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Are we ready to close psychiatric units for children?

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*O*ne budget reduction proposed by Gov. Tim Kaine, closure of the only state-run inpatient psychiatry units for children and adolescents, has provoked wide protest. The Commonwealth Center for Children and Adolescents in Staunton and Southwestern Virginia Mental Health Institute's adolescent unit in Marion together serve more than 800 children per year. Closing them by July 1 would save $6.6 million and set aside $2.1 million to purchase substitute care from private hospitals.

State officials planning the closures may have been caught off guard by the intensity of resistance. Ironically, in justifying the closures they invoke a principle that most child advocates strongly endorse — that of eliminating large, geographically distant institutions in favor of a community-based system of care which serves kids close to home and family. Yet these same advocates have formed a coalition to oppose the closures. Why?

One reason is practical: Based on available data, advocates have concluded that there is no realistic prospect of having a viable plan by July 1 to provide alternate inpatient care for the 800-plus children served annually. When the state-run beds go away, hundreds of children are likely to go unserved. Untreated acute psychiatric problems will have drastic consequences for these vulnerable children, their struggling families and their concerned communities. In the absence of realistic alternatives, it is ill-advised or even irresponsible to pursue a course which so clearly risks significant harm to children.

Can the private sector replace this care? Quite simply — no. Most of these children wind up at a state-run hospital precisely because private hospitals will not admit them. Many are uninsured; some have criminal charges or juvenile justice involvement; others have complicating medical conditions or disabilities. Furthermore, the $2.1 million set aside to purchase care in private hospitals, even if these hospitals had the capacity and willingness to provide this care, is enough to purchase only one-fifth of the bed days needed. Therefore, any plan banking on alternate care in private hospitals may be a reckless gamble.

The second factor driving opposition is more visceral: It is the palpable sense of been-here-before, still-waiting disappointment about prospects for reforming Virginia's inadequate child mental health system. This echoes in repeated questions: When will kids be the priority? How long must they wait? Until tomorrow? When will tomorrow come?

Consider this cruel irony: If Virginia had already made the fiscal and moral commitment

to develop a community-based, family-centered system of care, tomorrow would already be here, and we would now be able to close state-run facilities. Such a system reduces the need for inpatient care by providing crisis-oriented, community- based alternatives and when inpatient care is absolutely needed, provides it in local programs close to home and family.

For at least the past decade, numerous studies, planning groups and policy experts have recognized the inadequacies of Virginia's child mental health system and recommended drastic reform. These inadequacies were highlighted once again, tragically, in the Virginia Tech shootings. So, what's next? Can there be common cause between officials planning to immediately close these state- run facilities and those in opposition? A resounding "Yes!" — if all can unite to promote the political will and moral and financial commitment required to finally build a community- based, family-centered system of mental health care for children and adolescents. Those opposing the closings will eagerly join a unified effort to build this system so that these facilities are no longer needed. And surely, when tomorrow comes, today's protesters will be cheering the loudest.

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