level and across levels. It also encourages grantees to collaborate with

[69] The program was initially funded at $10 million and those funds were awarded to 18 grantees. The National Center for Child Traumatic Stress, which is a partnership between the University of California, Los Angeles, and Duke University, received about $3.1 million. Five Intervention Development and Evaluation Centers received grants ranging from about $568,000 to $600,000, and 12 Community Treatment and Services Centers received grants ranging from about $285,000 to about $348,000. In fiscal year 2002, the Congress appropriated an additional $20 million. In June 2002, SAMHSA awarded 5 additional Intervention Development and Evaluation Center grants, ranging from about $600,000 to about $1.8 million, and 13 additional Community Treatment and Services Center grants, ranging from about $117,000 to about $1 million. These additional grants totaled about $11.4 million.

professionals in various community service systems—including child protection, justice, education, and health care—that interact with children who have experienced trauma and their families. Because this initiative is in its early stages, information on the effectiveness of its efforts is not available.

Federal Programs with Broader Focus May Help Fund Services Needed by Children Who Experienced Trauma

Other federal grant programs not specifically targeted to assisting children who have experienced trauma may also help fund mental health and other services needed by these children and their families. These federal grants focus on broader issues, such as general mental health or maternal and child health services or services for specific populations, such as children in foster care, homeless youth, or migrant farmworkers. (See app. VI for descriptions of selected federal grant programs.) Grantees can, if they choose, use these funds to provide a range of services beneficial to children who have been traumatized. For example, funds from the Indian Health Service's Urban Indian Health Program, which provides health services to child and adult American Indians living in urban areas, can be used to screen, refer, and treat children who need mental health services due to trauma. ACF's Transitional Living for Homeless Youth program, which operates transitional living projects and promotes self-sufficiency for homeless youth, requires grantees to offer mental health services, either directly or by referral. SAMHSA's Comprehensive Community Health Services for Children and Their Families program, commonly known as the System-of-Care program, provides supportive services to children and adolescents with SED and their families. Many of the children served through this program have been exposed to violence in their homes and many have been referred by social service and law enforcement agencies. In fiscal year 2001, 45 communities received System-of-Care grants to fund a range of services, including case management, intensive home-based treatment services, family counseling, and respite care. State officials and service providers told us that some of the broader federal grants improved their ability to meet the needs of traumatized children and their families because the grants can fund services that are not always eligible for insurance reimbursement, such as case management and ancillary services for parents, including child care and transportation.

Some of these broader federal grants also support screening and identification of children with trauma-related mental health problems. For example, ACF's Head Start program, which promotes school readiness for low-income children, requires grantees to ensure that each child receives mental health screening within 45 days of entering the program. The grantees are required to consult with mental health or child development professionals, teachers, and family members in devising appropriate responses to address identified problems. In 1990, HRSA and CMS cosponsored the initiation of the Bright Futures project to help primary care health professionals promote the physical and mental well-being of children, recognize problems, and intervene early. Recently, HRSA funded the development of mental health practice guidelines outlining risk factors and potential interventions related to domestic and community violence.[70] In addition, HRSA and the National Highway Traffic Safety Administration administer the Emergency Medical Services for Children program, which provides funds to ensure that children's services are well integrated into the emergency medical system. Among its initiatives, the program provides training grants to improve the ability of emergency medical services workers and emergency department physicians and nurses to identify the mental health needs of children in emergency situations.

Because they are not specifically designed to assist the mental health needs of children who have experienced trauma, these grants' data reporting requirements often do not produce information on the extent to which children have been screened for trauma-related problems and the number of children who have obtained mental health services as a result of trauma. In addition, program officials were generally unable to provide specific information on the portion of program funds used to serve these children.

[70] Michael Jellinek, Bina P. Patel, and Mary C. Froehle (eds.), *Bright Futures in Practice: Mental Health Practice Guide*, *Volume 1* (Arlington, Va.: National Center for Education in Maternal and Child Health, 2002).

Few Federal Programs Have Evaluated Their Effectiveness in Assisting Children Who Experienced Trauma

Despite the many federal efforts that contribute to varying degrees to helping children who have experienced trauma and their families obtain mental health and other needed services, little is known about their effectiveness. Few programs have undertaken formal evaluations to assess program progress and results and to guide decisions to improve service to targeted beneficiaries. For example, FEMA and SAMHSA have not conducted an evaluation of the effectiveness of FEMA's crisis counseling program. SAMHSA officials told us that there were no immediate plans to conduct such an evaluation. In 1995, FEMA's Office of Inspector General recommended that the agency, in consultation with experts in disaster mental health and mental health outcomes research, evaluate the effectiveness and efficiency of the crisis counseling program.[71] In its response to the recommendation, FEMA indicated that FEMA and SAMHSA monitored grantee activities through grantee reports and joint site visits. However, these activities do not constitute an evaluation of the crisis counseling program. For example, the site visits generally involve monitoring the grantee's program to ensure that it is carrying out reported activities and providing technical assistance. SAMHSA recently developed guidance for grantees outlining recommended program evaluation strategies. An agency official told us that grantees are encouraged to conduct evaluations of their individual programs, but are not required to adhere to the guidance in managing their programs. According to HHS, the Department of Veterans Affairs' National Center for Post-Traumatic Stress Disorder will conduct case studies of past and current crisis counseling program grantees' programs and will make recommendations on programwide evaluation activities. The scope and nature of these efforts have not been fully determined. Education also has not evaluated Project SERV, which provides crisis response grants to schools, and ACF has not evaluated the Transitional Living for Homeless Youth program, which requires grantees to offer mental health services to homeless youth.

[71] FEMA, Office of Inspector General, *Inspection of FEMA's Crisis Counseling Assistance and Training Program*, Inspection Report I-01-95 (Washington, D.C.: June 1995).

Justice has funded a multiyear evaluation of the Crime Victim Compensation and Victim Assistance programs. The study was designed to, among other things, evaluate how the victim compensation and assistance programs serve crime victims and how variations in program administration and operations affect the effectiveness and efficiency of services to victims. The initial report, issued in March 2001, primarily consisted of a survey of state program managers' views on program operations and needed improvements.[72] The final report, which is scheduled for issuance in fall 2002, will be based on case studies of six states' compensation and assistance programs, including a survey of compensation claimants and a survey of assistance clients in those states. The results of the survey of compensation claimants will partly reflect the experience of child victims and of victims who used mental health services. Because the survey of assistance clients had less participation by adults who could comment on a child's experience, the study may provide less information about child victims' experience with the assistance program.[73] The case studies also involved discussions with state administrators and service providers that received victim assistance funds on the programs' ability to help child victims obtain mental health services.

Some federal grants include formal evaluation components, but have yet to establish their evaluation framework, including detailed outcome measures. For example, the Greenbook and Safe Start grants, which support coordination efforts, included a year-long planning process to develop their evaluation frameworks. However, as of May 2002, when these grants had been under way for almost 2 years, neither had finalized its evaluation process, including development of core performance measures. SAMHSA's National Child Traumatic Stress Initiative also plans to undertake an evaluation of the overall initiative and individual grantee projects. As of May 2002, SAMHSA and the grantees had begun to discuss the evaluation framework but had not finalized it. In addition, other grants have established their evaluation frameworks and performance measures, but their evaluations have yet to yield results. For example, the Safe Schools/Healthy Students program is collecting data, with an interim report planned for fiscal year 2002 and a final report in fiscal year 2004.

[72] Findings of that survey were discussed earlier in this report.

[73] Minors could not participate in either survey. Participants in the compensation survey included adults who filed claims on behalf of children.

Conclusions

Many children who have experienced trauma are resilient and may suffer few ill effects. Others, however, require mental health services to help them cope and minimize long-term psychological, emotional, or developmental difficulties. While most children have health insurance that covers mental health services to varying degrees, coverage limitations are common and may constrain children's ability to obtain care. Numerous federal grant programs could expand the number of children whose mental health services may be reimbursed or help increase the available services in a community, but some children who need services may not benefit from such programs. For example, some grants are awarded to a relatively small number of communities and expire after a defined period, and evidence suggests that families of some children who are eligible to benefit from Justice's victim compensation and assistance programs may not be aware of the programs.

The effectiveness of federal programs that could help children who have experienced trauma remains largely unknown. Some programs with planned evaluations, such as the Greenbook Project, have lagged in establishing their evaluation frameworks. SAMHSA's recent National Child Traumatic Stress Initiative, which focuses specifically on the mental health needs of these children, intends to evaluate the results of grantee projects and the overall program. This effort could develop information on ways to effectively provide mental health services to traumatized children, but because the initiative is new, it is too early to gauge its success. Justice's current evaluation of its Crime Victim Compensation and Crime Victim Assistance programs should provide some information on the experience of child victims in using the victim compensation program to obtain needed mental health services, but may provide less information on children's ability to obtain mental health services through the victim assistance program. FEMA and SAMHSA have not evaluated the effectiveness of the long-standing disaster crisis counseling program and have no immediate plans to conduct a programwide evaluation. Without evaluations of the effectiveness of federal programs that have a clear goal of helping children who experienced trauma to obtain mental health services, federal managers and policymakers lack information that would help them assess which federal efforts are successful; determine which programs could be improved, expanded, or replicated; and effectively allocate resources to identify and meet additional service needs.

Recommendation for Executive Action

We recommend that, to provide federal policymakers and program managers with additional information on federal grant programs serving children who have experienced disaster-related trauma, the Director of FEMA work with the Administrator of SAMHSA to evaluate the effectiveness of the Crisis Counseling Assistance and Training Program, including its assistance to children who need mental health services as the result of a disaster.

Agency Comments and Our Evaluation

We provided a draft of this report to four federal departments and agencies for their review. FEMA, HHS, and Education submitted written comments that are provided in appendixes VIII through X, respectively. HHS and Education also provided technical comments, as did Justice. We have modified the report, as appropriate, in response to written general and technical comments.

In general, HHS stated that the report will be a useful tool for policymakers and brings important attention to the needs of children exposed to traumatic events. HHS and FEMA both agreed with our description of the Crisis Counseling Assistance and Training Program and with our conclusions on the importance of evaluating the program's effectiveness. HHS stated that it strongly agreed that evaluation activities are critical for this program and other child trauma programs to ensure program effectiveness and the appropriate use of resources. Both agencies said they have begun, or plan to take steps, to engage in additional evaluation activities, and HHS commented that it plans to continue ongoing evaluation efforts to assure that services are appropriate, efficient, and responsive to the needs of disaster victims. At their request, we modified the report to reflect additional information the agencies provided on current evaluation activities. However, neither the FEMA and HHS activities that we described nor those that they cited in their comments constitute the programwide evaluation of the program's effectiveness that we are recommending. Furthermore, FEMA did not indicate in its response whether it intends to implement our recommendation to coordinate with SAMHSA to conduct such an evaluation, which is needed to help federal policymakers and program managers assess whether the Crisis Counseling Assistance and Training Program is effectively assisting children who have experienced disaster-related trauma.

HHS said that the draft report emphasized the lack of data on the prevalence of children exposed to trauma and their mental health needs

but did not discuss National Institutes of Health and National Institute of Mental Health research data, including data from nationally representative surveys. The types of research studies HHS referred to in its comments generally focus on specific communities or certain defined populations, and existing nationwide surveys have limitations such as not covering certain age ranges or addressing the full range of traumatic situations that children may experience. Appendix II of our draft report included ACF's nationwide data on children who have been abused and neglected and the number of those who received mental health services. However, for other kinds of trauma, there are few nationwide data estimating the number of children who need mental health services due to these traumas and the number who receive services.

HHS suggested that the report should more fully discuss the availability of providers trained to help children who have experienced trauma. The department said the country does not have a child mental health workforce with the capacity to meet the needs of children and that responding to PTSD in children requires even more specific training. The draft report did refer to workforce issues that could affect children's access to needed mental health services, and we have included additional information in response to HHS's comments. A detailed discussion of workforce issues, however, was not within the scope of this report. HHS also expressed concern that the report did not discuss the need for more research on specific mental disorders and effective treatments, the stigma often associated with mental health problems and its effect on the delivery of mental health services to children who have experienced trauma, or problems in the public mental health system. We agree that these are important issues and modified the report to acknowledge the potential role of stigma. However, a detailed discussion of these issues was also outside the scope of this report.

HHS further commented that the report should contain a more thorough discussion of HRSA's grants to help meet the mental health needs of children. Appendix VI of the draft report described several HRSA grants, including the Maternal and Child Health Block Grant. Based on the department's comments, we modified the appendix to describe additional HRSA grants.

HHS acknowledged that the report provides information on the limits insurance plans often place on mental health coverage, but said that the draft report did not address the ramifications of mental health parity. We added clarification that the federal mental health parity law does not

require group health plans to offer mental health benefits, but otherwise believe the report provides ample information on the limits of federal and state mental health parity laws.

Education concurred with the information discussed in the report. Like HHS, the department raised concerns about the availability of mental health providers to serve children who have experienced trauma.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We are sending copies of this report to the Secretary of Health and Human Services, the Attorney General, the Secretary of Education, the Director of the Federal Emergency Management Agency, appropriate congressional committees, and others who are interested. We will also make copies available to others who are interested upon request. In addition, the report will be available at no charge on the GAO Web site at *http://www.gao.gov*.

If you or your staffs have any questions, please contact me or Kathryn G. Allen, Director, Health Care—Medicaid and Private Insurance Issues, at (202) 512-7119. An additional contact and the names of other staff members who made contributions to this report are listed in appendix XI.

Janet Heinrich
Director, Health Care—Public Health Issues

Scope and Methodology

To do our work, we obtained program documents, pertinent studies, and data from the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of the Secretary, Office of the Assistant Secretary for Planning and Evaluation, and Substance Abuse and Mental Health Services Administration (SAMHSA); the Department of Justice's Bureau of Justice Statistics, National Institute of Justice, Office of Juvenile Justice and Delinquency Prevention, Office for Victims of Crime, and Violence Against Women Office; the Federal Emergency Management Agency; the Department of Education; and the Department of Agriculture. We also interviewed officials from these agencies. We also reviewed the relevant literature and interviewed officials or obtained information from national organizations including the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, American Public Human Services Association, Child Welfare League of America, Family Violence Prevention Fund, National Association of Crime Victim Compensation Boards, National Association of Social Workers, National Association of State Mental Health Program Directors, National Coalition Against Domestic Violence, National Council of Juvenile and Family Court Judges, and Prevent Child Abuse America.

To determine the extent to which private and public insurance programs cover mental health services for children, we reviewed national employer benefit surveys; reviewed the benefit design of health plans provided by 13 insurers in the individual market, state Medicaid programs, and State Children's Health Insurance Programs (SCHIP); and interviewed representatives of private insurers and public officials in California, Georgia, Illinois, Massachusetts, Minnesota, and Utah. These states were selected on the basis of variation in the number of beneficiaries covered, in geographic location, in the extent to which the insurance market is regulated, and in the design of the SCHIP program. For information on the extent to which employers offer mental health benefits to employees, as well as the conditions under which coverage is made available, we relied on private employer benefit surveys conducted in 2001, specifically those of (1) William M. Mercer, Incorporated (formerly produced by Foster Higgins) and (2) the Health Research and Educational Trust, sponsored by the Kaiser Family Foundation. These surveys are distinguished from a number of other private ones largely because of their random samples,

which allow their results to be generalized to a larger population of employers.

For the mental health services covered by private individual market insurers, we interviewed state insurance regulators in each of the six states to learn about state laws related to the provision of mental health benefits and to identify the insurers in the individual market in the state. We then reviewed the benefit designs of popular health plans sold in the individual market. To obtain information about the mental health coverage of the public insurance programs in these states, we reviewed state Medicaid and SCHIP plans, which specified program characteristics, including covered benefits and limitations, and we interviewed program officials to obtain information on income eligibility and service delivery models. In several of the states, we also interviewed Mental Health Department officials, providers, and consumer advocates.

To identify federal programs that help children who have experienced trauma receive mental health services, we reviewed the Catalog of Federal Domestic Assistance. After identifying programs, we interviewed and collected information from federal program officials to confirm whether these programs can support activities, such as mental health treatment, screening and referral services, educational outreach, training for medical and other professionals on the needs of children exposed to trauma, and research and evaluation of mental health services. The federal program officials also identified other programs and efforts that can address the mental health needs of children exposed to trauma and provided perspectives on barriers to these children receiving mental health services. We obtained additional information on grants that appeared to be most relevant to the population discussed in this report. The programs and efforts we discuss in this report do not represent an exhaustive list of all federally funded programs that can address the mental health needs of children exposed to trauma; they highlight a range of programs that target varied populations, services, and systems that come into contact with this population. We report that these programs can provide mental health services to this population because funds may be used for this purpose. We were not generally able to obtain information on the nature of the services provided or the level of service used by children exposed to trauma because some programs we identified do not collect information specifically on mental health services provided to children exposed to trauma.

We obtained additional information on selected federally supported programs and problems children face in obtaining needed mental health services through site visits in California and Massachusetts. In these states, we interviewed officials or obtained data from state and local mental health agencies, state crime victim compensation and assistance programs, child welfare and protective service agencies, and other organizations receiving federal grants. We also contacted service providers with federal grants located in Colorado, Illinois, Minnesota, and Oregon. We selected these locations to visit or contact because they have organizations receiving federal grants focused on children and trauma, such as SAMHSA's Child Traumatic Stress Initiative or HHS/Justice's Greenbook Project, or recognized experts in the field of child trauma.

We also obtained data on child abuse and neglect, domestic violence, and sexual assault that were collected and analyzed by HHS's ACF and Justice's Bureau of Justice Statistics, National Institute of Justice, and Federal Bureau of Investigation. We did not verify the accuracy of these data.

We conducted our work from September 2001 through August 2002 in accordance with generally accepted government auditing standards.

Victimization Data

This appendix presents information on child maltreatment,[74] intimate partner violence,[75] and sexual assault. ACF data provide information on children's entry into the child protective service system and the services that they and their families received (see tables 4 to 7); additional information was provided by ACF on a program to increase contact between children and their noncustodial parents. (See table 8.) Justice data provide information on individuals who were victims of intimate partner violence and sexual assault. (See tables 9 to 12 and fig. 3.) We did not confirm the accuracy of these data.

Child Abuse and Neglect Data Collected by HHS's Administration for Children and Families

In 1996, the Child Abuse Prevention and Treatment Act was amended to require states receiving a Child Abuse and Neglect State Grant to report to the National Child Abuse and Neglect Data System, to the extent practicable, 12 specific data items on child maltreatment, such as the number of victims of abuse and neglect and the number of children who received services. States can voluntarily report data in other categories, such as the number of children receiving mental health services. All states submitted data for 1999, the most recent year for which data are available. All states did not respond to all required items. For example, 10 states did not report information on the number of victims who received services. (See table 6.) ACF reported in *Child Maltreatment 1999* that the required child maltreatment data had been validated for consistency and clarity, but ACF officials told us that state definitions vary, making comparisons between states difficult.

[74] ACF defines child maltreatment as including physical abuse, neglect, medical neglect, sexual abuse, and psychological maltreatment.

[75] CDC defines intimate partner violence as actual or threatened physical or sexual violence, or psychological or emotional abuse by a spouse, ex-spouse, boyfriend, girlfriend, ex-boyfriend, ex-girlfriend, or date.

Table 4: Number of Referrals to Child Protective Services and Substantiated Cases of Child Maltreatment, by State, 1999

State	Child population (under 18)[a]	Referrals screened out[b]	Referrals screened in[b]	Number of investigations[c]	Number of investigations substantiating maltreatment[d]	Percentage of investigations substantiating maltreatment[d]
Alabama	1,066,177	[e]	24,586	24,586	8,610	35.0
Alaska	196,825	1,767	7,806	13,270	3,766	28.4
Arizona	1,334,564	[e]	32,635	32,635	5,650	17.3
Arkansas	660,224	11,883	17,036	17,036	5,482	32.2
California	8,923,423	[e]	227,561	227,561	73,188	32.2
Colorado	1,065,510	17,325	28,774	[e]	[e]	[e]
Connecticut	828,260	12,701	30,452	30,452	11,281	37.1
Delaware	182,450	2,049	6,316	5,965	1,346	22.6
District of Columbia	95,290	340	4,048	[e]	[e]	[e]
Florida	3,569,878	[e]	152,989	95,790	13,338	13.9
Georgia	2,056,885	22,917	47,032	47,032	16,024	34.1
Hawaii	289,340	4,861	2,733	4,646	2,669	57.5
Idaho	350,464	7,672	9,363	9,363	835	8.9
Illinois	3,181,338	[e]	61,773	61,773	18,779	30.4
Indiana	1,528,991	6,548	53,897	91,625	21,608	23.6
Iowa	719,685	11,464	18,666	18,666	6,716	36.0
Kansas	698,637	12,072	18,897	18,974	5,894	31.1
Kentucky	965,528	[e]	37,285	63,384	18,585	29.3
Louisiana	1,190,001	[e]	28,123	26,868	7,244	27.0
Maine	290,439	11,058	4,450	4,450	2,349	52.8
Maryland	1,309,432	[e]	31,220	31,220	8,103	26.0
Massachusetts	1,468,554	22,654	38,715	34,108	17,851	52.3
Michigan	2,561,139	58,596	69,133	65,591	13,721	20.9
Minnesota	1,271,850	[e]	16,466	16,466	7,228	43.9
Mississippi	752,866	[e]	18,389	18,389	4,077	22.2
Missouri	1,399,492	51,362	46,269	46,259	6,117	13.2
Montana	223,819	[e]	10,043	10,043	1,262	12.6
Nebraska	443,800	2,964	8,456	8,456	2,183	25.8
Nevada	491,476	[e]	13,384	13,384	3,983	29.8
New Hampshire	304,436	6,150	6,107	6,107	580	9.5
New Jersey	2,003,204	[e]	43,874	74,585	9,222	12.4
New Mexico	495,612	6,802	6,846	11,638	3,586	30.8
New York	4,440,924	179,879	139,564	136,489	46,980	34.4

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State	Child population (under 18)[a]	Referrals screened out[b]	Referrals screened in[b]	Number of investigations[c]	Number of investigations substantiating maltreatment[d]	Percentage of investigations substantiating maltreatment[d]
North Carolina	1,940,947	[e]	75,013	127,522	36,976	29.0
North Dakota	160,092	[e]	4,109	4,109	[e]	[e]
Ohio	2,844,071	[e]	79,400	79,400	8,749	11.0
Oklahoma	882,062	18,180	35,141	35,141	9,864	28.1
Oregon	827,501	16,989	17,686	17,686	8,073	45.7
Pennsylvania	2,852,520	6,135	13,175	22,437	5,076	22.6
Rhode Island	241,180	4,342	7,882	7,882	2,501	31.7
South Carolina	955,930	5,663	18,209	18,209	5,518	30.3
South Dakota	198,037	[e]	2,770	6,316	1,163	18.4
Tennessee	1,340,930	[e]	19,782	[e]	[e]	[e]
Texas	5,719,234	29,379	131,920	110,837	26,978	24.3
Utah	707,366	7,792	17,514	17,514	5,991	34.2
Vermont	139,346	[e]	2,263	2,263	923	40.8
Virginia	1,664,810	15,538	32,270	32,270	4,767	14.8
Washington	1,486,340	39,207	35,940	35,940	5,128	14.3
West Virginia	403,481	5,791	17,274	17,274	5,587	32.3
Wisconsin	1,348,268	[e]	20,183	34,311	9,791	28.5
Wyoming	126,807	2,305	2,505	2,505	855	34.1
Total for states reporting data	**70,199,435**	**1,177,874**	**1,795,924**	**1,838,427**	**486,197**	**26.5[f]**

[a]Child population data are from the U.S. Bureau of the Census 1999 population estimates, as reported by ACF.

[b]Referrals are screened out if the allegation does not warrant investigation. For example, the allegation may not meet the statutory definition of child maltreatment, may not contain sufficient information upon which to proceed, and/or may not pertain to the population served by the agency. Referrals alleging maltreatment are screened in if the child protective services agency decides that they are appropriate for investigation or assessment.

[c]ACF reports that the number of investigations may differ from the number of referrals screened in because referrals and investigations might not occur in the same year and there are variations in the way that states compile data. In most states, investigations may cover more than one child.

[d]An allegation is substantiated if the agency's investigation concludes that the allegation of maltreatment or risk of maltreatment is supported, according to law or policy set by the state.

[e]State did not report data.

[f]Average for all reporting states.

Source: HHS, ACF, *Child Maltreatment 1999: Reports from the States to the National Child Abuse and Neglect Data System* (Washington, D.C.: 2001).

Table 5: Information on Child Victims of Maltreatment, by State, 1999

State	Number of victims of maltreatment	Percentage of victims by category of maltreatment[a]		
		Physically abused	Neglected	Sexually abused
Alabama	13,773	40.9	46.0	23.1
Alaska	5,976	29.6	60.5	15.2
Arizona	9,205	24.8	58.4	5.6
Arkansas	7,564	27.2	68.9	37.0
California	130,510	17.5	56.3	9.1
Colorado	6,989	27.6	70.7	15.1
Connecticut	14,514	16.2	90.2	4.1
Delaware	2,111	25.3	37.5	11.1
District of Columbia	2,308	14.4	71.8	1.7
Florida	67,530	17.8	39.8	6.5
Georgia	26,888	13.4	63.1	8.4
Hawaii	2,669	6.5	8.1	5.3
Idaho	2,928	29.0	49.5	13.1
Illinois	33,125	11.2	40.6	10.2
Indiana	21,608	31.1	124.9	25.6
Iowa	9,763	25.2	63.1	11.1
Kansas	8,452	30.8	49.5	15.7
Kentucky	18,650	27.6	63.7	7.7
Louisiana	12,614	20.9	68.1	6.5
Maine	4,154	34.4	59.2	21.5
Maryland	15,451	[b]	[b]	[b]
Massachusetts	29,633	[b]	[b]	[b]
Michigan	24,505	20.9	70.8	6.5
Minnesota	11,113	24.8	77.4	7.3
Mississippi	6,523	26.6	47.0	21.1
Missouri	9,079	24.1	49.6	26.0
Montana	3,414	9.2	62.0	9.2
Nebraska	3,474	21.6	64.5	9.8
Nevada	8,238	14.6	22.1	2.8
New Hampshire	926	27.5	65.2	25.7
New Jersey	9,222	23.3	62.7	8.0
New Mexico	3,730	22.3	52.4	6.0
New York	64,045	24.8	23.3	5.6

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State	Number of victims of maltreatment	Percentage of victims by category of maltreatment[a]		
		Physically abused	Neglected	Sexually abused
North Carolina	36,976	3.6	87.8	3.7
North Dakota	1,284	12.5	64.0	7.2
Ohio	55,921	28.0	53.3	14.1
Oklahoma	16,210	24.9	98.0	8.0
Oregon	11,241	13.2	21.1	11.8
Pennsylvania	5,076	62.1	3.8	80.4
Rhode Island	3,485	26.6	84.6	8.9
South Carolina	9,580	13.7	54.8	6.3
South Dakota	2,561	25.1	70.9	10.0
Tennessee	10,611	20.0	43.5	21.0
Texas	39,488	29.3	59.6	14.9
Utah	8,660	16.6	28.8	21.8
Vermont	1,080	22.0	43.7	40.4
Virginia	8,199	31.1	64.7	14.4
Washington	8,039	27.1	70.8	9.0
West Virginia	8,609	25.1	43.8	8.6
Wisconsin	9,791	21.9	42.2	37.9
Wyoming	1,221	29.4	63.9	9.0
Total for states reporting data	**828,716**	**21.4[c]**	**56.0[c]**	**11.3[c]**

[a]Percentages do not add up to 100 because some states reported additional types of maltreatment that are not included here.

[b]State did not report data.

[c]Average for all reporting states.

Source: HHS, ACF.

Table 6: Services Provided to Child Victims of Maltreatment, by State, 1999

State	Number of victims of maltreatment	Percentage of victims who received services, by type of service			
		Any services	Family preservation services in the past 5 years[a]	Mental health services[b]	Counseling services[c]
Alabama	13,773	15.6	[d]	[d]	[d]
Alaska	5,976	30.7	[d]	[d]	[d]
Arizona	9,205	[d]	[d]	27.3	27.8
Arkansas	7,564	100.0	[d]	1.9	12.9
California	130,510	53.3	[d]	[d]	[d]
Colorado	6,989	34.4	24.0	[d]	[d]
Connecticut	14,514	53.6	[d]	[d]	[d]
Delaware	2,111	62.9	[d]	1.2	1.7
District of Columbia	2,308	71.4	[d]	[d]	[d]
Florida	67,530	64.5	25.3	[d]	[d]
Georgia	26,888	52.7	[d]	[d]	[d]
Hawaii	2,669	[d]	[d]	[d]	9.0
Idaho	2,928	30.6	13.8	[d]	[d]
Illinois	33,125	15.1	[d]	[d]	[d]
Indiana	21,608	51.8	[d]	0.1	<0.1
Iowa	9,763	65.2	4.1	[d]	[d]
Kansas	8,452	28.8	34.7	[d]	[d]
Kentucky	18,650	53.5	[d]	8.1	8.8
Louisiana	12,614	68.0	13.6	1.6	1.5
Maine	4,154	25.1	[d]	[d]	[d]
Maryland	15,451	[d]	[d]	[d]	[d]
Massachusetts	29,633	[d]	[d]	[d]	[d]
Michigan	24,505	81.0	[d]	[d]	[d]
Minnesota	11,113	84.2	[d]	[d]	[d]
Mississippi	6,523	100.0	[d]	[d]	[d]
Missouri	9,079	69.4	11.3	[d]	3.0
Montana	3,414	41.3	[d]	[d]	[d]
Nebraska	3,474	[d]	[d]	0.3	[d]
New Hampshire	926	65.7	[d]	[d]	[d]
New Jersey	9,222	69.0	[d]	0.1	<0.1
New Mexico	3,730	60.8	[d]	54.2	[d]
New York	64,045	[d]	[d]	<0.1	[d]
Nevada	8,238	[d]	[d]	[d]	[d]

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State	Number of victims of maltreatment	Percentage of victims who received services, by type of service: Any services	Family preservation services in the past 5 years[a]	Mental health services[b]	Counseling services[c]
North Carolina	36,976	52.1	0.3	[d]	20.0
North Dakota	1,284	[d]	[d]	[d]	[d]
Ohio	55,921	50.5	50.0	[d]	[d]
Oklahoma	16,210	56.2	18.0	[d]	3.0
Oregon	11,241	32.6	16.9	[d]	[d]
Pennsylvania	5,076	63.2	[d]	1.2	78.4
Rhode Island	3,485	100.0	[d]	34.5	[d]
South Carolina	9,580	99.9	[d]	[d]	[d]
South Dakota	2,561	60.3	[d]	[d]	[d]
Tennessee	10,611	[d]	[d]	[d]	[d]
Texas	39,488	[d]	11.1	21.4	29.9
Utah	8,660	54.3	5.2	20.6	9.4
Vermont	1,080	35.8	12.4	[d]	[d]
Virginia	8,199	74.8	[d]	[d]	[d]
Washington	8,039	84.5	[d]	[d]	4.5
West Virginia	8,609	48.7	7.6	0.1	[d]
Wisconsin	9,791	94.5	[d]	[d]	[d]
Wyoming	1,221	37.3	22.0	0.7	8.1
Total for states reporting data	**828,716**	**55.8[e]**	**21.6[e]**	**8.3[e]**	**14.8[e]**

[a]Family preservation services include services to prevent out-of-home placement, support reunification of children with their families, support the continued placement of children in adoptive homes, or support other permanent living arrangements.

[b]Mental health services are provided by clinicians, physicians, and social workers in mental health agencies to address clinically diagnosed problems. Services are often time-limited and may include residential and/or outpatient treatment.

[c]Counseling refers to family and individual counseling services provided by case workers and clinicians in social services agency settings.

[d]State did not report data.

[e]Average for all reporting states.

Source: HHS, ACF.

Table 7: Number of Reports of Child Maltreatment, by Source of Report and State, 1999

State	Social services	Medical	Mental health	Legal/law enforcement	Education	Parents	Other relatives and friends	Total reports[a]
Alabama	1,922	2,283	930	4,149	4,017	2,721	3,703	24,586
Alaska	2,136	1,112	[b]	1,962	2,471	832	1,925	13,270
Arizona	1,418	3,294	1,307	5,717	5,405	2,586	5,284	32,635
Arkansas	1,898	1,294	1,041	1,662	2,061	676	3,125	17,036
California	38,341	19,118	[b]	33,333	39,386	3	26,129	227,561
Colorado	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]
Connecticut	2,561	3,140	2,408	5,545	6,489	2,043	1,831	30,452
Delaware	280	515	260	1,628	955	581	828	6,316
District of Columbia	672	192	156	768	320	96	788	4,048
Florida	21,591	12,142	6,037	26,590	19,200	14,375	24,609	152,989
Georgia	3,979	3,660	2,784	7,445	8,677	3,885	9,552	47,032
Hawaii	630	564	[b]	688	674	193	510	5,063
Idaho	500	618	100	1,425	1,726	1,050	1,651	9,363
Illinois	9,451	8,695	b	9,989	10,265	4,551	7,780	61,773
Indiana	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]
Iowa	3,010	1,386	525	2,237	2,804	152	[b]	18,666
Kansas	3,279	1,501	181	1,741	3,694	1,957	2,344	18,834
Kentucky	1,139	683	[b]	2,164	2,355	6,075	14,387	63,384
Louisiana	3,631	2,900	[b]	3,771	4,896	1,802	4,364	28,123
Maine	503	317	426	503	765	253	785	4,450
Maryland	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]
Massachusetts	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]
Michigan	12,237	3,353	6,136	8,902	5,000	6,022	11,721	69,133
Minnesota	1,456	1,559	631	3,685	3,716	1,458	1,993	17,098
Mississippi	1,158	2,106	[b]	2,517	3,187	809	5,162	18,389
Missouri	5,136	3,058	2,364	5,544	5,243	1,738	13,813	46,269
Montana	1,182	548	219	1,504	1,687	808	2,144	10,043
Nebraska	464	555	280	1,737	987	593	1,245	8,456
Nevada	937	1,086	438	1,913	2,643	1,111	2,707	13,384
New Hampshire	749	510	560	799	1,217	172	1,157	6,107
New Jersey	8,138	9,358	[b]	11,874	14,564	6,617	10,903	74,585
New Mexico	807	893	610	3,957	2,616	627	1,900	11,638
New York	36,639	13,025	[b]	7,797	13,128	9,520	14,784	139,564
North Carolina	20,778	10,056	[b]	12,623	22,727	9,855	32,262	127,522

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State	Social services	Medical	Mental health	Legal/law enforcement	Education	Parents	Other relatives and friends	Total reports[a]
North Dakota	533	217	288	817	780	361	552	4,109
Ohio	12,198	4,990	2,737	12,260	8,974	[b]	20,124	79,400
Oklahoma	4,191	2,283	2,223	3,755	3,939	2,021	7956	35,141
Oregon	1,824	1,721	145	5,043	2,650	567	1,995	17,686
Pennsylvania	3,011	3,431	1,290	1,725	5,067	2,210	1,940	22,397
Rhode Island	1,020	1,223	[b]	962	1,431	527	825	9,168
South Carolina	1,724	2,198	502	2,763	3,558	1,433	2,785	18,209
South Dakota	[b]	259	172	1,175	899	284	903	4,709
Tennessee	2,419	2,906	[b]	6,352	4,187	1,454	9,251	33,682
Texas	6,992	14,637	4,183	15,944	24,322	13,450	27,380	131,920
Utah	2,034	937	454	3,642	1,361	755	2,981	17,514
Vermont	160	165	191	393	502	221	242	2,273
Virginia	1,948	2,626	1,364	4,951	6,430	3,114	5,355	32,270
Washington	6,822	2,929	1,452	3,844	5,908	2,804	6,656	35,940
West Virginia	2,025	913	699	1,221	2,166	1,774	3,243	17,274
Wisconsin	5,354	1,868	1,628	6,849	6,114	3,169	5,062	36,295
Wyoming	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]
Total for states reporting data	**238,877**	**152,824**	**44,721**	**245,865**	**271,163**	**117,305**	**306,636**	**1,805,756**
Percentage of total reports	**13.2**	**8.5**	**2.5**	**13.6**	**15.0**	**6.5**	**17.0**	**100.0**

Note: According to ACF officials, the number of reports is based on those reports of child maltreatment that resulted in an investigation, but there are variations in the way that states compile their data. Social services personnel, medical personnel, mental health personnel, legal and law enforcement personnel, educators, child day care providers, and foster care and adoption providers may, depending on state law, be legally required to report suspected maltreatment as part of their job.

[a]Total for each state also includes reports from other sources not listed in the table. Of the approximately 1.8 million reports nationwide, 3 percent of the reports came from child day care providers, foster care and adoption providers, alleged victims, or alleged perpetrators, and 20.7 percent of the reports came from another or unknown source.

[b]State did not report data.

Source: HHS, ACF, *Child Maltreatment 1999: Reports from the States to the National Child Abuse and Neglect Data System* (Washington, D.C.: 2001).

Child Access and Visitation Data Collected by HHS's Administration for Children and Families

The Personal Responsibility and Opportunity Act of 1996 authorized ACF to provide $10 million to states to establish and operate access and visitation programs. The overall goal of the program is to increase children's contact with their noncustodial parents. Individual grantees, however, often have additional goals that relate to child well-being, such as providing a safe, stress-free environment in which children and noncustodial parents can interact, when a court has said that the child is at risk for harm. Most families either self-refer to access and visitation programs or are referred by courts, child support agencies, or child welfare agencies. Eligible services include, but are not limited to, mediation, counseling, education, development of parenting plans, visitation enforcement, and development of guidelines for visitation and alternative custody arrangements. These services are provided in urban, suburban, and rural locations and are administered by state and county agencies, courts, and nonprofit organizations. As a condition of receiving these funds, states must report annually on program activities funded through the grant and on funding priorities for the next fiscal year, one of which can be counseling. (See table 8.)

Table 8: Child Access and Visitation Grant Data, by State

State	Parents served in fiscal year 1998	Counseling targeted as a priority area in fiscal year 2000
Alabama	276	Yes
Alaska	8	No
Arizona	[a]	Yes
Arkansas	222	Yes
California	5,812	Yes
Colorado	588	Yes
Connecticut	[a]	Yes
Delaware	18	No
District of Columbia	158	No
Florida	6,668	No
Georgia	213	Yes
Hawaii	200	Yes
Idaho	230	Yes
Illinois	359	Yes
Indiana	1,166	Yes
Iowa	189	Yes

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State	Parents served in fiscal year 1998	Counseling targeted as a priority area in fiscal year 2000
Kansas	329	[a]
Kentucky	1,630	Yes
Louisiana	290	No
Maine	774	Yes
Maryland	156	Yes
Massachusetts	265	Yes
Michigan	456	[a]
Minnesota	314	[a]
Mississippi	305	Yes
Missouri	1,051	Yes
Montana	389	Yes
Nebraska	211	Yes
Nevada	248	Yes
New Hampshire	112	Yes
New Jersey	6,363	Yes
New Mexico	539	Yes
New York	1,021	Yes
North Carolina	[b]	Yes
North Dakota	[a]	[a]
Ohio	1,045	[a]
Oklahoma	56	Yes
Oregon	464	Yes
Pennsylvania	878	Yes
Rhode Island	71	[a]
South Carolina	166	Yes
South Dakota	264	[a]
Tennessee	3,622	[a]
Texas	3,649	Yes
Utah	392	[a]
Vermont	1,079	Yes
Virginia	1,108	Yes
Washington	1,061	[a]
West Virginia	[a]	Yes
Wisconsin	276	Yes
Wyoming	[a]	Yes
Total for states reporting data	**44,691**	

Note: The most recent year for which states reported data on parents served is fiscal year 1998. Information on the provision of counseling services comes from state descriptions of their proposed activities and funding priorities for fiscal year 2000, not the services they actually provided. This table includes only those programs that reported serving parents. States may not have reported these data for some service programs or may have funded additional programs for purposes other than serving parents, such as general training.

[a]State did not report data.

[b]North Carolina reported that the fiscal year 1998 money was returned to ACF, so there are no data to report.

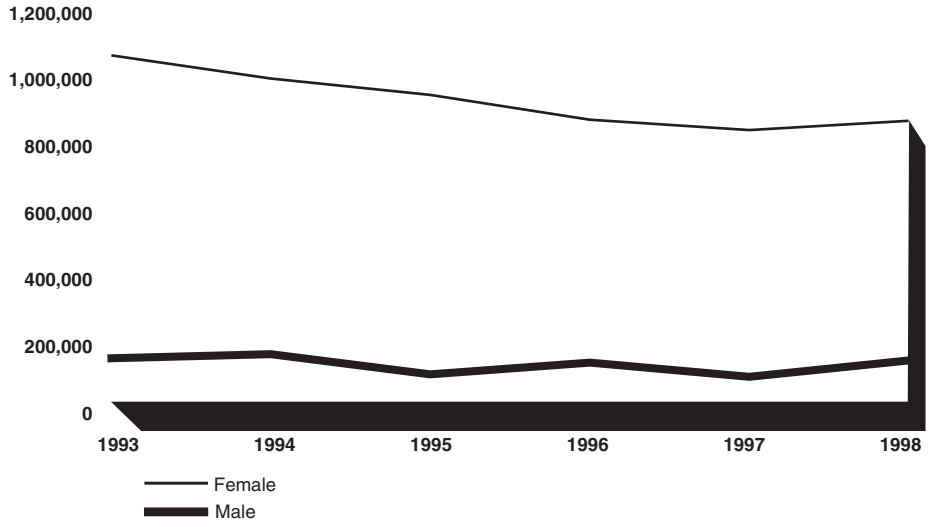
Source: HHS, ACF, *Child Access and Visitation Grants: State Profiles* (Washington, D.C.: Oct. 2001) http://www.acf.dhhs.gov/programs//cse/pol/im-01-03a/index.html (downloaded March 4, 2002).

Victimization Data Collected by the Department of Justice

Data that Justice has collected on victimization include information on intimate partner violence and sexual assault. Justice's Bureau of Justice Statistics' National Crime Victimization Survey provided estimates on intimate partner violence over time (see figure 3), while the National Violence Against Women Survey, jointly conducted by the National Institute of Justice and HHS's Centers for Disease Control and Prevention, provided more detailed descriptions of intimate partner violence and victim behavior. (See tables 9 and 10.) Justice's Federal Bureau of Investigation collects data on the forcible rape[76] of women using the Uniform Crime Reporting Program. (See table 11.) The program collects annual counts of reported criminal activity from city, county, and state law enforcement agencies; incidents not reported to law enforcement are not included in counts. In addition, the Bureau of Justice Statistics collects information on sexual assault convictions using the National Judicial Reporting Program. (See table 12.)

[76]Forcible rape includes assaults or attempts to commit rape by force or threat of force, but does not include statutory rape or other sex offenses.

Figure 3: Estimated Number of Victims of Intimate Partner Violence, by Sex, 1993 to 1998



Source: Department of Justice, Bureau of Justice Statistics, *Bureau of Justice Statistics Special Report: Intimate Partner Violence* (Washington, D.C.: 2000).

Table 9: Estimated Number of Persons Raped or Physically Assaulted by an Intimate Partner during Lifetime and Previous 12 Months, by Sex of Victim

	Lifetime		Previous 12 months	
Type of violence	Women	Men	Women	Men
Rape	7,754,000	278,000	201,000	[a]
Physical assault	22,254,000	6,863,000	1,309,000	835,000

Note: Based on estimates of men and women in the United States aged 18 years and older, U.S. Bureau of Census, *Current Population Survey, 1995*.

[a]The number of male rape victims was insufficient to calculate a reliable estimate.

Source: Department of Justice, National Institute of Justice and HHS, Centers for Disease Control and Prevention, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* (Washington, D.C.: 1998). The federal National Violence Against Women Survey consisted of a nationally representative sample of 8,000 U.S. women and 8,000 U.S. men. The survey was conducted from November 1995 to May 1996.

Table 10: Estimated Rates of Law Enforcement Actions, as Reported by Victims of Selected Intimate Partner Crimes

	Rape victims[a]	Physical assault victims		Stalking victims	
	Women	Women	Men	Women	Men
Total crime victims (n)	**441**	**1,149**	**541**	**343**	**47**
Reported to police (%)	17.2	26.7	13.5	51.9	36.2
Did not report to police (%)	82.8	73.3	86.5	48.1	63.8
Crime victims reporting to police (n)[b]	**75**	**370**	**73**	**178**	**17**
Police took report (%)	77.6	76.2	64.4	67.4	64.7
Police arrested or detained attacker (%)	47.4	36.4	12.3	28.7	[c]
Police referred victim to prosecutor or court (%)	10.5	33.9	23.3	28.1	[c]
Police referred victim to services (%)	[c]	25.1	17.8	21.3	[c]
Police gave victim advice on self-protective measures (%)	[c]	26.1	17.8	23.1	35.3
Police did nothing (%)	[c]	11.1	19.2	18.5	[c]

Note: Estimates are based on the most recent intimate partner victimization since age 18.

[a]Estimates not calculated for male rape victims due to the small sample size.

[b]Estimates are based on responses from victims whose victimization was reported to police and exceed 100 percent because some victims reported multiple police responses.

[c]Estimates not calculated because fewer than five in sample cell.

Source: Department of Justice, National Institute of Justice and HHS, Centers for Disease Control and Prevention, *Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey* (Washington, D.C.: 2000). The federal National Violence Against Women Survey consisted of a nationally representative sample of 8,000 U.S. women and 8,000 U.S. men. The survey was conducted from November 1995 to May 1996.

Table 11: Instances of Forcible Rape of Women Reported to Police, All Ages, 2000

State	Forcible rape
Alabama	1,482
Alaska	497
Arizona	1,577
Arkansas	848
California	9,785
Colorado	1,774
Connecticut	678
Delaware	424
District of Columbia	251
Florida	7,057
Georgia	1,968
Hawaii	346
Idaho	384
Illinois	4,090
Indiana	1,759
Iowa	676
Kansas	1,022
Kentucky	1,091
Louisiana	1,497
Maine	320
Maryland	1,543
Massachusetts	1,696
Michigan	5,025
Minnesota	2,240
Mississippi	1,019
Missouri	1,351
Montana	301
Nebraska	436
Nevada	860
New Hampshire	522
New Jersey	1,357
New Mexico	922
New York	3,530
North Carolina	2,181
North Dakota	169

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State	Forcible rape
Ohio	4,271
Oklahoma	1,422
Oregon	1,286
Pennsylvania	3,247
Rhode Island	412
South Carolina	1,511
South Dakota	305
Tennessee	2,186
Texas	7,856
Utah	863
Vermont	140
Virginia	1,616
Washington	2,737
West Virginia	331
Wisconsin	1,165
Wyoming	160
Total	**90,186**

Source: Department of Justice, Federal Bureau of Investigation, *Crime in the United States 2000* (Washington, D.C.: 2001).

Table 12: Sexual Assault Convictions in State Courts, 1998

	Estimated number of convictions	Percentage of felons sentenced to incarceration	Mean maximum sentence for felons sentenced to incarceration
Sexual assault	29,693	82	94 months
Rape	11,622	84	125 months
Other assault	18,071	80	74 months
All felony offenses	927,717	68	39 months

Source: Department of Justice, Bureau of Justice Statistics, *Felony Sentences in State Courts, 1998* (Washington, D.C.: 2001).

Information on SCHIP Programs in the 50 States and the District of Columbia

States have flexibility in the way they design their SCHIP program. They may expand their Medicaid programs, develop a separate child health program that functions independently of the Medicaid program, or do a combination of both. Although SCHIP is generally targeted to families with incomes at or below 200 percent of the federal poverty level, each state may set its own income eligibility limits within certain guidelines. (See table 13.)

Table 13: Program Type, Maximum Income Eligibility Levels, and Fiscal Year 2001 Enrollment for SCHIP Programs in the 50 States and the District of Columbia

	SCHIP program type				
State	Medicaid expansion	Separate SCHIP	Combination	Maximum income eligibility by percent federal poverty level	Enrollment - fiscal year 2001
Alabama			X	200	68,179
Alaska	X			200	21,831
Arizona		X		200	86,863
Arkansas	X			100	2,884
California			X	250	693,048
Colorado		X		185	45,773
Connecticut			X	300	18,720
District of Columbia	X			200	2,807
Delaware		X		200	5,567
Florida			X	200	298,705
Georgia		X		235	182,762
Hawaii	X			200	7,137
Idaho	X			150	16,896
Illinois			X	185	83,510
Indiana			X	200	56,986
Iowa			X	200	23,270
Kansas		X		200	34,241
Kentucky			X	200	66,796
Louisiana	X			150	69,579
Maine			X	200	27,003
Maryland			X	300	109,983
Massachusetts			X	200	105,072
Michigan			X	200	76,181

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	SCHIP program type				
State	Medicaid expansion	Separate SCHIP	Combination	Maximum income eligibility by percent federal poverty level	Enrollment - fiscal year 2001
Minnesota	X			280	49[a]
Mississippi			X	200	52,436
Missouri	X			300	106,594
Montana		X		150	13,518
Nebraska	X			185	13,933
Nevada		X		200	28,026
New Hampshire			X	300	5,982
New Jersey			X	350	99,847
New Mexico	X			235	10,347
New York			X	250	872,949
North Carolina		X		200	98,650
North Dakota			X	140	3,404
Ohio	X			200	158,265
Oklahoma	X			185	38,858
Oregon		X		170	41,468
Pennsylvania		X		200	141,163
Rhode Island	X			250	17,398
South Carolina	X			150	66,183
South Dakota			X	200	8,937
Tennessee	X			100	8,615
Texas			X	200	500,950
Utah		X		200	34,655
Vermont		X		300	2,996
Virginia		X		200	73,102
Washington		X		250	7,621
West Virginia		X		200	33,144
Wisconsin	X			185	57,183
Wyoming		X		133	4,652
Total	**16**	**16**	**19**		**4,601,098**

[a]Minnesota's SCHIP program covers children under age 2 who are in families with incomes that are from 275 to 280 percent of the federal poverty level. Minnesota has a state-funded insurance program that covers most non-Medicaid children in families with incomes up to 275 percent of the federal poverty level.

Source: Centers for Medicare & Medicaid Services, *The State Children's Health Insurance Program Annual Enrollment Report: Federal Fiscal Year 2001* (Baltimore, Md.: Feb. 6, 2002), p. 10,

www.hcfa.gov/init/chip-map.htm (downloaded on March 6, 2002). Since the CMS report did not have year-end data available for Idaho, we contacted the state SCHIP program.

Selected Individual Insurers' Coverage for Specified Mental Health Coverage in Six States as of 2002

The over 3 million children who are covered by an individual insurance plan may face limitations in mental health coverage, largely because federal and most state parity laws do not apply to health plans sold in this market. Unless precluded by state law, restrictions on mental health benefits in the individual market can include limitations on hospital days or outpatient office visits or higher out-of-pocket expenses. Figure 4 summarizes differences in individual market preferred provider organization (PPO) and health maintenance organization (HMO) health plan coverage for certain mental health treatments available to children in six states.

Figure 4: Selected Individual Insurers' Coverage for Specified Mental Health Services Available to Children in Six States

	California[a]		Georgia		Illinois		Massachusetts		Minnesota		Utah	
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J	Plan K	Plan L
Plan type	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	PPO
Deductible amount	$1,000	$0	$500	$0	$1,000	$0	$250	$0	$500	$500	$500	$500
Individual therapy	◑[b]	◑[b]	○	●[c]	◑[d]	◑[b]	●	●	●	●	◑[e]	◑[f]
Group therapy	◑[b]	◑[b]	○	●[c]	◑[d]	◑[b]	●	●	●	●	○	◑[f]
Family therapy	◑[b]	◑[b]	○	●[c]	◑[d]	◑[b,g]	●	●	○	●	○	◑[f]
Inpatient care	◑[h]	◑[i]	◑[h]	●[j]	◑[h]	◑[k]	●	●	●	●	◑[k]	◑[f]
Residential care[l]	○	◑[i]	○	○	○	○	○	○	●	●[m]	◑[n]	○

Key: ● = service covered; ◑ = service covered with limitations; and ○ = service not covered.

[a]Under California's parity law, limits do not apply to children with severe mental illnesses (SMI) or those diagnosed with a serious emotional disturbance (SED).

[b]Maximum of 20 total outpatient visits per year.

[c]Patient is responsible for additional cost-sharing after the 48th individual or family therapy visit each year. For group therapy, one visit is equal to half of an individual or family therapy visit, and enrollees are responsible for the full treatment cost after the 96th group therapy visit each year.

[d]Maximum of 30 outpatient visits per year with a maximum of 100 visits per lifetime.

[e]Maximum of 15 outpatient visits per year.

[f]All mental health services are limited to a total benefit of $1,500 per member per year.

[g]One family therapy session is equal to two outpatient visits.

[h]Maximum of 30 inpatient days per year.

[i]Maximum of 45 inpatient days per year. One residential treatment day is counted as one inpatient day.

[j]Patient is responsible for additional cost-sharing after the 30th inpatient day each year.

[k]Maximum of 10 inpatient days per year.

[l]Care received in a residential treatment center (a licensed 24-hour facility that offers mental health treatment).

[m]Room and board costs are not covered.

[n]One day of residential care is equal to two inpatient days.

Source: Individual insurers in each of the six states. We obtained this information from insurers from February through April 2002.

Summary of Selected Laws Regarding Mental Health Coverage in Six States

Many states have sought to equalize mental health and other benefits beyond the requirements of the federal Mental Health Parity Act of 1996 (MHPA), which prohibited certain group health plans that are sponsored by employers with more than 50 employees and include mental health benefits from imposing annual or lifetime dollar limits on mental health benefits that are more restrictive than those imposed on other benefits. Laws in the six states we reviewed differed in the extent to which they addressed mental health coverage and limitations.

Three states we reviewed—California, Massachusetts, and Minnesota—enacted laws that are more comprehensive than the federal parity law, requiring certain health plans to offer mental health benefits to certain populations with parity in service limits and cost-sharing. For example, California law requires all health plans to provide mental health coverage with the same restrictions and limits as other benefits to members with severe mental illnesses (SMI) and children with serious emotional disturbances (SED). (See table 14.) While states have primary responsibility for regulating the business of insurance, they are preempted by the Employee Retirement and Income Security Act of 1974 (ERISA) from regulating employer-sponsored health plans. Therefore, state laws that have sought to equalize mental and other benefits beyond MHPA do not apply to self-funded employer-sponsored plans, through which close to 50 percent of employees with employer-sponsored coverage obtain health insurance.

Table 14: Summary of Parity Laws That Exceed Federal Standards in Three States

	California[a]	Massachusetts[b]	Minnesota[c]
Health plan applicability[d]	Every health care service plan that provides hospital, medical, or surgical coverage	Any individual, group, and HMO plan	All HMOs; all individual and group plans that provide mental health or chemical benefits
Population covered	All plan members with SMI and children with SED[e]	Plan members (1) with biologically based mental illness, (2) in need of rape-related services, and (3) who are children under 19 with certain non-biologically based mental illnesses[f]	All enrolled individuals
State law requires	Mental health benefits must be provided and have the same limits and restrictions as physical benefits	No mental health service limitation can be less than those imposed for physical conditions[g]	Mental health benefits must be provided and have the same limits as medical condition benefits

[a]See California Health & Safety Code § 1374.72 (2002).

[b]See General Laws of Massachusetts, Chapter 175, Section 47B (2002).

[c]See Minnesota Statutes §§ 62Q.47(a); 62A.152; 62E.06 (2001).

[d]These state laws generally apply to group health plans that employers purchase for their employees but not to employers who self-fund their plans, meaning they pay their employees' health expenses directly.

[e]SMI is defined as (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder (manic-depressive illness), (4) major depressive disorders, (5) panic disorder, (6) obsessive-compulsive disorder, (7) pervasive developmental disorder or autism, (8) anorexia nervosa, and (9) bulimia nervosa. SED children are generally defined as having mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that result in behavior inappropriate to their age. As a result of their mental disorders, SED children will also (1) have substantial impairment in at least two specified areas, such as self-care or family relationships, and one of the following must occur–child must be at risk of removal from the home or have already been removed or the child must have mental disorders and impairments present for more than 6 months; (2) display psychotic features or have risk of suicide or violence; or (3) meet special education eligibility requirements.

[f]Biologically based mental illnesses are defined as (1) schizophrenia, (2) schizoaffective disorder, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive-compulsive disorder, (7) panic disorder, (8) delirium and dementia, (9) affective disorders, and (10) any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by certain state officials. Rape-related services include the diagnosis and treatment of rape-related mental or emotional disorders for victims of a rape or an assault with intent to commit rape. Covered services for children under 19 include the diagnosis and treatment of non-biologically based mental, behavioral, or emotional disorders that substantially interfere with or substantially limit the functioning and social interactions of such child or adolescent, evidenced by (1) inability to attend school as a result of the disorder; (2) need to hospitalize as a result of the

disorder; or (3) a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others.

[g] State law also mandates medically necessary minimum benefits of 60 inpatient days and 24 outpatient visits for members over 19 with non-biologically based mental disorders.

Source: Individual state laws.

Illinois's mental health coverage laws do not apply to all health plans; further, Illinois's laws allow health plans to limit the number of visits or days of mental health treatment for children and require parity only for serious mental illness.[77] For example, Illinois law requires HMOs to offer mental health coverage with annual minimums of 10 inpatient days and 20 individual outpatient visits for each member. Similar requirements, however, do not exist for other types of health plans, such as PPOs. In addition, Illinois requires group health plans with more than 50 employees to provide coverage for serious mental illnesses under the same conditions as coverage for other illnesses. (See table 15.)

Table 15: Summary of Selected Laws Related to Mental Health Coverage in Illinois

	All HMOs[a]	Group health plans[b]
Population covered	All enrolled individuals	Members with serious mental illnesses[c]
State law requires	Plans must offer an annual minimum of 10 inpatient days and 20 individual outpatient visits of mental health coverage	Mental health benefits must be under the same conditions as coverage for other illnesses with a minimum of 45 inpatient days and 35 outpatient visits annually

Note: These state laws generally apply to group health plans that employers purchase for their employees but not to employers who self-fund their plans, meaning they pay their employees' health expenses directly.

[a] See 50 Illinois Administrative Code § 5421.130 (2002).

[b] See 215 Illinois Compiled Statutes Annotated § 5/370c (2001).

[c] Serious mental illness means the following psychiatric illnesses as defined in the most current edition of the DSM published by the American Psychiatric Association: (1) schizophrenia; (2) paranoid and other psychotic disorders; (3) bipolar disorders (hypomanic, manic, depressive, and mixed); (4) major depressive disorders (single episode or recurrent); (5) schizoaffective disorders (bipolar or depressive); (6) pervasive developmental disorders; (7) obsessive-compulsive disorders; (8) depression in childhood and adolescence; and (9) panic disorder. See 215 Illinois Compiled Statutes Annotated § 5/370c (2001).

Source: Illinois state law.

[77] For individuals who do not suffer serious mental illness, Illinois law requires group plans to offer coverage for reasonable and necessary treatment and services, but permits the plan to require the insured to pay up to 50 percent of treatment expenses.

The remaining two states—Georgia and Utah—address mental health coverage similarly. State laws in Georgia and Utah do not require health plans to include a minimum level of mental health coverage. Rather, both of these states require health plans to offer an additional plan that exclusively covers mental health services and can be purchased in addition to the standard health plan. For example, Georgia's mandated offer requirement applies to individual, small group, and large group major medical health plans, and requires coverage for annual and lifetime dollar mental health benefits to be equal to or greater than coverage for physical illnesses.[78] Utah's law requires only that group health plans offer mental health coverage as an option.

[78] However, Georgia law permits individual and small group major medical health plans to impose annual limits on the number of inpatient treatment days and outpatient treatment visits for mental health benefits that differ from those imposed for physical illnesses.

Selected Federal Grant Programs That May Be Used to Help Children Exposed to Trauma Obtain Mental Health Services

Table 16 is a nonexhaustive list of federal grants that may be used to help children who were exposed to trauma obtain mental health services. The list includes 15 formula grants and 38 discretionary grants from seven departments and agencies.

Table 16: Selected Federal Grant Programs That May Be Used to Help Children Exposed to Trauma Obtain Mental Health Services

Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Department of Agriculture				
Cooperative State Research, Education, and Extension Service				
Discretionary grants				
Children, Youth and Families at Risk	$8,481,000	Land grant universities' extension services	Children and youth at risk of not having their fundamental needs for safety, shelter, food, and care met	To support educational programs that target high-risk youth. Programs may include mental health education and referrals. Activities allowed under this grant include parental education, public awareness programs, and technical assistance and training to providers who interact with children and their families.
Department of Education				
Office of Elementary and Secondary Education				
Formula grants				
Safe and Drug-Free Schools and Communities: State Grants	$472,017,000	State departments of education	Children and youth who are enrolled in and attending school (primarily kindergarten through grade 12)	To support programs that prevent violence in and around schools, prevent illegal use of alcohol, tobacco, and drugs, and coordinate with federal, state, school, and community efforts to foster a safe and drug-free learning environment.
		Governors	Children and youth not normally served by state or local educational agencies, or populations that need special services or additional resources (for example, youth in detention facilities, runaway and homeless youth)	The Governor's Program supports programs of drug and violence prevention and early intervention by community-based organizations and other public and private entities. For both these program components, medical treatment is prohibited but counseling and therapeutic services provided by mental or behavioral health professionals are allowed.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Discretionary grants				
School Emergency Response to Violence (Project SERV)	$10,000,000	Local educational agencies	School-aged children and others affected by school violence (kindergarten through grade 12)	To help schools respond to immediate and long-term needs resulting from a violent or traumatic crisis and to provide increased security and ongoing counseling. The program can support screening, assessment, counseling, and referrals to mental health professionals.
Elementary School Counseling Demonstration Program	$32,500,000	Local educational agencies	Children, families, schools, and counseling staff	To support the establishment or expansion of elementary school counseling programs, including hiring and training of school counselors, school psychologists, and school social workers. School counseling programs are encouraged to provide in-service training on counseling issues to school personnel.
Department of Health and Human Services (HHS)				
Administration for Children and Families				
Formula grants				
Child Abuse and Neglect State Grants	$22,013,000	States	Abused and neglected children and their families	To support and improve state child protective service systems. Funds can be used to develop structural elements that could help with mental health service delivery to children in the child protection system.
Child Welfare Services: State Grants	$291,986,000	States, Indian tribes	Families and children in need of child welfare services	To establish, extend, and strengthen child welfare services provided by public welfare agencies to enable children to remain in their own homes, or, where that is impossible, to provide alternate permanent homes for them. Allowable services include mental health screening, assessment, treatment, and referral.
Promoting Safe and Stable Families	$375,000,000	States, certain Indian tribes that are determined to be eligible based on grant formula	Families and children in need of services to stabilize their lives, enhance child development, and promote adoption	To assist families and children to stabilize their lives, prevent out-of-home placement of children, enhance child development, and increase competence in parenting abilities. Mental health service may be provided if it promotes adoption or family preservation needs.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Children's Justice Act Formula Grant	$17,000,000[c]	States	Victims of child abuse and neglect, child sexual abuse and exploitation State governments	To improve the handling and prosecution of child abuse cases and reduce trauma for children. The grant does not fund direct service provision, but could support child advocacy centers and mental health referrals and assessments.
Family Violence Prevention and Services/Grants for Battered Women's Shelters: Grants to States and Indian Tribes	$116,918,000[c]	States, Indian tribes, tribal organizations	Victims of family violence and their dependents	To assist in establishing, maintaining, and expanding programs and projects to prevent family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents. Children's mental health services are not a focus of this program, but may be supported by grant recipients.
Family Violence Prevention and Services/Grants for Battered Women's Shelters: Grants to State Domestic Violence Coalitions	$11,937,300[c]	State domestic violence coalitions	Victims of domestic violence, their dependents, families, other interested persons, and the general public	To support planning and coordination efforts, intervention and prevention activities, and efforts to increase the public awareness of domestic violence issues and services for battered women and their children. Children's mental health services are not a focus of this program, but may be supported by grant recipients.
Social Services Block Grant	$1,700,000,000	States	Individuals and families in need of social services	To assist states in delivering a wide range of social services to needy children and adults. States may address the prevention of neglect, abuse, or exploitation of children and adults. Service categories include counseling services and information and referral services.
Temporary Assistance for Needy Families	$16,488,667,000[c]	States, federally recognized tribes, specified Alaskan Native entities	Needy families with children	To provide assistance so that children can be cared for in their own homes, including collaboration with child welfare services to identify and provide counseling services to children in needy families who are at risk of abuse or neglect; to reduce dependency by promoting job preparation, work, and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families.

(Continued From Previous Page)

Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Discretionary grants				
Child Abuse and Neglect Discretionary Activities	$26,150,000	Grants: Depending on grant priorities, may include state and local public agencies, nonprofit organizations, universities Contracts: For-profit companies, small businesses, and other organizations meeting qualifications of the request for proposals	Abused and neglected children and their families	To improve activities to prevent, assess, identify, and treat child abuse and neglect through research, information dissemination, and technical assistance.
Family Violence Prevention and Services/Grants for Battered Women's Shelters: Discretionary Grants	$11,937,300[c]	Public and private agencies, federally recognized Indian tribes, Alaska Native villages, or Alaska Native Regional Corporations	Victims of family violence, their dependents, families, other interested persons, and the general public	To establish, maintain, and expand programs to prevent family violence and provide immediate shelter and assistance to victims and their dependents through the funding of federally selected subject areas, such as family violence community awareness campaigns. Children's mental health services are not a focus of this program, but may be supported by grant recipients.
Grants to States for Access and Visitation Programs	$10,000,000[c]	States	Custodial and noncustodial parents and children	To support and facilitate access and visitation by noncustodial parents with their children. Activities may include mediation, counseling, development of parenting plans, visitation enforcement, and development of guidelines for visitation.

(Continued From Previous Page)

Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Head Start[d]	$6,535,000,000	Localities, federally recognized Indian tribes, public or private nonprofit or for-profit agencies	Low income children, birth to approximately age 5	To ensure school readiness and parental involvement and to promote comprehensive health, educational, nutritional, social, and other services for low-income children. Grantees are encouraged to build collaborative relationships with mental health providers and promote access to mental health services, including screening, assessments, and referrals.
Runaway and Homeless Youth (Basic Center Program)	$41,963,780	States, localities, federally recognized Indian tribes, private entities, and coordinated networks of these entities. None of these entities may be part of the law enforcement or juvenile justice system.	Runaway and homeless youth under the age of 21 and their families	To assist community programs that address the immediate needs of runaway youth and their families. Services are delivered outside of law enforcement, child welfare, mental health, and juvenile justice systems, and may include mental health screening, treatment, referral, and public awareness programs.
Education and Prevention to Reduce Sexual Abuse of Runaway, Homeless and Street Youth	$14,999,000	Private nonprofit agencies, including nonfederally recognized Indian tribes and urban Indian organizations	Runaway and homeless street youth under the age of 21	To provide street-based services to youth living on the street who are at risk of, or being subjected to, sexual abuse, prostitution, or sexual exploitation. Allowable activities include mental health screening, treatment, referral, and public awareness programs.

(Continued From Previous Page)

Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Transitional Living for Homeless Youth	$39,201,020	States, localities, federally recognized Indian organizations, private entities, and coordinated networks of these entities. None of these entities may be part of the law enforcement or juvenile justice system.	Homeless youth, ages 16 to 21	To establish and operate transitional living projects, promote self-sufficiency, and avoid long-term dependency for homeless youth. Services may include counseling or mental health referrals.
Centers for Medicare & Medicaid Services				
Formula grants				
Medical Assistance Program (Medicaid)	$143,029,433,000[c]	States	Low-income persons who are over age 65, blind or disabled, members of families with dependent children, low-income children and pregnant women, certain Medicare beneficiaries, and others as determined by the state within federal guidelines	To assist states in the provision of adequate medical care to eligible needy persons.
State Children's Health Insurance Program	$3,115,200,000[c]	States	Targeted low-income children	To initiate and expand health assistance to uninsured, low-income children.
Health Resources and Services Administration				
Formula grants				
Maternal and Child Health Services Block Grant to States	$595,727,279[c]	States	Pregnant women, mothers, infants and children, and children with special health care needs, particularly those of low-income families	To maintain and strengthen state leadership in planning, promoting, coordinating, and evaluating health care services. Allowable services can include mental health screening, diagnosis, referral, parent and public education, and training of professionals.

(Continued From Previous Page)

Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Discretionary grants				
Community Health Centers[e]	$1,077,578,000	Public and nonprofit private entities, including faith-based and community-based organizations	People in medically underserved areas	To develop and operate community health centers that provide preventive and primary health care services, and link clients with Medicaid and mental health and substance abuse treatment. Allowable services include mental health screening, diagnosis, treatment, referral, and public awareness programs.
Health Center Grants for Homeless Populations[e]	$109,790,000	Public and nonprofit private entities, including faith-based and community-based organizations	Homeless individuals, including children	To deliver primary health services and substance abuse services. Allowable services include mental health screening, diagnosis, treatment, referral, and public awareness programs.
Health Centers Grants for Migrant and Seasonal Farmworkers[e]	$113,617,000	Public and nonprofit private entities, including faith-based and community-based organizations	Migrant agricultural workers, seasonal agricultural workers, and members of their families	To develop and operate health centers and migrant health programs that provide primary health care services, supplemental health services, technical assistance, and environmental health services. Allowable services include mental health screening, diagnosis, treatment, referral, and public awareness programs.
Health Centers Grants for Residents of Public Housing[e]	$16,237,000	Public and nonprofit private entities, including faith-based and community-based organizations	Residents of public housing	To improve access to primary care services and to reduce infant mortality by providing public housing residents health services. Allowable services include mental health screening, diagnosis, treatment, referral, and public awareness programs.
Healthy Schools, Healthy Communities[e]	$19,500,000	Public and nonprofit private entities, including faith-based and community-based organizations	Students attending schools (kindergarten through grade 12) that serve low income or high-risk children	To increase access to comprehensive primary and preventive health care for underserved children, adolescents, and their families. Allowable services include mental health screening, diagnosis, treatment, referral, and public awareness programs.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Emergency Medical Services for Children[f]	$18,986,000[c]	States, schools of medicine	Children who come in contact with emergency medical services systems	To improve existing emergency medical services systems and develop and evaluate improved procedures and protocols for treating children. Allowable activities include development of mental health practice guidelines, prevention activities, and training of professionals.
Indian Health Services				
Discretionary grants				
Urban Indian Health Program	$1,352,654	Urban Indian organizations with which the Secretary of Health and Human Services has entered into a contract or grant under Title V of the Indian Health Care Improvement Act	Indians residing in urban centers	To provide health-related services, including mental health services, alcohol and substance abuse services, immunization services, and child abuse prevention and treatment. Allowable activities include mental health screening, treatment, referral, and public awareness programs.
Office of the Secretary				
Discretionary grants				
Public Health and Social Services Emergency Fund	$265,000,000[g]	Federal agencies, states, localities, and other service providers in affected areas	Individuals and families in areas affected by public health and social services emergencies	To provide supplemental funding for public health and social service emergencies.
Substance Abuse and Mental Health Services Administration				
Formula grants				
Community Mental Health Services Block Grant	$398,999,999[c]	States	Children with serious emotional disturbance and adults with serious mental illness	To enable states to implement a comprehensive community-based system of care for children with serious emotional disturbance and adults with serious mental illness. Allowable services are defined by the state's mental health plan, and can include outreach, mental and other health care services, individualized supports, rehabilitation, housing, and education.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Discretionary grants				
National Child Traumatic Stress Initiative[h]	$30,000,000	States, localities, Indian tribes, nonprofit organizations	Children and adolescents exposed to trauma, service providers, and researchers	To identify or develop effective treatments and services; collect clinical data on child trauma cases and services; develop resources on trauma for professionals, consumers, and the public; develop trauma-focused public education initiatives and professional training programs.
Circles of Care	$2,400,000	Tribal governments, urban Indian organizations	American Indian/Alaskan Native children and their families who are experiencing or at risk for serious emotional disturbance	To provide American Indian/Alaska Native communities with tools and resources to design systems of care for people with mental health service needs. Allowable activities include public awareness programs and professional training.
Community Prevention Coalitions (Partnership) Demonstration Grant	$7,800,000[c]	Local governments, local private nonprofit organizations and agencies[i]	Youth, community providers, and localities	To promote mental health and prevent youth violence and substance abuse through the development of self-sustaining coalitions between government and community service delivery systems. Allowable activities include mental health screening, treatment, referral, and public awareness programs.
Community Action Grants for Service System Change	$5,500,000	States, localities, nonprofit organizations, tribal governments	Children with serious emotional disturbance and adults with serious emotional illness	To adopt and implement exemplary practices related to the delivery and organization of mental health services for children with serious emotional disturbance, adults with serious mental illness, and those with co-occurring disorders.
Comprehensive Community Mental Health Services for Children and Their Families	$96,000,000	States, localities, federally recognized tribal governments	Children under age 22 with a diagnosed serious emotional disturbance, serious behavioral disorder, or serious mental disorder	To develop collaborative community-based systems of care. Grantees will ensure that children receive an individualized service plan; each plan designates a case manager; and funding is provided for the mental health services required to meet the child's needs.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Targeted Capacity Expansion Cooperative Agreements to Meet Emerging and Urgent Mental Health Services Needs of Communities: Building Mentally Healthy Communities	$14,500,000	Localities, Indian tribes	Children (pre-natal to 18), youth in the juvenile justice system, homeless persons, persons with co-occurring mental illness and substance abuse, and adults in the criminal justice system. Five and one-half million of the total $14.5 million was targeted for children, prenatal to 18.	To increase the capacity of cities, counties, and tribal governments to provide prevention and treatment services to meet emerging and urgent mental health needs in their communities by building service system infrastructure. Allowable activities include mental health screening, assessment, treatment, referral, and parent education.
Youth Violence Prevention Cooperative Agreements–Cooperative Agreements for Collaborative Community Actions To Prevent Youth Violence and Promote Youth Development	$9,100,000	States, localities, private organizations, Indian tribes, schools and school systems, community coalitions. Only education, mental health, and substance abuse agencies of state and local governments may apply.	Children and families	To support collaborations of community organizations to promote the prevention of youth violence, substance abuse, and other mental health and behavior problems, and to implement interventions and treatment services to enhance positive mental health in youth. Allowable activities include youth violence prevention and mental health promotion activities and programs.
Department of Justice				
Office of Justice Programs				
Formula grants				
Crime Victim Compensation	$93,957,000[j]	States	Victims of crime that results in physical or personal injury[k]	To compensate crime victims for expenses resulting from the crime, including mental health counseling and care, loss of wages, and funeral expenses.
Crime Victim Assistance	$383,027,323[j]	States	Victims of crime and those who are survivors of victims of crime	To support state victim assistance programs. These programs provide funds to community agencies that assist crime victims through crisis intervention, counseling, emergency shelter, and criminal justice advocacy.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Discretionary grants				
Child Development: Community Policing	$514,000[l]	University[m]	Children and youth exposed to family, school, and community violence, and professionals who respond to community violence	To develop a model program to help police officers and mental health professionals provide each other with training, consultation, and support and provide direct intervention to children who are victims, witnesses, or perpetrators of violent crime.
Safe Havens: Supervised Visitation and Safe Exchange Grant Program	$15,000,000	States, local governments, and Indian tribal governments in cooperation with public or private entities	Children and parents in abusive situations	To support safe places for supervised visitation and safe exchange of children by and between parents through implementation, planning, and demonstration grants. Implementation funds may be used to expand the services offered by supervised visitation centers, including mental health services.
Safe Kids/Safe Streets Initiative	$3,000,000[n]	Local communities, Indian tribal Governments[o]	Children and adolescents who have been, or are at risk of being, abused or neglected, and their families	To break the cycle of early childhood victimization and later juvenile delinquency by strengthening community approaches, including system reform, provision of services, prevention education, and data collection and evaluation. Allowable services include mental health screening, referral, counseling, and public awareness.
Safe Start Initiative	$10,000,000	States, localities, and tribal governments applying on behalf of a collaborative group of public or private agencies and organizations	Children between birth and age 6 at high risk of exposure to violence or who have been exposed to violence	To create comprehensive community service delivery systems by expanding partnerships and improving access to services for young children at high risk of exposure to violence, or who have been exposed to violence, and their families. Grantees may provide mental health screening, treatment services, referrals, and public awareness as part of their program.
Tribal Youth Program, Mental Health Project	$1,000,000	Federally recognized American Indian and Alaskan Native tribes	American Indian and Alaskan Native Youth	To improve mental health and substance abuse services for American Indian/Alaskan Native youth and to support juvenile delinquency prevention and intervention efforts by developing culturally sensitive services for youth involved in or at risk of needing tribal or state juvenile mental health programs.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Victims of Child Abuse	$23,085,926[c]	National organizations designated in the congressional appropriations process. Funds are provided to the National Children's Alliance to support Children's Advocacy Centers. Funds also support National Court Appointed Special Advocates.	Children, families, and agencies who provide services to child abuse victims	To promote training of judicial personnel regarding child abuse, investigation and prosecution of child abuse through the criminal justice system, court-appointed special advocates, and children's advocacy centers.
Children's Justice Act Partnerships for Indian Communities	$3,000,000[c]	Federally recognized Indian tribes, nonprofit Indian organizations	Native American youth who are victims of child abuse	To improve how child sexual abuse cases are handled by American Indian tribes with emphasis placed on reducing additional trauma to the child victim. Allowable services include mental health treatment and support services, referral to mental health providers, and public awareness programs.
Crime Victim Assistance/ Discretionary Grants	$17,817,630[c]	American Indian and Alaska Native tribes and tribal organizations, states, eligible victim service agencies, private nonprofit agencies, and others. Eligible applicants vary based on the grant program.	Victims of federal crimes, victim assistance agencies	To support training and technical assistance to crime victim assistance programs, fund demonstration projects conducted by assistance programs, and support services provided to victims of federal crimes assistance programs. This grant supports the Crime Victim Assistance in Indian Country program.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Rural Domestic Violence and Child Victimization Enforcement Grant Program	$39,945,000	Rural states: states, localities, nongovernmental agencies, and federally recognized Indian tribes[p] Nonrural states: states on behalf of rural communities in the state	Rural women and children who are the victims of domestic violence, dating violence, and child abuse	To support projects that provide treatment, counseling, and assistance to victims of child abuse, dating violence, and domestic abuse; to address cooperative efforts between systems to investigate and prosecute cases; and to develop prevention and education strategies.
Multiagency				
Discretionary grants				
Collaborations To Address Domestic Violence and Child Maltreatment (HHS/Justice)[q]	$3,750,000[r]	Nonprofit organizations and government agencies	Maltreated children and parents who have experienced domestic violence	To promote collaborations between child protective services, domestic violence service providers, courts, and community groups and to plan and implement policies and procedures that promote the safety and well-being of battered parents and their maltreated children.
Crisis Counseling Assistance and Training Program (Federal Emergency Management Agency/HHS)	$16,240,509[s]	States	Disaster victims in federally designated major disaster areas	To provide immediate, short-term crisis counseling services to address mental health problems caused or aggravated by a major disaster or its aftermath.
Safe Schools/Healthy Students (Education/ HHS/Justice)	$171,588,449[t]	Local education agencies in partnership with local public mental health authorities, law enforcement agencies	Preschool and school age children, adolescents, and their families who are at risk of being involved in violence as perpetrators, victims, or witnesses	To assist school districts in developing comprehensive services to promote healthy childhood development and prevent violence and alcohol and other drug abuse. Grantees must enter into a formal agreement with mental health service providers that describes referrals and other procedures for providing mental health services to students.

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Grant/agency	Funding for fiscal year 2002 (unless otherwise noted)[a]	Eligible applicants[b]	Targeted beneficiaries	Grant program description
Mental Health and Community Safety Initiative for American Indian/Alaska Native Children, Youth and Families Grants (Justice/ HHS/ Education/ Department of the Interior)[u]	$6,072,466	Federally recognized Indian tribes, tribal organizations	Tribal Indian communities with youth mental health and community safety problems (for example, child abuse and youth violence)	To establish demonstration programs that promote Indian youth mental health, education, and substance abuse-related services, and support juvenile delinquency prevention and intervention through the development of culturally sensitive programs. Allowable services include mental health screening, treatment, referral, and public awareness programs.

[a]All funding is amount appropriated unless otherwise noted.

[b] In this column, the term "state" includes the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, and generally any other territory or possession of the United States unless otherwise noted.

[c]Estimated fiscal year 2002 obligations.

[d]This program description includes Head Start and Early Head Start. Head Start and Early Head Start programs are for children from birth to the age when the child enters the school system, which will vary by child. Head Start and Early Head Start must serve children until kindergarten or first grade if kindergarten is not available in the child's community.

[e]Community Health Centers, Health Center Grants for Homeless Populations, Health Centers Grants for Migrant and Seasonal Farmworkers, Health Centers Grants for Residents of Public Housing, and Healthy Schools, Healthy Communities are all part of HRSA's Consolidated Health Centers Program. Under this program there have been periodic opportunities for existing grantees to compete for additional program funds to help them expand and enhance specific services, such as mental health/substance abuse services.

[f]This program is jointly administered with the Department of Transportation's National Highway Traffic Safety Administration.

[g]Estimated fiscal year 2001 obligations.

[h]This program is not currently accepting new applications.

[i]The localities and nonprofit organizations/agencies that are designated to act on behalf of a larger coalition may apply. The coalition must consist of at least seven organizations or agencies.

[j]Fiscal year 2002 allocation.

[k]Victims must be determined to be eligible under the state victim compensation statute, which may declare that coverage extends generally to any crime resulting in injury, or may list all specific crimes that can be covered.

[l]Fiscal year 2000 obligation.

[m]This grant was awarded to the Child Development-Community Policing Program at the Yale Child Study Center at the Yale University School of Medicine, in collaboration with the New Haven Department of Police Service, New Haven, Connecticut.

[n]Fiscal year 2002 obligation.

[o]Units of local or state governments and nonprofit agencies may apply for the grant on behalf of a collaboration of community groups.

[p]States designated as rural are Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming.

[q]This program is more commonly referred to as the "Greenbook Project," and is a one-time demonstration initiative.

[r]Funds are not separately appropriated for this program, rather, they are allocated by the participating agencies from discretionary accounts.

[s]Fiscal year 2001 obligation.

[t]Estimated fiscal year 2002 obligation as of July 22, 2002.

[u]The departments participating in this initiative, which is administered by HHS's Indian Health Service, have identified several grant programs that will be coordinating in this effort, including Justice's Community-Oriented Policing Services Public Safety Partnership and Community Policing Grants, funded in cooperation with Education, and HHS's American Indian and Alaskan Native Community Planning program. The initiative also involves Justice's Tribal Youth Program, Mental Health Project and HHS's Circles of Care Program, which are described in this table, respectively, under Justice's Office of Justice Programs discretionary grants and HHS's SAMHSA discretionary grants.

Sources: Agency program officials, GAO analysis of agency grant documents, and the *Catalog of Federal Domestic Assistance* (Washington, D.C.: General Services Administration, 2002), http://www.cfda.gov, (downloaded at various times between September 2001 and August 2002).

State Crime Victim Compensation Benefits, May 2002

The federal Crime Victims Fund, administered by Justice's Office for Victims of Crime, provides annual crime victim compensation grants to the states' crime victim compensation programs. Federal victim compensation funds can help crime victims who file claims with state victim compensation agencies obtain reimbursement for mental health expenses, as well as lost wages, loss of support, and medical, dental, and funeral expenses. Federal law requires that states provide certain benefits, including mental health counseling benefits. However, states have discretion in setting program eligibility requirements and benefit amounts. According to the National Association of Crime Victim Compensation Boards, most states' overall maximum benefit is linked to the individual crime rather than to individual primary victims, family members, or other persons affected by the crime. When there are multiple secondary victims of an individual crime, they typically must share the available maximum benefits. However, maximum mental health counseling benefits are typically linked to individual victims, with each family member or secondary victim typically eligible for mental health counseling benefits up to specified caps, unless otherwise stated. (See table 17.)

Table 17: Crime Victim Compensation Maximum Overall Benefits and Maximum Mental Health Benefits

State	Maximum overall per crime	Maximum mental health counseling benefits per crime
Alabama	$15,000	Up to 50 outpatient treatment sessions in 2 years ($6,250 cap); $15,000 cap for inpatient treatment.
Alaska	$40,000; $80,000 in death cases with multiple victims	$2,600 cap for primary victims; $600 cap for secondary victims; $1,200 cap for custodial parents of sexually abused victims
Arizona	$20,000	Up to 36 months
Arkansas	$10,000; $25,000 for catastrophic injuries[a]	$3,500 cap outpatient; $3,500 cap inpatient
California	$70,000	$10,000 cap for direct victims, family of homicide victims, custodial parents or primary caretakers of minor victims, and per relative in homicides; $3,000 cap for other secondary victims
Colorado	$20,000 (each judicial district in the state may set lower maximum)[b]	Determined by district compensation programs (each district can specify limits)
Connecticut	$15,000; $25,000 in homicides	$15,000 cap; $25,000 cap in homicides (up to six sessions for family of homicide victims without submitting application for compensation)
Delaware	$25,000; $50,000 for catastrophic injuries[a]	$25,000 cap; $50,000 cap in catastrophic cases
District of Columbia	$25,000	$25,000 cap
Florida	$25,000; $50,000 in catastrophic cases[a]	$2,500 cap or up to 3 years for adults; $10,000 cap for minor victims; $2,500 cap for child witnesses

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State	Maximum overall per crime	Maximum mental health counseling benefits per crime
Georgia	$25,000	$3,000 cap
Hawaii	$20,000	$5,000 cap
Idaho	$25,000	$2,500 cap for direct victims; $500 cap per family member in homicide and sexual assault victims (maximum of $1,500 per family)
Illinois	$27,000	$27,000 cap
Indiana	$15,000	$1,500 cap for direct victims if therapist charges sliding scale fees based on victims' income and $1,000 cap if no sliding scale used; $1,000 cap per family member in homicide, sexual assault, and domestic violence cases
Iowa	No overall limit; maximums for each expense category, e.g., $15,000 medical	$3,000 cap for nonmedical therapy; therapy under psychiatrist's supervision is considered under medical benefits category with $15,000 cap for primary victims and $3,000 limit for survivors of homicide victims; $1,000 cap per family member of non-homicide victims
Kansas	$25,000	$3,500 cap; $1,000 cap per family member in homicides
Kentucky	$25,000	$25,000 cap
Louisiana	$10,000; $25,000 when injuries result in total and permanent disability	Up to 26 sessions or 6 months, whichever comes first, with $5,000 cap for direct victims, $2,000 cap for indirect victims
Maine	$15,000	$15,000 cap
Maryland	$45,000	$5,000 cap; $1,000 cap for each family member up to $5,000
Massachusetts	$25,000	$25,000 cap
Michigan	$15,000	Up to 26 sessions
Minnesota	$50,000	$7,500 cap for direct victims; up to 20 sessions for each secondary victim
Mississippi	$15,000	$3,000 cap
Missouri	$25,000	$2,500 cap
Montana	$25,000	$2,000 cap or 12 months with possibility of extension (based on review by a mental health professional working with the Crime Victims Unit Board of Control) for primary victims; for secondary victims, $2,000 cap or 12 months per person for spouse, parent, child, or sibling of a homicide victims and for the parent or sibling of a minor who is the victim of a sex crime
Nebraska	$10,000	$2,000 cap
Nevada	$50,000	$3,500 cap; additional $5,000 in extreme cases
New Hampshire	$10,000 per primary victim and secondary victim for each victimization occurring on or after July 1, 1997; $5,000 otherwise	$2,000 cap
New Jersey	$25,000; $50,000 for catastrophic injuries[a]	Up to 100 sessions or $10,000 cap, whichever is greater
New Mexico	$20,000; $50,000 for catastrophic injuries[a]	Up to 30 sessions; preauthorization required for additional sessions

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State	Maximum overall per crime	Maximum mental health counseling benefits per crime
New York	No medical maximum; $30,000 lost wages/support	No categorical limit
North Carolina	$30,000; $33,500 in homicides	Up to 1 year for adults; 2 years for children age 10 and under
North Dakota	$25,000	80% of charges
Ohio	$50,000 per victim per incident	$50,000 cap; $2,500 cap per immediate family member
Oklahoma	$20,000	$3,000 cap for primary victims may be waived in extreme cases. For families of homicide victims, $500 cap per person and $3,000 cap per family. Complex or lengthy therapy is reviewed by panel composed of mental health professionals working with the Crime Victims Compensation Board.
Oregon	$44,000	$20,000 cap for direct victims and family in homicides; $10,000 cap for children who witness domestic violence; limited family therapy in child sexual abuse cases
Pennsylvania	$35,000	$35,000 cap
Puerto Rico	$3,000 per person; $5,000 per family	$3,000 cap per person; $5,000 per family
Rhode Island	$25,000	$25,000 cap
South Carolina	$15,000; $25,000 for catastrophic injuries per Crime Victims' Advisory Board approval[a]	Up to 180 days of treatment or 20 sessions, whichever is greater
South Dakota	$15,000	Up to 24 sessions for primary victims; 18 sessions for family members in homicides; 6 sessions for parents of juvenile victims and spouses of rape victims
Tennessee	$30,000	$30,000 cap
Texas	$50,000; with additional $75,000 for catastrophic injuries[a]	$3,000 cap; $400 per day, 30-day limit on inpatient psychiatric care
Utah	$25,000; $50,000 medical in homicide, attempted homicide, aggravated assault, drunk driving	$2,500 cap for primary victims; $1,000 cap for secondary victims (immediate family members, individuals residing in the household at the time of the crime, and other individuals essential to well-being and treatment of primary victims); may be extended after review by mental health professionals working with the Office of Crime Victim Reparations
Vermont	$10,000	Up to 20 sessions with treatment plan, may request extensions at 20-session increments for crime-related symptoms still needing treatment
Virginia	$15,000	$15,000 cap for direct victims; $2,500 cap for survivors of homicide victims
Virgin Islands	$25,000	Up to 10 sessions
Washington	$150,000 for medical and mental health costs, which may be waived in special circumstances; $30,000 for nonmedical expenses; $40,000 for pension and death benefits, less other nonmedical expenses paid	Up to 40 sessions for children; reports are required after 6 sessions and after 15 sessions; report to the state Crime Victim Compensation Program and preauthorization required for more sessions.
West Virginia	$25,000 in personal injury cases; $35,000 in homicides	$25,000 cap for direct victims; $1,000 cap for secondary victims

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State	Maximum overall per crime	Maximum mental health counseling benefits per crime
Wisconsin	$40,000; plus additional $2,000 for funeral expenses	$40,000 cap
Wyoming	$15,000; $25,000 for catastrophic injuries[a]	$15,000 cap direct victims; $1,500 cap for associated victims

[a]Each state uses its own definition of catastrophic injuries.

[b]In Colorado, each of the 22 judicial districts has a victim compensation program.

Source: National Association of Crime Victim Compensation Boards, 2002.

Comments from the Federal Emergency Management Agency

Federal Emergency Management Agency
Washington, D.C. 20472
AUG 1 2002

Ms. Janet Heinrich
Director, Health Care -- Public Health Issues
General Accounting Office
Washington, D. C. 20548

Dear Ms. Heinrich:

Thank you for the opportunity to respond to your draft report entitled, MENTAL HEALTH SERVICES: *Effectiveness of Insurance Coverage and Federal Programs for Traumatized Children Largely Unknown (GAO-02-813).*

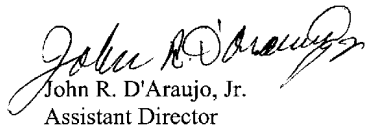
Following a review of the report, we conclude that the report is generally correct in the description of services of the Federal Emergency Management Agency (FEMA) and the Crisis Counseling Assistance and Training Program. The FEMA Crisis Counseling Assistance and Training Program is conducted through a partnership of FEMA and the Center for Mental Health Services (CMHS) within the U.S. Department of Health and Human Services.

The GAO report accurately states that there has not been a comprehensive evaluation of the Crisis Counseling Assistance and Training Program since the program's inception. This is factually correct; however, there are evaluation methods that have been and are currently being used to measure program effectiveness. The Crisis Counseling Assistance and Training Program has been piloting data collection procedures—which are currently being utilized by States (New Jersey, New York and Virginia) affected by September 11th—to develop a standardized toolkit. The data collection standardized toolkit will provide an evaluation component to enhance data collection services and help monitor the quality of services being offered. This service was initially developed by evaluation experts and program administrators and will continue to be provided as program guidance to future grantees.

We agree with the GAO report that evaluation is an important tool for program effectiveness. It is our intent to continue developing evaluation and implementation methods to ensure that the Crisis Counseling Assistance and Training Program is administered to the highest degree of effectiveness to disaster victims.

Thank you again for the chance to provide clarification on this issue. If you have any further questions, please feel free contact me at 202-646-3692 or my staff at 202-646-3683.

Sincerely,



John R. D'Araujo, Jr.
Assistant Director
Response and Recovery Directorate

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUL 29 2002

Ms. Janet Heinrich
Director, Health Care - Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Heinrich:

Enclosed are the Department's comments on your draft report entitled, "Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Traumatized Children Largely Unknown." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

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

Sincerely,

Michael Mangano

for Janet Rehnquist
Inspector General

Enclosure

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

Comments of the Department of Health and Human Services on the U.S. General Accounting Office's Draft Report, "Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Traumatized Children Largely Unknown"

General Comments

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on this draft report. Based on our review, the GAO Report on Child Trauma Emergency Services and Insurance will be a useful tool for policy makers and brings important attention to the needs of children exposed to traumatic events. The report includes extensive information describing services provided through the Crisis Counseling Assistance and Training Program, which is conducted through a partnership of the Federal Emergency Management Agency (FEMA) and the Center for Mental Health Services (CMHS), which is a subcomponent of the Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS.

The report is generally accurate in its description of the structure and operations of the Crisis Counseling Program and in its description of the services provided through the program. The report accurately notes that a program-wide evaluation has not been conducted for the Crisis Counseling Program and asserts that evaluation activities are critical for this program and for other child trauma programs. However, HHS would like to provide additional information regarding evaluation activities that have been conducted in the program and are planned for the future.

The HHS strongly agrees that evaluation activities are critical to ensure program effectiveness and appropriate use of resources, and have instituted a number of evaluations in recent years. Based on input from evaluation experts and program administrators, SAMHSA/CMHS recently developed new guidance for grantees regarding recommended evaluation activities for grantees.

After significant review, new evaluation guidance materials were developed and released in September of 2001, shortly before the September 11 terrorist attacks. These materials have been used by grantees in New York, New Jersey, and Virginia, to develop data collection and evaluation plans. Data collected through these evaluation activities are being used for ongoing quality assurance purposes and we expect that the evaluation activities conducted by these grantees will provide important information for future programs.

Based on the data collection approaches and evaluation activities being conducted through these programs, the Crisis Counseling Program is currently developing a standardized data toolkit, which will result in additional cross-site evaluation and improved monitoring of services. Improved data collection processes will be critical in conducting high quality evaluation activities in the future.

In addition, CMHS, through an interagency agreement with the National Center for Post Traumatic Stress Disorder (NCPTSD) within the U.S. Department of Veterans Affairs, has requested additional guidance from leading researchers in the field of disaster mental health regarding needs assessment and program-wide evaluation approaches that can be implemented in

the program. Among the activities to be conducted in the upcoming year in this interagency agreement, NCPTSD staff will be conducting "case studies" of current and past programs. The Department has also asked NCPTSD to consult with research experts and recommend additional evaluation activities in the Crisis Counseling Program. We plan to continue ongoing evaluation planning and implementation to assure that services are appropriate, efficient, and responsive to the needs of disaster victims and appreciate the attention the GAO has brought to this issue.

Several places in the report emphasize the lack of data on the prevalence of mental health needs and services for child trauma victims/survivors. It should be noted that several components of the National Institutes of Health (NIH) as well as other HHS agencies have significant research programs in this area. For example, the NIH Child Abuse and Neglect Working Group coordinates NIH and other agency research on victims of child abuse and neglect. The National Institute of Mental Health (NIMH) Traumatic Stress Research Program supports research, including post 9/11/01 studies, on the prevalence of child trauma exposure, how such experiences increase risk for adverse mental health outcomes, and interventions to prevent mental disorders. Additionally, NIMH supports nationally representative surveys, some down to age 13, on the prevalence of mental disorders, adverse life events/trauma, service need and use, medication use, functional impairments and disability. Some of these efforts were in the field prior to September 2001 and are therefore able to address pre-post 9-11-01 trauma exposure. Collectively, these programs are helping us to better understand the needs of traumatized children and effective methods for organizing and delivering care. Moreover, building on significant advances in biological and behavioral research, and with a significant scientific push, these programs have the potential to rapidly advance our understanding of and interventions to reduce trauma-related mental health disorders, including posttraumatic stress disorder.

In addition, SAMHSA agrees with NIH that this report assumes that well-trained mental health providers capable of delivering these services to a child population are available. In reality, a child mental health workforce with the capacity to meet the mental health needs of the children and adolescents in this country does not exist. Responding to post traumatic stress in children requires even more specialized training. Unless this gap is addressed, the knowledge that we have already acquired related to the delivery of effective mental health services will not be implemented, and services will not be available to those who need them most, the nation's children. The gap between what we know works in mental health treatment and what services are actually delivered was clearly documented in Mental Health: A Report of the Surgeon General in 1999 and further elaborated upon in a Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda in 2000. Both of these reports recognized the need for public education to reduce stigma and for training of frontline providers to recognize and manage mental healthcare issues, as well as the need to educate mental health providers about scientifically-proven prevention and treatment services.

It is vitally important for us as a nation to be able to provide quality mental health care to every child who may need such care in our communities. The report should emphasize that this requires that adequately trained mental health practitioners, including psychiatrists, clinical psychologists, psychiatric social workers, nurses and other relevant professionals, are in fact available and accessible to those who need them. Providing good care also assumes the

availability of in-patient and out-patient facilities in the community, along with a range of effective diagnostic and treatment tools and procedures. Moreover, it also assumes that non-psychiatric physicians (general practitioners, internists, pediatricians and others) in the community are all sufficiently informed about trauma-related psychiatric disorders and able to diagnose and treat these conditions, or to refer these patients to knowledgeable specialists who can provide appropriate treatment.

The report should note that even if sufficient human and material resources are made available for the mental health services needed, there remain some fundamental questions concerning the effectiveness of some present-day approaches to the treatment and prevention of such highly misunderstood and stigmatized illnesses as depression, panic and anxiety disorders, posttraumatic stress and conduct disorders. This is due to the simple fact that at the present stage of the scientific development in this field, our knowledge of the neurobiological nature, cause, pathogenesis and treatment of many of these conditions is extremely limited. We currently know how to manage and ameliorate some of these problems but the fundamental knowledge needed to cure or prevent them is simply not available to us at the present time. Several reasons include:

1) In the past we have not recognized the full magnitude of the social, economic and health burdens of mental disorders in comparison with other diseases and adverse events which threaten human life or diminish its quality.

2) Another issue is the need to increase the understanding of the etiology and pathogenesis of specific mental disorders and to increase the availability of effective treatments for them. Therefore, two specific goals must be addressed in this area: a) to increase our knowledge through comprehensive programs of empirical research that target the genetic and other biochemical, psycho-social and environmental causes of brain-behavior disorders and b) to develop additional new, effective methods of treatment and prevention to reduce or eliminate the suffering and disabilities of our patients and their families and to reduce the profound social and economic costs of mental illness to society.

3) A third fundamental problem is the general public's misconception about causes of mental disorders and the prejudice, shame and stigma that seem universally associated with them. The education of the public with regard to the biological and behavioral bases of mental disorders will go a long way toward removing stigma and prejudice and facilitating a more realistic and appropriate response to individuals with mental illness in the community, a response similar to that afforded to persons with, for example, arthritis, diabetes or heart disease.

The GAO's draft report should include a more thorough discussion of the Health Resources and Services Administration's (HRSA) funding of programs to meet the mental health needs of uninsured and underserved children. Specifically, on page four of the report, the section on other Federally supported mental health services should include HRSA's Consolidated Health Center program. In FY 2001, under this program, health centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Health Centers and

School-based Health Centers) provided primary health care services, including mental health services, to nearly four million children. Among these health center users, visits for mental health services were one of the most frequently reported encounters.

HRSA's Bureau of Primary Health Care (BPHC), which administers the Comprehensive Community Health Center Program, has initiated the "Mental Health/Substance Abuse Service Expansion Grant program." The purpose of this grant program is to fund on-site primary mental health and substance abuse service delivery within federally-funded Community Health Centers in order to 1) improve patient access to these services on-site, and; 2) to reduce health disparities among the poor and uninsured populations seen in health centers and the U.S. population in general. Through a competitive grant process the BPHC "Mental Health/Substance Abuse Service Expansion Grant" program provides annual funding of $100,000 to federally-funded community health centers to provide on-site primary mental health/substance abuse services. Over the past 4 years, nearly 237 health centers have been funded to provide expanded primary mental health/substance abuse services to health center patients. These funds are used to hire mental health and/or substance abuse providers to practice as a member of the health center's primary care team, and to deliver their services in collaboration with the primary medical providers within the community health center's primary care clinics. This funding offers health centers the opportunity to begin to serve their patients' mental health needs within the privacy and confidentiality of the primary care clinic setting, thereby increasing patient access to mental health services and improving the health outcomes of patients with a history of trauma and other mental health problems.

While the GAO's draft report states that most insurance plans place limits on mental health coverage (including very limited coverage on the types of mental health services, the number of visits, the number of days of hospitalization, and the type of mental health provider), GAO does not portray the very limited access that even insured children have to mental health services. For example, GAO's draft report does not discuss the ramifications of discontinuous coverage of children under Medicaid and the State Children's Health Insurance Program, and does not address the ramifications of other complex issues such as 'mental health parity.'

The GAO report should contain a discussion of problems within the public mental health system. This system, funded in part by the SAMHSA's Mental Health Block Grant, serves Medicaid and uninsured populations, and focuses their service delivery on the seriously mentally ill only. But access to mental health services within this State-based system has been deteriorating nationwide for many years. Without adequate funding, State public mental health systems have been unable to hire enough providers and have been unable to support the requests for services that are being made by the populations they are supposed to serve. As this system has deteriorated, access to mental health services by uninsured populations has disappeared.

The GAO draft report does not reference research highlighting problems of underserved populations in accessing mental health for children, i.e., according to the Rand Research Brief 2001, "the majority of troubled youth do not get the mental health services they need."

The GAO's draft report should include a discussion of stigma as an important reason why families do not access mental health services for traumatized children. The fact that most pediatric and primary care service providers offer little if any direct access to mental health screening and service delivery should also be discussed. In general, parents must request these services. But to actually obtain mental health services, the child must be referred to a separate mental health provider, usually at another physical location, often at some distance from their pediatric or primary care provider. This is a significant barrier to many families seeking mental health care for their children.

Furthermore, it should mention the influences of familial ethnicity and cultural background on attitudes of mental disorders and the use of mental health services. Frequently, other family members' symptoms of trauma may interfere with their ability to obtain help for their children. This is especially important, as it has been found that the family support environment has a critical influence on recovery.

Primary care clinicians could serve as an important portal of entry to specialty mental health services for traumatized children. The large majority of children do visit primary care providers at least once a year. In addition, primary care providers are an important part of family's support systems. Graduate medical education programs should ensure that primary care clinicians receive education and training on identifying, treating as appropriate, and working with mental health specialists to better help children with mental health problems and their families. Furthermore, GAO should cite the influences of familial ethnicity and cultural background on attitudes of mental disorders and the use of mental health services.

Certain populations of youth are at risk for acquiring HIV and AIDS as a result of sexual exploitation. Many of these children face life long disability due to physical and emotional abuse. Some consideration should be given within the report to this largely unknown population of children. Approximately 16 percent of new HIV infections worldwide in 2001 occurred among children less than 15 years of age (UNAIDS, *AIDS Epidemic Update,* December 2001). Although virtually all the pediatric AIDS in this country is a result of perinatal transmission, it is necessary to consider the global epidemic when reviewing service needs within the U.S.

The inadequate availability of mental health personnel for services to children in trauma may be successfully ameliorated through the use of telehealth mental health services. However, funding problems limit the use of such services. It may be advantageous for GAO's report to suggest that the States look more closely at such an approach.

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Comments from the Department of Education

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

THE ASSISTANT SECRETARY

JUL 26 2002

Ms. Janet Heinrich, Director
Health Care, Public Health Issues
United States General Accounting Office
Washington, DC 20548

Dear Ms Heinrich:

Thank you for providing an opportunity for us to review your draft report, *Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Traumatized Children Largely Unknown.*

Generally, we believe that the information that you have included in the report concerning activities administered by the US Department of Education accurately describes those programs and initiatives. We have included information about recommended minor technical revisions as an enclosure to this letter.

While the report provides a thorough discussion of the various Federal programs that may address the needs of traumatized children, I believe that the report would be strengthened by including some discussion that addresses the issue or whether or not the pool of qualified mental health service providers trained to deal with the needs of children, and more particularly children experiencing trauma, is sufficient. We have worked closely with several school districts that have been the site of school shootings or other traumatic events, and this issue has emerged repeatedly.

Again, thank you for providing a copy of this draft report for our review.

Sincerely,

Susan B. Neuman

Enclosure

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GAO Contact and Staff Acknowledgments

GAO Contact

Helene F. Toiv, (202) 512-7162

Staff Acknowledgments

In addition to the person named above, key contributors to this report were Susan Anthony, Alice L. London, Janina Austin, Sari Bloom, Emily Gamble Gardiner, William D. Hadley, Christi Turner, and Behn Miller.

Related GAO Products

Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders. GAO-02-339. Washington, D.C.: February 28, 2002.

Bioterrorism: Public Health and Medical Preparedness. GAO-01-915. Washington, D.C.: September 28, 2001.

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

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

Health and Human Services: Status of Achieving Key Outcomes and Addressing Major Management Challenges. GAO-01-748. Washington, D.C.: June 15, 2001.

Major Management Challenges and Program Risks: Department of Health and Human Services. GAO-01-247. Washington, D.C.: January 1, 2001.

Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited. T-HEHS-00-113. Washington, D.C.: May 18, 2000.

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