

*CT COUNCIL OF CHILD AND ADOLESCENT
PSYCHIATRY
AND
CT CHAPTER OF THE AMERICAN ACADEMY OF
PEDIATRICS*

*Testimony regarding HB 5144 AN ACT CONCERNING THE OPERATION OF
RIVERVIEW HOSPITAL AND CONNECTICUT CHILDREN'S PLACE.*

I am Dr Jill Barron, representing the CT Council of Child and Adolescent Psychiatry and I am here with Dr. Sandra Carbonari representing the CT Chapter of the American Academy of Pediatrics. We would like to comment on the proposed transition of operation of Riverview and CT Children's Place from DCF to DHMAS.

The proposal asks that the following be addressed: (1) improve patient care, (2) create greater efficiency in the operation of each facility, (3) permit the Department of Children and Families to increase its focus on child protection and welfare, and (4) benefit each facility by utilizing the Department of Mental Health and Addiction Service's expertise in providing treatment to residents of each facility who have psychiatric illnesses and disabilities.

First, we will address the improvement of patient care and DHMAS's expertise in people with psychiatric illness and disabilities.

We notice that the language refers to "people" and not specifically children. Riverview Hospital is an accredited 88 bed hospital that provides mental health treatment for children 5 to 18 years of age with extreme emotional and behavioral difficulties. The children at Riverview have been diagnosed with illnesses such as schizophrenia, bipolar disorder, and depression, and often pose a chronic danger to themselves and/or others. As part of admission criteria, they have failed treatment in other acute inpatient settings. Riverview patients come from places like Yale-New Haven Hospital, The Institute of Living, Connecticut Children's Medical Center, and Natchaug Hospital. The window of opportunity for chronic stabilization, improvement, or a cure in many cases, is at this young age; otherwise, inevitably many will fill our prisons, hospitals and streets as adults -- becoming a much larger financial and emotional burden for generations to come.

Because of the severity and chronicity of the illnesses, and sometimes the difficulty in finding a suitable placement upon discharge from the hospital, the average length of stay during 2008 was 154 days -- as opposed to one to two weeks in the acute hospital settings.

The teams at RVH and CCP include Child Psychiatrists, Pediatricians, Psychologists, Social

Workers, Nurses, Rehabilitation Staff, Occupational Therapists, and Dentists. This team concept is unique to Riverview and CCP, and DCF. These professionals have special education, training and experience, which cannot be replicated at DHMAS.

A Child Psychiatrists receives an extra 2 years of training after adult training before they can treat children and adolescents. Pediatricians are specific to children's health. They both have the perspective of looking at growth and development from birth to young adulthood. These providers understand how to work with families which is an essential part of treatment.

The point of view at DHMAS is to work with adult patients. Diseases and treatments are very different for children. You all are aware that children are not just small adults. It is much more complicated, and we must not go backwards to a time where we treated them as adults.

The language of the bill also asks that efficiency be addressed. While it is important to save money, this worries us, as we continue to hear suggestions that Riverview should be closed to save that money.

A recent report by the Agency for Healthcare Research and Quality summarizes the five most costly conditions for children ages 0-17 in 2006. The report demonstrates that the "highest expenditures were for care and treatment of mental disorders." It also points out that the distribution of expenditures for reimbursement for mental disorders was lowest from private insurers, and highest for out-of-pocket expense. At capacity, the daily cost of a bed at Riverview is about \$1800, comparable to the cost of a general hospital bed. The cost of a Riverview stay is partially reimbursed by Medicaid if the patient is insured by the HUSKY program. There is little to no reimbursement from private insurers.

Instead of reducing medically necessary care of the most severely ill children in our state, lawmakers might consider requiring private insurers to reimburse for psychiatric care, to relieve the burden on taxpayers and private and public hospitals. These children and their families/caregivers rely on Riverview for lifesaving and life altering treatment. It would be irresponsible to blindly cut these services without thinking about the devastating results.

Riverview is a highly competitive site for clinical training of both child and adolescent psychiatrists from Yale and UCONN and child and adolescent psychologists from Yale. It also serves for clinical training for Licensed Clinical Social Workers from several colleges and universities in the northeast. According to the Surgeon General's 2000 report, we are in need of at least 35,000 child and adolescent psychiatrists to adequately meet the increasing mental health needs of our nation's children -- and we only have approximately 7000 in the US, and only about 200 in CT. At a time when we are striving

to provide increased numbers of trainees, it would be counterproductive to terminate the Riverview program.

We, the providers of children's mental health services in Connecticut's communities, must speak loudly on the behalf of those who cannot. Changing the state agency in charge does not make the situation better for the children in our care, and it could make it worse.

The simple part of this testimony is that DHMAS is not a bad agency. It simply is not designed nor run by professionals who are trained in the intricacies of dealing with sick children. It is not as simple as changing who is in charge. The patients and their families have a great deal of need, and this solution of changing the agency does not make any sense. We would be more prudent to explore ways to achieve cost savings and increase revenues without crippling children's mental health care in Connecticut.

The CTAAP and CCCAP in a child psychiatric/child mental health task force have collaborated over the past year to design a solution improve access and quality of mental health care of children. The proposal relies only on existing levels of professional manpower and resources that are currently being paid for by the state, as well as on current resource levels from commercial insurance companies and private charitable sources. We refer to this solution as the Mental Health Blue Print for Children. We can make copies available and would be very happy to discuss the Blue Print with anyone who wishes to.

