Testimony of Robyn L. Ostrander MD
In Support of LD 181,
“Resolve, Directing the Department of Health and Human Services to Implement Secure Children’s Psychiatric Residential Treatment Facility Services”
March 21, 2023

Senator Baldacci, Representative Meyer and members of the Joint Standing Committee on Health and Human Services, my name is Robyn Ostrander. I am testifying on behalf of MaineHealth in favor of LD 181, “Resolve, Directing the Department of Health and Human Services to Implement Secure Children’s Psychiatric Residential Treatment Facility Services.” I have practiced Child Psychiatry for the past 18 years, initially in Brattleboro Vermont where I worked in inpatient and secure residential programs, then for the past 7 years in Southern Maine. I am currently the Division Medical Director of Child & Adolescent Psychiatry as well as the Vice Chair of Psychiatry at Maine Medical Center, and an Assistant Professor of Psychiatry with Tufts University School of Medicine. My medical degree is from Harvard Medical School. I completed training in Adult and Child Psychiatry at then-Dartmouth Hitchcock Medical Center in New Hampshire.

For the bulk of my career, I provided treatment to school age and teenage patients in a staff-secure residential setting. It was not anything like juvenile detention. The doors were not locked. They were alarmed, so if a patient decided abruptly to leave, staff would follow them and talk to them until they returned safely, or gather more support if needed. Treatment included seeing a masters-level social work therapist for evidence based individual, family and group psychotherapy. They met with their psychiatrist (me) weekly, given the multiple co-morbid mental health conditions they experienced, and the complex medication regimens required for these youth who had already tried and been failed by introductory lines of medication. They had daily access to a nurse with specialty pediatric and psychiatric expertise, and daily contact with mental health technicians who supported them in the residential homes, at school and in the community. They attended an on-campus therapeutic school with instructors trained in special education and core subjects. They lived in house-style residences of 6 to 8 kids each. They saw pediatricians and dentists and gynecologists as needed, had time in the outdoors, visited local animal rescues and went on hikes. They learned life skills like grocery shopping, cooking and laundry. We even sent a few off to college. With time and a gentle hand, many formed therapeutic relationships with us which were deeply meaningful.

Most importantly, throughout their care, they interacted with their families and other community supports like child protective services case workers often. Families, including siblings (and sometimes pets), attended treatment sessions and joined visits in the community. And yet these kids were among the most ill I have treated in my career. They were largely survivors of extensive trauma and disrupted relationships with parents. They could not function safely in the community, many had violent or aggressive behaviors, and most had had many inpatient psychiatric hospitalizations. The beauty of the program was that they were allowed to be treated in their home state. They did not languish in psychiatric hospital beds or the
emergency room. And they were not shipped out of state to programs where their families had little opportunity to visit or participate in their treatment. And, they got better.

It is a great sadness to me that this level of care is not available to my patients now, in the state of Maine. Many patients can’t be safely cared for in open residential programs, as is clear from the number of patients discharged from local residential facilities to emergency rooms. Emergency rooms are not treatment facilities for youth. They are loud environments which separate kids from their families, needed treatment, and their education, and they provide a minimum of medical care.

Some youth are also stuck in inpatient psychiatric hospitals due to a lack of secure residential treatment. These youth deteriorate in this restrictive setting, with limited time with family and friends and only minimal access to education.

And for every child or teen languishing in a bed in our psychiatric hospitals for months to over a year, dozens of acutely ill children in Maine emergency rooms are unable to access the short-term inpatient care they need. Some would benefit from a brief psychiatric hospitalization, for example after a suicide attempt. Now their parents must choose for their child an extended wait in an emergency room, or going home with a treatment plan piecemealed together with community programs and waitlists. The new patient spots in my outpatient practice are almost all taken by highly risky patients referred from emergency rooms. Less ill children wait many months to see a child psychiatrist.

In my 18 years practicing child psychiatry, I have never seen youth in Maine as ill as they are right now. You are no doubt aware that leading children’s health organizations including the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children’s Hospital Association have declared a national emergency in child and adolescent mental health. Youth are, simply, dying in record numbers. It is also a very challenging and unrewarding situation as a healthcare professional who has vowed to connect kids with needed medical treatment. Many of my peers prefer to work in other states where there is access to the care their patients need.

Maine does not tolerate gaps in specialty care for other childhood medical conditions. We do not ask families to send their children to Utah or Florida for specialized cancer or cardiac care. The lack of state support for an actual continuum of mental healthcare has an opportunity to end, by funding the treatment which kids need, and healthcare providers in the state are equipped to offer. I strongly urge you to support this legislation.