The CSA: Problems and Solutions

A Presentation to the Joint Committee Studying the CSA

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Child and Family Behavioral Health Policy and Planning Committee (330-F) Authorizing Language

"The DMHMRSAS, the DJJ and the DMAS, in cooperation with the Office of Comprehensive Services, Community Service Boards, Court Service Units, and representatives from CPMTs representing various regions of the Commonwealth shall develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders, to mental health, substance abuse, and mental retardation services…."

Child and Family Behavioral Health Policy and Planning Committee (330-F) Authorizing Language

"…The plan shall also examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private day and residential treatment facilities for services and make recommendations regarding how rural localities can improve prevention, intervention and treatment for high-risk children and families, with the goal of broadening treatment options and improving quality and cost effectiveness."

Strengths of the CSA

CSA Strengths

- Pooling of funds to serve children
- Based on developing systems of care where services and providers work together to help troubled and at-risk children and their families
- Local community teams decide what is best for their children
- Provides flexible use of funds, allowing children to receive services that public and private insurance do not fund

CSA Strengths

- Child-centered
- Family-focused
- Community-based
- Hiring Kim McGaughey as Executive Director

Problem 1:

The CSA Does Not Serve Much of Its Target Population

CSA Target Population

- Troubled and at-risk children and their families
- Virginia has 64,000 Seriously Emotionally Disturbed (SED) children
- SED children have an impairment that significantly impacts their functioning in their home, school and/or community environments

2005 CSA Population

- 16,272 children served
- This is 1/4 of the target population

Mandated and Non-Mandated Children

- Federally mandated populations
  - Children in state custody (8,000)
  - Children requiring residential care to meet their special education needs (hundreds)
- 95% of CSA expenditures are for mandated populations
- 5% of CSA funds are left for more than 55,000 children

Problem 2:

Funding Formula Inequity

CSA Funding Formula Inequity

- Established in 1994
- Based on locality population and need
  - Poverty used as the measure of need
- Population distribution has changed significantly in 12 years
- Poverty distribution has also changed

CSA Funding Formula Inequity

- Some communities have less money than they need
- The cost of providing services for one high-needs child can use up most of a small community's budget

Problem 3:

Insufficient Community-Based Services

Virginia Expenditures on Residential Care 2005

- Residential care keeps children out of their families and communities
- More than $185 million spent in FY 2005
  - $57.1 million in Medicaid funds
  - $128 million in CSA funds
- 47% of CSA expenditures spent on residential care

Why Is So Much Spent on Residential Care in Virginia?

- Lack of community-based services capacity
- Expenditures on high-end (hospital, residential, and group homes) and low-end (outpatient treatment) services
- Lack of intermediate level services
  - Wraparound
  - Day treatment
  - Intensive outpatient
  - Crisis intervention
  - Crisis stabilization
  - Mobile crisis teams
  - Behavioral aides
  - Respite care
  - Afterschool behavioral health programs
  - Intensive case management
  - Drop-in centers
  - In-home family therapy
  - Intensive in-home services

Why Is So Much Spent on Residential Care in Virginia?

- In CSA, the money follows the child
- That means almost all money is spent on services that are available
- That means money is spent on services that were available in 1994
- This leaves out many effective and less-expensive services that have been developed in other states in the last 12 years

Increasing Community-Based Services

- Residential care should only be used as a last resort
- Need for start-up funds
- Need to increase the size of the workforce
  - Child Psychiatrists
  - Child Psychologists
- Need to increase the workforce in rural communities

Office of Comprehensive Services Initiatives 2005-2006

OCS Initiatives 2005-2006

- Joint Committee with CFBHPPC (330-F) on Expanding Community-Based Services
- Legislature provided $750,000 in start-up funds to expand community-based services
- Identifying desired outcomes and indicators
- Identifying performance measures for CSA system

Recommendations to Improve the CSA System

Recommendations

1. OCS should to continue to work to return CSA to its original intent of serving troubled and at-risk children
2. OCS should officially eliminate the distinction between mandated and non-mandated children
3. The Legislature should require that the CSA funding formula be recalculated after each decennial census

Recommendations

4. The Legislature should provide an amount equal to 2.5% of total CSA expenditures to help start up new community-based services, particularly intermediate-level services
5. The Legislature should authorize the OCS to use CSA funds flexibly to help start up new community-based services (for example, to allow several communities to pool their funds to start up a service that none could have individually)

Recommendations

6. The Legislature should fund four child psychiatry fellowship and four child psychology internship slots with payback provisions to work in underserved areas in Virginia at a cost of $493,000 annually