

I appreciate the opportunity to be here today. I am Sherri Wittwer, the Executive Director of NAMI Utah (the National Alliance on Mental Illness). NAMI is a group that offers support, education, and advocacy for individuals living with mental illness and their families. I speak to you today also with the perspective of a mother of four children – one who has a serious mental illness.

We are at a serious crossroads with the children's mental health system. The children's unit at the State Hospital is in serious disrepair – we know that children should not be housed in such a facility. Doing nothing at this juncture cannot be an option. However, per the recommendations of the Legislative Audit on the State Hospital that was released this past January, as a State, we need to decide what our policy is for the treatment for children with serious mental illness. This policy needs to be determined BEFORE we consider investing 55 million dollars in a structure that will surely encourage the long-term placement of children for many years to come.

I would like to say upfront that most families and mental health professionals would agree that community based care rather than institutionalization for children (and adults for that matter) is the preferred way of delivering services. It is why we have developed and are invested in a community mental health system. However, in my many conversations with leadership from various mental health and other public agencies and families, most people are frankly reluctant to even have this conversation because they do not want to lose what we currently have. This is a fair concern given the historical precedent that has been set. In the 60's and the 70's when the focus in this country was to deinstitutionalize, the funding to treat individuals with mental illness in the community never fully materialized. The mental health system has struggled to address the need ever since. In addition, the children currently housed at the State Hospital are children with complex needs and treating these children in the community is hard. Still, the fear of losing what we have, the difficulty of major systems change, and/or a commitment to the status quo does not excuse us from having these conversations as a community to create the best policy for delivering mental health services for our children and their families.

I would suggest to you, that the thinking of some of the leading experts in children's mental health in the nation, including SAMHSA (the Substance Abuse and Mental Health Services Administration), and the Surgeon General, that our State's focus should not be on building a building, but on building home and community based services to allow children to stay in their homes and communities and keep families intact whenever possible. We have learned that we erred by thinking that we could put children with serious emotional disturbance in an institution to be "fixed" and bring them home when they were better. In fact, kids need to be treated while they are still with their families, in school, and living in their community. They often get worse when they are put in a hospital, and worse again when transitioned back home. Treating them in their community allows for parents, grandparents, teachers and clergy to be part of the treatment planning.

SAMSHA has a vision statement that says, "a life in the community for everyone." SAMHSA has developed guiding principles on mental health care for children and adolescents that call for care to be

delivered to children in the least restrictive setting and that keeps children at home, with their families, and in their community¹.

The U.S. Surgeon General's Report on Mental Health addressed inpatient hospitalization for children and adolescents:

"Inpatient hospitalization is the most restrictive type of care in the continuum of mental health services for children and adolescents... Inpatient care consumes about half of child mental health resources, based on the latest estimate available (Burns, 1991), but it is the clinical intervention with the weakest research support... Only three controlled studies evaluated the effectiveness of inpatient treatment: All three studies demonstrated that community care was at least as effective as inpatient treatment..."

The National Council on Community Behavioral Healthcare states that "High quality community-based care for mental illnesses and addictions comes at lower cost – to the taxpayer and private payer – than institutionalization."

Furthermore the legislative performance audit of the Utah State Hospital released in this past January reported:

"Utah is one of two western states in our sample that has a children's unit at a state hospital. Further, our consultant believes children should be treated in the community as much as possible. While he praised the children's unit very highly, he also noted that there are downsides to the pediatric hospitalization of children (e.g. stigmatization of the child) and in general, he is biased against the practice except when absolutely necessary. With the proposed construction of a new pediatric treatment facility, we believe this is a very good time for policy finalization by the Division of Mental Health regarding the appropriate placement of treatment for severely emotionally disturbed children. Regarding the number of adolescent beds, currently there does not appear to be sufficient demand to justify maintaining 50 adolescent beds at the State Hospital."

The current situation in our State is this:

Many hospitals have decreased or eliminated acute care psychiatric beds in local communities because of the low reimbursement rates for these services which has created a dependency on the State Hospital.

The AVERAGE length of stay for children at the Utah State Hospital is 9 months although many children have much longer stays. Imagine being 8 years old and being removed from your family, school, and friends for a 9 month hospital stay.

The State Hospital, centrally located in the State prevents far too many families from having regular contact with their child and from being active members of their child's treatment team.

¹ Center for Mental Health Services – Child, Adolescent, and Family Branch, SAMHSA. Information accessed at www.systemsofcare.samhsa.gov.

Studies show that there appear to be severe risks associated with residential and or/inpatient treatment, including the learning of antisocial or bizarre behavior from exposure to deviant peers, failure to learn behavior needed in the community, possibility of trauma associated with separation from the family, difficulty returning to the family, and victimization. Why not treat children in the community when it is after all, the family and community that will carry the responsibility for them and be of value to the children over their lifetime?

The argument has been that there are only 72 beds at the Children's Unit and that most children are treated in their communities. The question is, where in the community are these children being served? We know that too many of these children are being shifted to DCFS and to the Juvenile Justice System and courts and that families sometimes have no choice but to relinquish custody to the State in order to obtain mental health services for their children.

Building a community-based children's mental health system that includes early identification and intervention is much more likely to produce long-term benefits for the children who are in need of services, those currently in State Hospital, those kids in multiple systems, and would benefit the State as a whole. This means that we are at a critical juncture--building the systems-of-care we need for children at the State Hospital can profoundly alter the way we approach treatment of hundreds of children and youth in the community mental health system.

The good news is there are many states already doing this and many models out there that are proven to work. These models have shown that proven to be able to replace hospital beds with a community-based system, in a more cost-effective manner -- worst case, on a cost neutral basis.

The cost savings can be found in a variety of arenas: the long-term benefits of using effective treatment for youth is improved school attendance and performance, improved family and peer relationships, decreased involvement with law enforcement and the juvenile justice system, reduction in self-harm and suicide, decreased rates of substance use and abuse, and decreased subsequent out-of-home placements. Such potential outcomes surely warrant our serious consideration.

The principles of keeping with the values of our State, taking serious care to ensure that we "first do no harm," getting the best value for our investment in mental health services, and the commitment to keeping families intact whenever possible, are a sound foundation for good policy. Again, the professional mental health community and family organizations are at virtual consensus that children and youth are best treated in their communities as opposed to institutional care. Years of research has documented that this can be done for at least the same cost as building and operating an institution. The only barrier is the fear that, if the institution isn't built, we will be left with *no* resource to deal with these children. That is why NAMI Utah is advocating that if this is left as a DCFM facilities matter, we are not looking at what we know works best for our children and youth. We request that this issue be considered a Health/Human Services issue, so we can build best practices in the communities and with families.

Thank you and I offer NAMI's support to assist in any way possible.