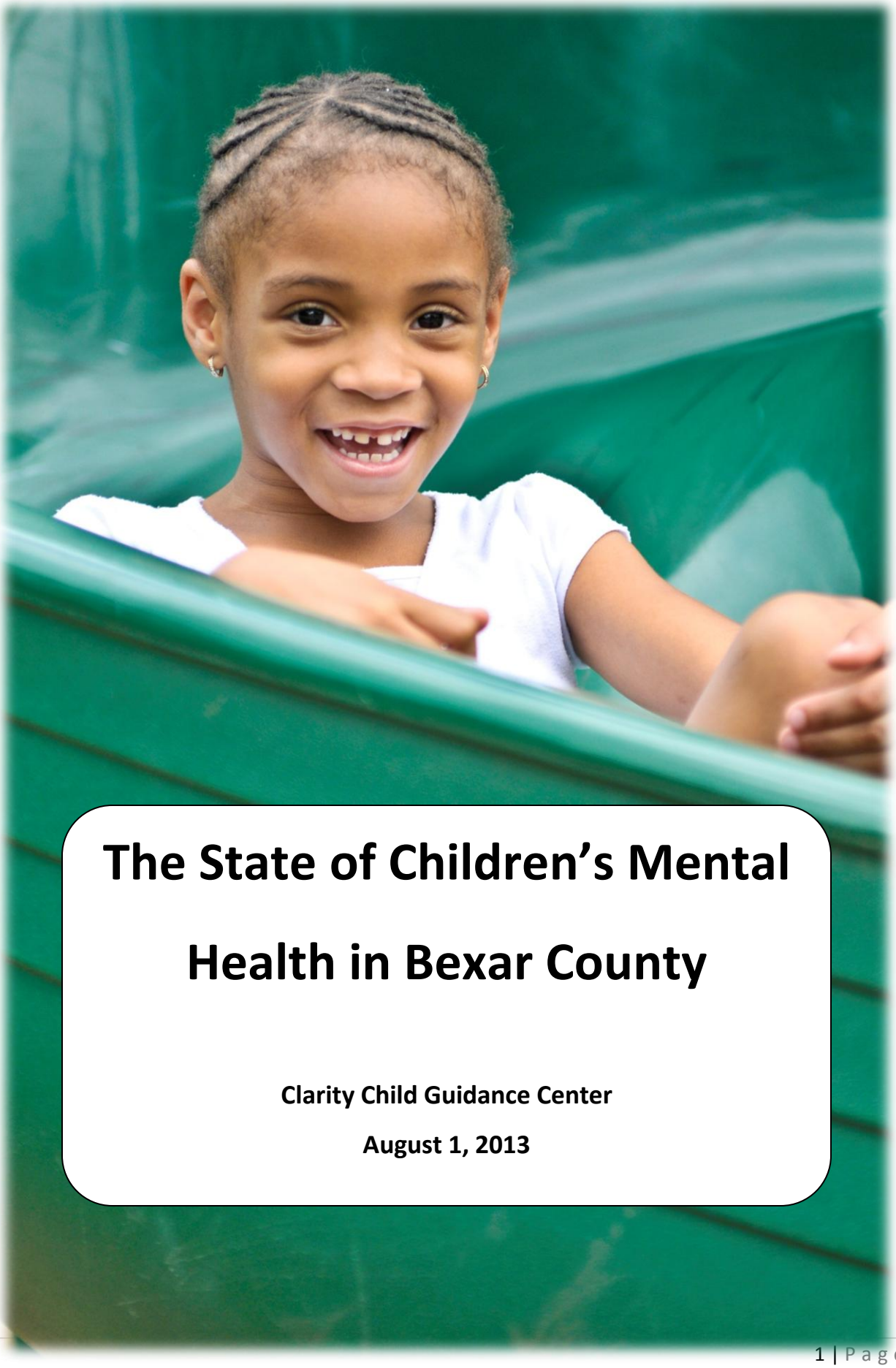


The State of Children's Mental Health in Bexar County

Clarity Child Guidance Center

August 1, 2013

I. About Clarity Child Guidance Center

Clarity Child Guidance Center's legacy dates back to 1886 when thirteen caring and entrepreneurial women founded an orphanage for children who had been left behind by society. Over the years, the children who most often lived at the orphanage throughout their entire childhood years were children suffering from mental, emotional and behavioral (MEB) disorders. The agency evolved over decades to become a premiere resource for children in need of mental health treatment.

Another significant event occurred in 2010, when a merger created the region's only nonprofit providing a continuum of mental health care for children ages 3-17 suffering from serious disorders. Clarity CGC services include assessments (psychiatric, developmental, and neuropsychological) and individual, family and group therapy. Intense services include day treatment and acute inpatient care at our children's psychiatric hospital. Wraparound supports include case management for families as well as education continuation for our patients via our on-campus school. Art, music and play therapy are also integrated into our treatment plans.

In 2012, we are projecting 22,000 outpatient therapy visits and 16,000 inpatient days in our 52-bed hospital. Over 6,000 children receive care each year, and the need is growing. Services are delivered by the region's largest staff of psychiatrists, psychologists, nurses, and mental health counselors who are all specialists in treating MEB disorders. Further, Clarity CGC is affiliated with The University of Texas Health Science Center where Child and Adolescent Psychiatry residents and fellows are receiving training in their field of study. We also partner with several nursing schools to provide psychiatric training on our campus and over 100 nurses participated in the past year.

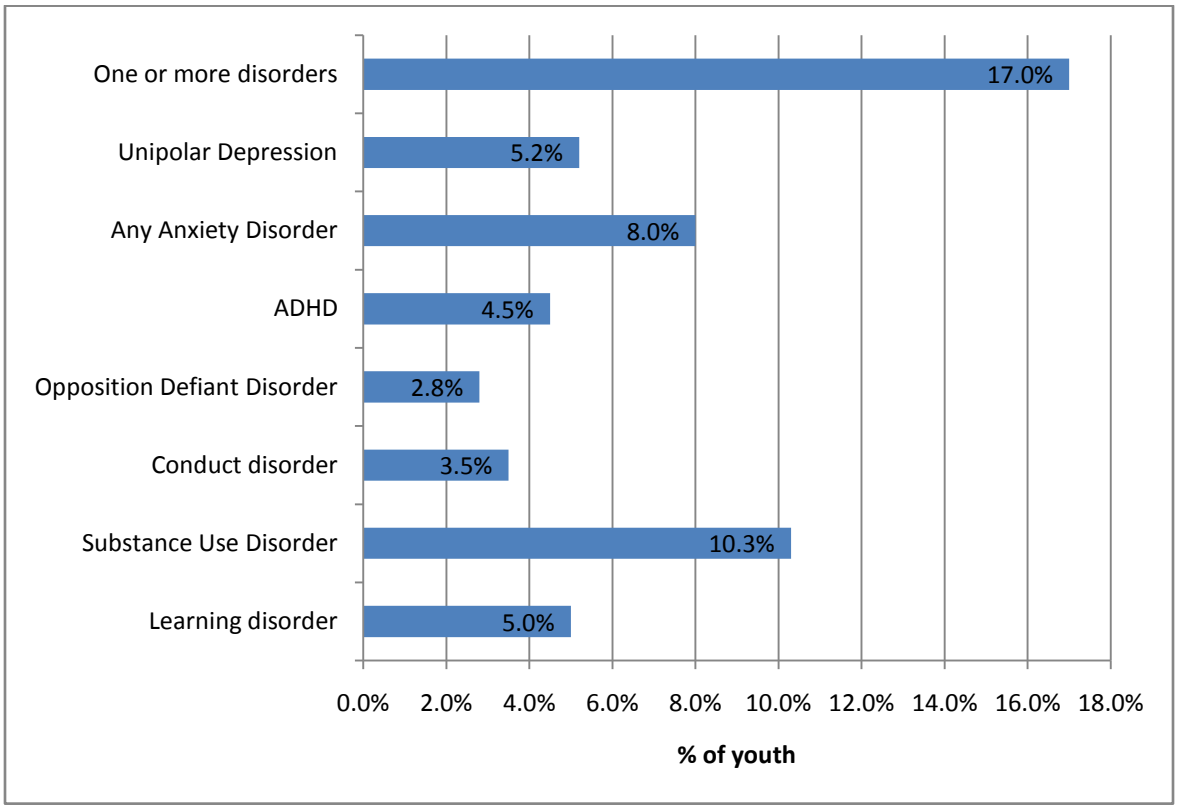
80% of Clarity CGC's patients are Medicaid/CHIP enrolled and we treat all children, regardless of their ability to pay for services. As a nonprofit, we choose to provide the right level of care for children in crisis – whether ensuring a staff to patient ratio of 3-4 per ten children (excluding an RN and LVN on each Unit), or hiring our own teacher for children who haven't yet qualified to be enrolled in our on campus Northside Independent School.

This leads to our mission: to help children, adolescents and families overcome the disabling effects of mental illness, and improve their ability to function successfully at home, at school and in the community. As a result, we help heal young minds and hearts.

II. The needs for children mental health care in Bexar County

State of the Community – Children's Mental Health

Almost one in five young people in the U.S have one or more mental, emotional or behavioral (MEB) disorders, and one in 10 youth has mental health problems that are severe enough to impair how they function at home, school, or in the community[i]. Applying the prevalence of MEB disorders to Bexar County census data for children ages 0-17 results in an estimated 80,000 children suffering from MEB problems in this county alone[ii]. The chart below shows more specifically the prevalence of certain conditions at a national scale[iii].



Drivers increasing mental health disorders among youth

Several indicators confirm that the need for help is increasing. Poverty, single parenting, trauma from abuse, and obesity are factors that drive the need for mental health care among youth.

- The number of children living in poverty in Bexar County has increased 27%, from 90,000 in 2000 to 114,400 in 2010.
- A recent study shows that children receiving welfare and living with a "never married caregiver" are five times more likely to have elevated scores for mental health risks[iv]. In Bexar County, the number of single parent households has grown by 30% between 2000 and 2010, faster than two parents household which grew by 24%. On average, 33% of Bexar County children grow up in single family households[v].
- Between 2001 and 2011 the rate of victims of child abuse has grown from 9 per 1,000 children to 13.5. As a result, the number of children in foster care has grown 63% from 2,260 to 3,675 in the same period. 80% of the children treated at Clarity Child Guidance Center are Medicaid or CHIP, and 25% are under CPS custody, so these changes greatly affect the demand for our services.
- As nutrition and fitness play a role in mental health, the rates of obesity among children can have an effect on the needs for help. During the past 30 years, the number of overweight young people in the United States has more than tripled among children 6 to 11 years old and more than doubled among adolescents 12 to 19 years old. In Bexar County, 23% of children on the WIC program are overweight or obese (Metro Health, 2008). These children are more likely to have depression.

Future growth in demand

The current population of Bexar county residents age 0-17 is predicted to grow by 20% by 2020, which would take it from 464,703 per the 2010 census to 557,644. This organic growth combined with the drivers described above can only increase the need for care. A 2010 study for Methodist Healthcare Ministries[vi] (which we'll refer to as MHM Study) predicts a 19% growth in youth inpatient discharges between 2009 and 2019 and a 9% increase in outpatient visits between 2009 and 2014. We actually find this a conservative estimate for two reasons:

- Youth population will grow by 20%
- Children covered under Medicaid will increase at the same time by 20% as the result of healthcare reform, which is noted below in Section III.

III. The barriers to access care

Only 20% of the children who need treatment receive it[vii]. Sometimes, the fear and stigma surrounding mental health is a barrier to treatment, and more often than not, it's a lack of funding. It touches especially our community with 114,000 children living in poverty.

Poverty and lack of insurance

16% of Texas children 0-17 are uninsured, of which 2/3 are below 200% of the FPL[viii]. While the uninsured rate has gone down since 2001, so has the rate of privately insured children (down to 47%), while the rate of kids insured by public insurance has gone up from 21% to 42%. It will continue as there are still 500,000 to 600,000 Texas children who qualify for Medicaid or CHIP right now but are not enrolled. Based on the population size of Bexar County and its overall uninsured rate, we can estimate that 40,710 children in this county are not enrolled with Medicaid. When they enroll in 2014 as required under the healthcare reform law, it will increase the number of children covered by 20% to 241,000 in the county.

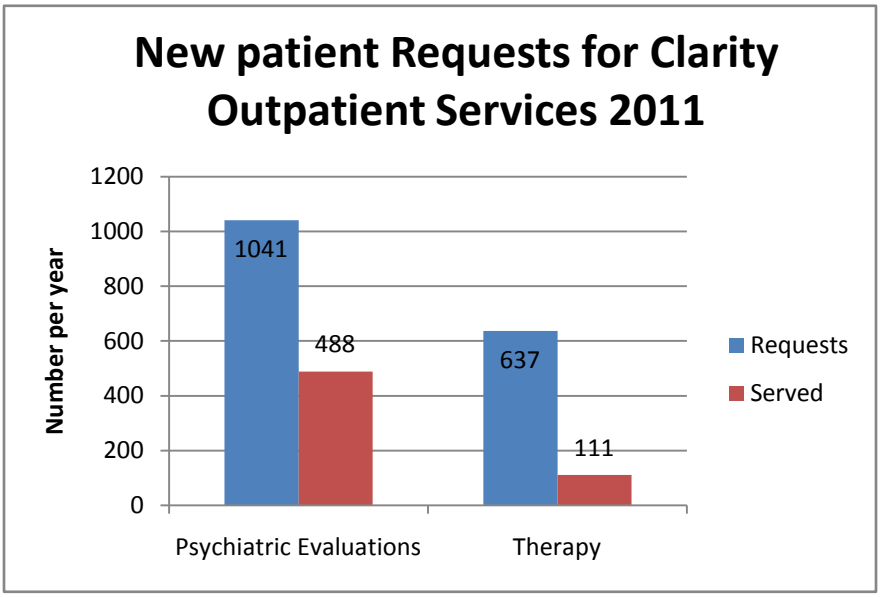
Lack of state services

Texas ranks last of all states in relation to expenditures for children's mental health, with $18.85 per capita compared to $80 per capita for the National median of 51 States. To exacerbate the problem, the state budget for children's mental health care was slashed even further in 2012 to pre-2008 funding levels.

Lack of providers causes delays in treatment

Bexar County and South Texas also lack providers to adequately treat children with MEB disorders. San Antonio only offers 7.53 child and adolescent psychiatrists for every 100,000 children, below the woefully inadequate 9.45 in the U.S. Outside the city of San Antonio, the rates drop dramatically to less than 2 per 100,000. Only 6 child psychiatrists practice in the border counties, serving a population of 861,524 children. As a result, the wait time in order to obtain an initial appointment with a child psychiatrist is typically 3 to 6 months.

Clarity CGC's own system, which provides in excess of 22,000 outpatient visit a year to over 3,000 children is under a lot of stress to provide sufficient services. The chart below shows how many requests we get compared to the number of new patients we accept.



Lack of inpatient beds in Bexar County

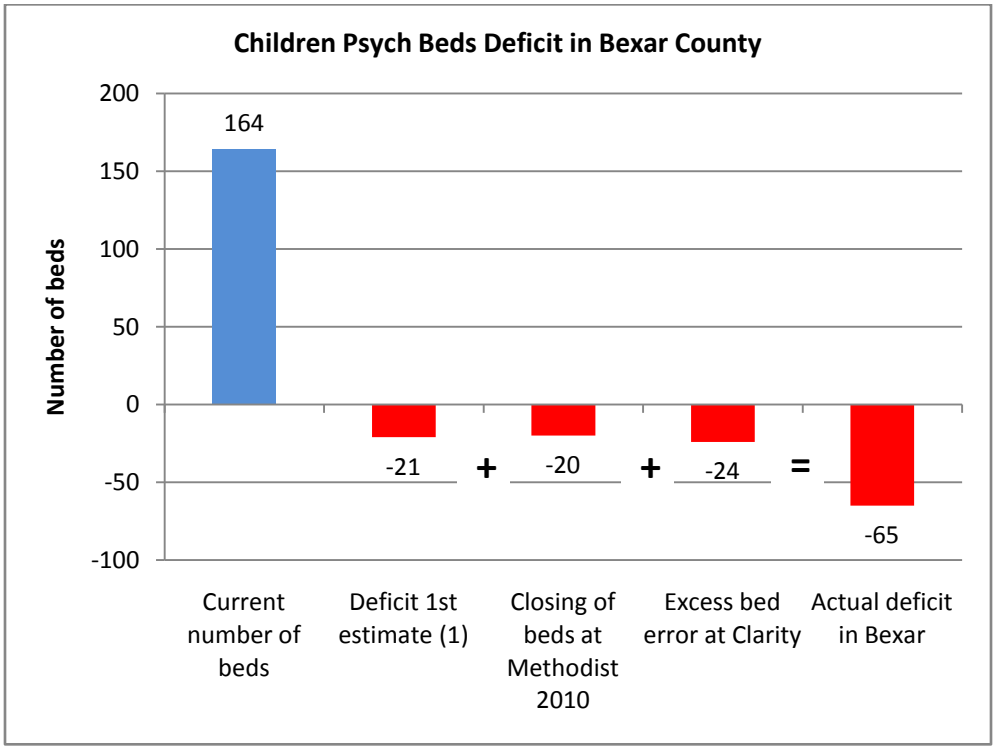
From 1955 to 2005, a significant change has occurred with mental health access – while needs increased, the number of psychiatric beds decreased significantly. As evidence, for every 20 public psychiatric beds that existed in the United States in 1955, only one such bed existed in 2005. And, Texas continues to be one of the worst offenders in providing access to care. With 12 beds per 100,000 population, Texas was listed second to last among the states with "severe bed shortage", when it's recommended to have 50 beds per 100,000 population.

Further, in 2010 Methodist Healthcare Ministries estimated that there was a deficit of 21 child and adolescent psychiatric beds in Bexar County based on occupancy rates at local psychiatric hospitals. This number was based on a total of 245 beds. The following changes affect this estimate:

- In this number Clarity's occupancy rate was under-evaluated at 38% instead of an actual 77%, which resulted in a "24-bed" extra capacity which we don't have.
- At the end of 2010 Methodist Hospital closed down their child and adolescent unit eliminating 20 beds in 2010.

As a result the actual deficit for the next 10 years is actually not 21 beds but at least 65 beds (21 plus 24 plus 20).

Note: included in the data were 120 beds at Laurel Ridge: the actual number of beds for acute children is 40 expandable to 60, the rest being dedicated to residential and substance abuse treatment. It doesn't affect the deficit, as their occupancy rate overall remains the same. Christus Santa Rosa, while planning a children's hospital downtown, has already noted the services will not include psychiatric beds.



The burden on ER and the consequence on patients' care

With a lack of psychiatric care and available beds in our community, a significant consequence is the increase of emergency room (ER) visits by children and teens with a MEB diagnosis. This is the most expensive and ineffective option for the children of our community, but it's happening every single day.

Between 1992 and 2001, ER encounters for suicide attempt and self injury of all ages increased by 47% in the US[ix]. A 2008 study with Medical Directors of ER departments nationwide shows that:

- 99% reported admitting psychiatric patients every week and 64% reported admitting psychiatric patients daily
- 79% said psychiatric patients are boarded (from 4 to 24 hours) in their emergency department, because 62% offer no psychiatric services at their hospital

An ER setting is particularly not suited for such patients. A recent article in the *Hospitals & Health Network* publication noted that psychiatric patients wait two times longer in an ER setting than other patients, contributing to the stress and increasing symptoms related to the patient's crisis. Diagnosis and intervention in a traditional ER setting must wait for a specialist's arrival following an initial general physicians' evaluation. ER staff may be undertrained in mental health treatment resulting in more complications, and "staff callousness and disregard". The emergency setting is likely to exacerbate the situation as it is not offering the nurturing calming setting required for such patients. In Bexar County, over 1300 estimated children were admitted to a local ER for psychiatric reasons, often with no care provided at the hospital for their needs. Further, this does not include all the children who may have not been accurately diagnosed in this report because of the absence of specialists in the ER[x].

According to a recent study published in the last issue of the Journal of the American Academy of Child & Adolescent Psychiatry[xi], "a substantial proportion of young Medicaid beneficiaries who present to ERs with deliberate self-harm are discharged to the community and do not receive emergency mental health assessments or follow-up outpatient mental health care". The article is based on a study of over 3,000 cases of youth 10-19 admitted to ER for self harm:

- 73% of the youth in the study where discharged in the community
- 39% of the discharged patients received an assessment in the ED
- 43% received follow-up outpatient mental healthcare

The lack of a regional Psychiatric Emergency Service Center specifically for children is at the root cause of these troubling issues for our community. The lack of children's psychiatric beds will only increase as the population grows and hospitals continue to eliminate these departments due to low profitability and lack of requirement to provide these services. We are already at a deficit in the community – and the problem is growing exponentially.

IV. What happens when children are not treated

Absence of treatment harms children and their families and often leads to more trauma:

- Nationally, 50 percent of children with serious emotional disturbances drop out of high school, as do 30 percent of all students with disabilities[xii]. High school attrition rates in Bexar County, which compares the number of students who start in 9th grade with how many finish 4 years later is 37% compared to 27% on average for Texas[xiii].
- A 2005 national study showed that youth with a major depressive episode were about twice as likely to start using alcohol or an illicit drug as youth who had not experienced a major depressive episode in the past year[xiv]. In Bexar County, the number of deaths due to drugs has grown by 67% in last 10 years[xv].
- Between one half and three fourths of youth in the juvenile justice system nationally are estimated to have a diagnosable mental health disorder[xvi]. The population in juvenile facilities in Bexar County has grown by 39% between 2000 and 2010. The number of juvenile violent crimes grew from 83 in 2000 to 180 in 2007.

Based on the needs described above, Clarity Child Guidance Center has been working on two initiatives: one is geared to making outpatient care more accessible and respond to local crisis need, the other geared to respond to the need of a Regional Mental Health ER for children and increased bed capacity.

V. Rapid Access Clinic

Concept and benefits

The concept of Rapid Access Clinic is similar to an Urgent Care clinic but specialized in children mental health. It provides the following benefits:

- Proximity: with outpatient treatment, location plays an important role as transportation and time issues often prevent access to care or consistent care. Such a clinic would be located within 15 minutes of a critical need area, and in the proximity of major high school campuses.

- Quick access and rapid response: the possibility for the patient to just walk-in or call our admission department and get an immediate initial screening, and a more elaborate assessment within a week or two will play an important role in preventing escalation and more acute treatment down the road.
- Rapid resolution: the clinic concentrates on patients whose presenting symptoms can be addressed in 4 to 8 therapeutic sessions. It improves overall coping strategies and problem solving methods so that a child could rapidly resume his/her activities within the community.

The "Rapid Access Clinics" plan includes the deployment of five small clinics in strategically placed areas of the community. Three would be located in economically disadvantaged areas with high Medicaid/CHIP enrollments, requiring subsidization in which to bring the concept to the proposed areas. Two of the clinics would be placed in mixed income areas where private insurance and private pay clients would fund the model, requiring no outside funding support. In the first phase, we would be piloting a clinic in an economically disadvantaged area.

Modeled after a concept deployed in Glasgow, Scotland and similar to the approach of a Texas Med Clinic, the Rapid Access Clinics will provide much needed access and increase capacity for serving children in need. The model deployed in Scotland demonstrated efficiencies, while ensuring 80% of the patients completed their therapeutic care.

The goal of the Clarity network of care would be to see kids on a walk-in basis or within 24 hours of contact to provide a screening assessment. To accomplish this, each clinic would be staffed with two full-time master's level social workers. The initial assessment will determine whether the child should see a psychiatrist for further evaluation and possible medication, or if therapy can address the situation. The Glasgow, Scotland clinics found that roughly 50% of the patients could be addressed with outpatient therapeutic care, typically in 4-8 visits. If a psychiatric evaluation is required, we anticipate scheduling a child and adolescent psychiatrist at each of the clinics one day per week. Children who would normally wait weeks to months for a first appointment with a psychiatrist would now have access within a week.

A 2010 article published by the Canadian Academy of Child and Adolescent Psychiatry[xvii] reports that for children and youth mental health treatment "no-show rates for initial intake appointments ranged from 48% (Harrison, McKay & Bannon, 2004) to 62% (McKay, McCadam, & Gonzales, 1996)". Conversely, an article describing the Rapid Access Program designed in New Jersey by the Association of Advancement of Mental Health (AAMH)[xviii] explains that "80% of youth who receive prompt evaluation follow through with a course of treatment." In summary, the sooner the child is scheduled for assessment or therapy, the more likely they are to complete the prescribed course of action.

Unlike many nonprofit initiatives, this clinic has a social entrepreneurial core that would create sustainability upon availability to the community. The cost for establishing the clinics is relatively low and would enable them to be sustained on a diversified mixture of private insurance, Medicaid and sliding fee private pay. Private insurance and private pay patients would help to subsidize indigent care and Medicaid/CHIP costs to serve. Further, each clinic would serve as a referral source for inpatient care, which would also subsidize the clinics. Our revenue analysis further reveals that as awareness of the clinic grows, patient volume increases offsetting the expenses as the year progresses. First year revenue would not cover all expenses, as shown in the summary below, but the clinic has the capability to increase capacity, receive subsidies from more profitable clinics in the North/North Central area as well as refer patients to inpatient care, again offsetting expenses.

VI. Regional Psychiatric Emergency Service

The second phase of our plan involves a deeper capital investment. Per the research cited in this proposal, our community lacks child and adolescent psychiatric beds for ER purposes. In dialoguing with the Christus Santa Rosa Children's Hospital administrators, staff physicians and nurses, we learned that children with psychiatric issues are often held in the ER for eight to twenty-four hours pending admission to an appropriate psychiatric facility. If they are unable to arrange a transfer for a child within that timeframe, they are admitting the child to the pediatric intensive care unit, driving cost up and undermining treatment. These anecdotal conversations

with Christus' staff validate the research provided in this proposal that ER treatment is inadequate and detrimental in the case of child and adolescent mental health.

A Regional Psychiatric Emergency Service presents the following benefits[xix]:

- Diagnosis and treatment can be conducted much faster
- Triage can redirect non-acute cases to appropriate services
- A study showed a drop in admissions from 52% to just 36% by using the Triage Model
- Trained and compassionate personnel are immediately handling the patient, which in turn increases speed of resolution
- Faster stabilization can reduce length of stay
- Locked areas are available providing safety
- Can accept ambulances, police deliveries, and self referrals
- Minimizes unnecessary inpatient admissions and frees other hospital ER departments' capacity.

Clarity CGC is the region's expert on child and adolescent mental, emotional and behavioral care of children ages 3-17. With this in mind, we propose the development of a children's ER on our campus at 8535 Tom Slick Drive. The campus already boasts a continuum of care – from assessments (psychiatric, developmental, physiological and neuropsychological), therapeutic rehabilitation, individual, family and group therapy, and inpatient care. Wraparound supports include case management support for families and classes at our on-campus school.

The ER would be an addition to the current inpatient living unit and would be staffed by trained child and adolescent psychiatrists as well as pediatric emergency room physicians to ensure that the patients brought to the facility are medically cleared before being admitted. An estimated fifteen to twenty additional inpatient beds (to augment the current 52) could be added to the facility at the same time to help reduce the current shortage of beds.

In order to provide appropriate staffing for the emergency facility, we anticipate expanding our relationship with The University of Texas Health Science Center to include the pediatric

department. The ER would be associated with other children's hospitals in the region, of which the majority have no children's psychiatric beds.

Conclusion

The following quote[xx] summarizes the situation we are experiencing.

> "The expectation that the range of interventions offered by inpatient facilities would be effectively replaced by community based services has not been fulfilled". This error has led to "children and adolescents with serious emotional disturbance being "warehoused" in juvenile detention centers, stuck in emergency rooms, and inappropriately placed in child welfare".

Only with a major community effort and the careful coordination of expert services can we significantly impact San Antonio youth at risk. Half of adults with MEB disorders were first diagnosed by age 14 and three fourths were diagnosed by age 24[xxi]. It is clear that early detection and treatment of children not only affect their group today but the future of our community. A recent study in Australia found that "the Federal Government bore around 31 percent - or $1 billion a year - of the overall cost for mental illness in men aged 19-25 through payments for health care, welfare and unemployment benefits. Australia loses more than nine million working days - or 9.5 days per person - each year because of the issue, and the cost to business was around $237 million a year due to extra leave taken, the report found."[xxii] Bexar County and South Texas are among the fastest growing areas in the United States for both economy and population. It is imperative that we work together to provide sufficient health care services to support this growth and help foster more peaceful and harmonious lives for our families and children.

[i] *Preventing Mental, Emotional and Behavioral Disorders Among Young People*, 2009. National Research Council and Institute of Medicine, of National Academies

[ii] Census 2010: 464,703 is the total population of 0-17 years old in Bexar County

[iii] Source: *Preventing Mental, Emotional and Behavioral Disorders Among Young People, 2009*. National Research Council and Institute of Medicine, of National Academies.

[iv] Journal of the American Academy of Child & Adolescent Psychiatry, Volume 51, Issue 6 , Pages 572-581, June 2012 "Mental Health Problems in Young Children Investigated by U.S. Child Welfare Agencies"

[v] Center for Public Policy Priorities, 2006-2010 Kids Count
http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TX&ind=3059

[vi] Mental Health Care Services Project, July and August 2010, study conducted by Capital Healthcare Planning of Houston, TX for Methodist Health Care Ministries of South Texas.

[vii] 2003 report by the Mental Health Association of Texas

[viii] US Census, 2010

[ix] Source: Larkin GL, Smith RP, Beautrais AL. Trends in US ED visits for suicide attempts, 1992-2001. Crisis 2008.

[x] Bexar County Mental Health Assessment conducted by MAJ Samantha S. Hinchman based on studying admissions at 15 hospitals within Bexar County from July 1 to Dec 31 , 2009. Published 3/1/2011

[xi] Volume 51, Issue 2 , Pages 213-222.e1, February 2012. "Outpatient Care of Young People After Emergency Treatment of Deliberate Self-Harm". Jeffrey A. Bridge, Ph.D, Steven C. Marcus, Ph.D., Mark Olfson, M.D., M.P.H.

[xii] Texans Care for Children, 2009 report

[xiii] Source IDRA

[xiv] SAMHSA's 2005 National Survey on Drug Use and Health

[xv] Bexar County Medical Examiner, Annual reports

[xvi] Texans Care for Children, 2009 report

[xvii] Engaging Families into Child Mental Health Treatment: Updates and Special Considerations, Geetha Gopalan, LCSW, PhD, Leah Goldstein, LMSW, Kathryn Klingenstein, Carolyn Sicher, Psy.D, Clair Blake, BA, and Mary M. McKay, LCSW, PhD. Copyright © 2010 Canadian Academy of Child and Adolescent Psychiatry.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938751/#b135-ccap19_3p182

[xviii] Bristol-Myers Squibb: "New Jersey Youth Get Rapid Access To Mental Health Services"
http://www.bms.com/news/features/2009/Pages/rapid_access_mental_health.aspx

[xix] Source: Treatment of Psychiatric Patients in Emergency Settings, Scott L. Zeller, Primary Psychiatry, 2010

[xx] The premature Demise of Public Child and Adolescent Inpatient Psychiatric Beds. Part I. Jeffrey L. Geller, MD, MPH; Kathleen Biebel, PhD. Published online on August 16, 2006.

[xxi] Children Mental Health Facts by the National Council for Community Behavioral Healthcare
http://www.thenationalcouncil.org/cs/childrens_mental_health_facts_the_national_council

[xxii] http://www.abc.net.au/news/2012-05-30/business-urged-to-act-on-male-mental-health/4042126?section=business
Full Report: Counting the cost: the impact of young men's mental health on the Australian economy. Ernst & Young and Inspire Foundation, http://www.cplx.com.au/Cost_of_Illness_Report.pdf