Community Health Needs Assessment

clarity child guidance center
healing young minds & hearts

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Introduction

IRC Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- Conduct a community health needs assessment every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the community health needs assessment and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The community health needs assessment must consider input from persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge or expertise in public health. The hospital facility must make the community health needs assessment widely available to the public.

The community health needs assessment, which describes both a process and a document, is intended to document Clarity Child Guidance Center's compliance with IRC Section 501 (r). Health needs of the community have been identified and prioritized so that Clarity Child Guidance Center (Clarity CGC) may adopt an implementation strategy to address specific needs of the community.

The process involved:

- Collection and analysis of data specifically related to children's mental health, as we are a unique, specialty care hospital serving the needs of children with severe mental illnesses, representing ages 3 to 17.
- Review of reports including extensive interviews with stakeholders that have specific knowledge and/or responsibility to the well-being of our community in relation to mental health care.

This document represents a summary of all the available information collected during this newly added IRS requirement. It will serve as a compliance document as well as a resource until the next assessment cycle in 2024.

Both the process and document serve as the basis for prioritizing the community's mental health needs and will aid in planning to meet those needs.

Summary of Community Health Needs

Based on guidance from the treasury and IRS, the following steps were conducted as part of Clarity CGC's community health needs assessment:

- The "community" served by Clarity CGC was defined by utilizing inpatient and outpatient data regarding patient origin. This process is further described in Community Served by Clarity CGC but can be summarized as children and adolescents ages 3 to 17, along with their legal guardian who would make decisions on their care.
- Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various annotated sources.
- An inventory of mental health facilities and resources was prepared and a demand for physician and hospital services was estimated through a third-party resource. This data was then evaluated for unmet needs.
- Community input was provided through the review of recent stakeholders and community studies showing the needs, challenges, and opportunities in our region. It includes reports from the Meadows Mental Health Policy Institute (2019) and work from the Center for Young Minds at the San Antonio Ecumenical Center.
- Information in the above steps was analyzed and reviewed to identify health issues of uninsured persons, low-income persons, and minority groups, and the community's mental health needs as a whole.
- Recommendations based on this assessment have been communicated to Clarity CGC's leadership and Board of Directors.

General Description of Hospital

Clarity Child Guidance's mission is to help children, adolescents, and families cope with the disabling effects of mental illness and improve their ability to function successfully at home, at school, and in the community.

Clarity Child Guidance Center's legacy in San Antonio, Texas dates back to 1886 when thirteen caring and industrious 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, eventually merging Southwest Mental Health Center and Child Guidance Center to become Clarity Child Guidance Center, the premiere resource for children in need of mental health treatment.

Clarity CGC's 19-member volunteer board of directors creates the strategies for providing mental health services to the children of Bexar County and the surrounding counties where no care is available. Leadership and staff at Clarity CGC execute the strategies and ensure successful operations. Clarity CGC is staffed with over 300 professionals dedicated to the mission of helping children and families suffering from mental illness. Our treatment team consists of psychiatrists, psychologists, licensed professional counselors, caseworkers, therapeutic recreation specialists, and nurses. Southwest Psychiatric Physicians is our onsite team of doctors providing outpatient and inpatient care. They represent the largest group of psychiatrists specialized in children and adolescents in South Texas as well as the largest group of bilingual psychiatrists in all of Texas.

Internally, we have a Strategic Quality Council made up of our President and CEO, Jessica Knudsen, and the senior officers of the eight departments at Clarity. This group meets weekly to discuss hospital operations and concerns, and to ensure we are meeting treatment and development goals. We are Joint Commission Accredited as a hospital and in behavioral health, meaning we pass rigorous standards set by the Joint Commission to ensure we offer safe and effective care of the highest quality possible.

Today, Clarity CGC is the only nonprofit providing a continuum of mental health care exclusively for children ages 3-17 in Bexar County. Clarity CGC services include prevention and education, assessments, individual, family, and group therapy, partial hospitalization (day treatment), crisis services / psychiatric emergency services (PES), and acute inpatient care. Our crisis assessment service added in late 2015 allows walk-ins to be seen by a licensed professional within hours, keeping them safe until the appropriate level of care is determined. Intensive services, day treatment, and acute inpatient care take place at our children's 66-bed psychiatric hospital. Case management for families provides wraparound support during and after inpatient and day treatment. Art, music, and play therapy are also integrated into our treatment plans. We never turn away a family if they are unable to pay. Our services help heal young minds and hearts.

Community Served by Clarity CGC

Clarity CGC is located in San Antonio, Texas, the county seat for Bexar. San Antonio is widely reported as the 7th largest city in the nation, but its population of nearly 2 million is spread over a wide area, creating rural pockets within a metropolitan base. San Antonio is 75 miles from the state capital in Austin, Texas, 190 miles from Houston, and 208 miles from the Dallas/Ft. Worth metroplex.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. The criteria established to define the community is as follows:

- A zip code area must represent two percent or more of Clarity CGC's total discharges and outpatient visits.
- Clarity CGC's market share in the zip code area must be greater than or equal to 20 percent.
- The area is contiguous to the geographical area encompassing the Hospital.

Based on the patient origin of acute care discharges and outpatient services for fiscal year 2020, management has identified the community to include the cities, relevant counties, and primary zip codes listed in Exhibit 1. Exhibit 1 presents Clarity CGC's patient origin, which is primarily comprised of San Antonio, Texas (84%). Within the San Antonio area, several zip codes demonstrate the top 9 areas of service, as well as outlying areas that comprise the remaining share of location service based on patient origin.

Exhibit 1

Clarity CGC Internal Data

Summary of Inpatient Discharges and Outpatient Services by County and Zip Code FY2020

County / Zip Code	Discharges (Outpatient & Inpatient Combined)	Percent of Total Discharges
Bexar County	**4764**	**84%**
78254	*275*	*5%*
78245	*270*	*5%*
78253	*228*	*4%*
78251	*198*	*3%*
78228	*181*	*3%*
78250	*181*	*3%*
78227	*169*	*3%*
78240	*121*	*2%*
78242	*118*	*2%*
78237	*115*	*2%*
Other Bexar County Zip Codes	*2908*	*51%*
All Other Zip Codes*	**907**	**16%**
Total Served	**5671**	**100%**

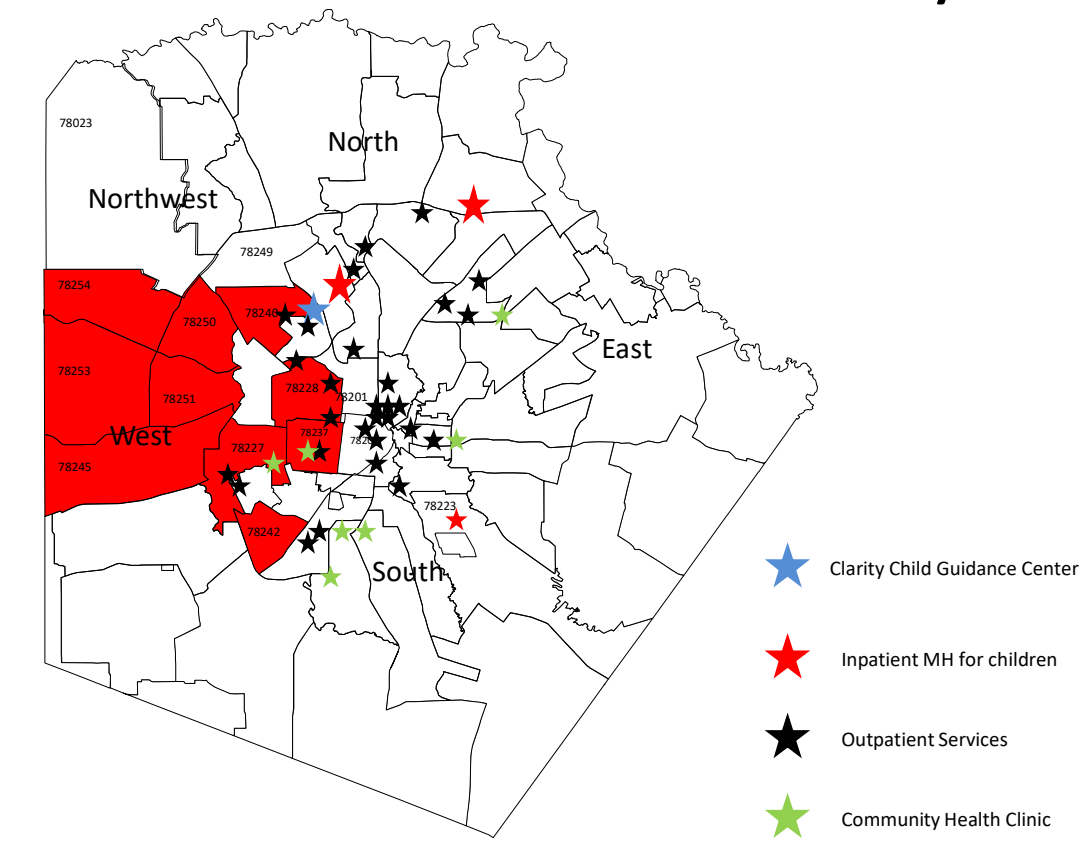
*Comprised primarily of outlying surrounding counties.

Community Details

Identification and Description of Geographical Community

The following map (Exhibit 2) illustrates the geographic location of Clarity CGC and other community mental health resources. This visual illustration of mental health services, grouped by category of service, highlights existing gaps in care. San Antonio, which is the county seat and the largest portion of Bexar County, is home to 84% of our patients. One out of every three children served resides in one of the 10 highlighted zip codes below.

Exhibit 2
Clarity CGC Internal Research and Data
Geographic View of Defined Community, with 84% of Patients Residing in San Antonio



Community Population and Demographics

At the time of this publication, the U.S. Census Bureau's 2020 census results have not been released. Population and demographic data contained in this Community Health Needs Assessment is based on the 2010 census, while population estimates projections for 2021 were from the Texas State Data Center and other annotated sources.

Exhibit 3 illustrates that the overall population is projected to increase over the five-year period from 2016 to 2021. Also included in Exhibit 3 is a comparison of our projected population growth to that of the State of Texas and the United States for comparison purposes. The data in the table reflects children under the age of 18.

The age category that utilizes our mental health services "Under 18 Years" is projected to increase by 5% in that time period, a stronger growth than that of the US and that of Texas, and a net increase of over 42,000 children and teens in 5 years.

Exhibit 3

Estimated 2019 Children's Population vs. Projected 2024 Population Percent Difference

Area	Estimated 2019	Projection 2021	Projected 2024	Growth 2024/2021
Bexar County	525,295	541,891	567,782	5%
Comal County	31,531	33,681	37,473	11%
Texas	7,437,514	7,594,941	7,843,350	3%
U.S.	79,730,194	80,868,986	82,551,147	4%

Sources: Bexar, Comal and Texas: Texas State Data Center http://txsdc.utsa.edu/Data/TPEPP/Estimates/Index.aspx; Source for U.S.: CDC http://wonder.cdc.gov/population-projections.html

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. Exhibit 4 shows the children's population of the community by ethnicity along with projected changes by 2024 as compared to the State of Texas. Hispanic children constitute the largest group in Bexar County, with 68% of the total population of children. This group has maintained its growth every year since 2015 from 345,000 to an estimated 386,453 in 2024. The population of Black children is also predicted to be the fastest growing between 2021 and 2024 to reach 6.4% of the population in this age group. The Anglo population is also growing at a nearly 4% rate, above state and national rates, and will reach over 111,000 kids in 2024.

Exhibit 4

Projected '21 Population vs. Projected '24 Population Percent Children's Ethnicities

	2021			Projected 2024			Difference		
Ethnicity	Anglo	Hispanic	Black	Anglo	Hispanic	Black	Anglo	Hispanic	Black
Bexar County	107,225	370,155	34,932	111,363	386,453	36,847	3.9%	4.4%	5.5%
Comal County	17,582	14,242	812	18,982	16,235	1,064	8.0%	14.0%	31.0%
Texas	2,322,156	3,754,305	902,468	2,338,055	3,883,787	939,258	0.7%	3.4%	4.1%
U.S.	57,740,456	20,783,329	12,292,086	58,363,661	21,380,747	12,712,877	1.1%	2.9%	3.4%

Sources: Bexar, Comal and Texas: Texas State Data Center http://txsdc.utsa.edu/Data/TPEPP/Estimates/Index.aspx
Source for U.S.: Childstats.gov http://www.childstats.gov/americaschildren/tables.asp

Socioeconomic Characteristics of the Community

The socioeconomic characteristics of a geographic area influence the way residents access mental health care services and perceive the need for services within society. The following exhibits and statistics are a compilation of data that are specifically indicators and factors related to mental health care. Key factors include income levels and poverty, trauma from abuse, children in foster care, single-parent homes, and insurance availability.

Income Levels and Poverty Rates

Between 2016 and 2019, income levels in Bexar County have gone up by 9%. However, they remain below that of Texas or the US. During that period, the total number of individuals living in poverty in Bexar County has increased by almost 5% from 108,698 to 114,000. Poverty rates among Bexar County children continue to go down, now at 23%, 4.6 points below what it was in 2016.

Exhibit 5

Household Income Comparisons

	Median	
Income	2016	2019
Bexar County	$ 52,353	$ 57,157
Comal County	$ 69,666	$ 79,936
Texas	$ 54,727	$ 64,034
U.S.	$ 55,322	$ 65,712

Source: US Census American Community Survey

Exhibit 6

Poverty Rate Comparisons

	Number of Children under 18		Rate as % of children		Change between 2016 and 2019	
	2016	2019	2016	2019	Number	Percentage points
Bexar County	108,698	114,000	27.6%	23.0%	4.9%	-4.6%
Comal County	3,954	1,253	15.1%	3.6%	-68.3%	-11.5%
Texas	1,616,085	1,400,918	25.8%	19.2%	-13.3%	-6.6%
U.S.	14,115,713	12,000,470	19.5%	16.8%	-15.0%	-2.7%

Source: Source: US Census American Fact Finder

Other Critical Factors

Trauma from abuse, obesity, children in foster care without family infrastructure, and the stress of single parent homes are also factors that drive the need for mental health care among youth.

Child abuse and neglect is a major factor for mental health problems, as reflected in the fact that 17.5% of the children who are treated at Clarity CGC are in the foster care system.

While child abuse numbers in Bexar County were on the down trend between 2007 and 2015, they are now trending up. The number of victims was up 8.7% between 2015 and 2019. At 10.2 victims per thousand children, the rate is above state and national rates.

Exhibit 7

Incidence of Child Abuse Comparisons

	Victims		Rate per 1,000 children age 0-17		Change between 2015 and 2019	
Area	2015	2019	2015	2019	Victims	Rate change
Bexar County	4,941	5,373	9.9	10.2	8.7%	0.3
Comal County	489	332	17.5	10.5	-32.1%	-7.0
Texas	66,706	67,313	9.1	9.1	0.9%	0.0
U.S.	678,765	652,253	9.2	8.9	-3.9%	-0.3

Source: Annie E. Casey Foundation

The number of Bexar County children in foster care has grown dramatically since 2015, with a 75% increase resulting in 5,471 kids in 2018. The rate has almost doubled from 6.3 per thousand to 11.3, following a trend in Texas which is way above national rates. Comal County is also at a much higher level.

Exhibit 8

Children in Foster Care Comparisons

	Children		Rate per 1,000 children age 0-17		Change between 2015 and 2019	
Area	2015	2018	2015	2019	Children	Rate change
Bexar County	3,130	5,751	6.3	11.3	83.7%	5.0
Comal County	233	414	8.3	12.7	77.7%	4.4
Texas	30,427	52,397	4.2	7.1	72.2%	2.9
U.S.	410,459	424,653	5.6	5.8	3.5%	0.2

Source US: www.acf.hhs.gov/programs/cb

Single parent households are more likely to live in poverty, with 38% of single mothers and 19% of single fathers vs. 8% of married couples living under the poverty line (Source: CPPP analysis of U.S. Census Bureau, American Community Survey, 2017 1-year estimates). Poverty comes with a number of potential issues for the child: "Children living in poverty tend to have worse health than children who do not live in poverty. Low-income children also tend to perform less well on standardized tests of math and reading. They are also at higher risk for abuse and neglect." (State of Texas Children 2015 by the Center for Public Policy Priorities). In Bexar County, the number of single-parent households has grown by 41% between 2000 and 2013 and by 5% between the 2009-2013 period and 2013-2017 period. However, the rate has remained stable in that same period.

Exhibit 9

Children Living in Single-Parent Homes Comparison

	Children in single family households		Rate		Change between 2013 and 2017	
Area	2009-2013	2013-2017	2009-2013	2013-2017	Children	Rate change
Bexar County	137,315	144,489	34.4%	34.6%	5.2%	0%
Comal County	4,481	6,400	19.1%	23.8%	42.8%	5%
Texas	1,845,486	1,898,630	30.8%	30.3%	2.9%	-1%

Source: Annie E. Casey Foundation

As nutrition and fitness play a role in mental health, the rates of obesity among children can influence the need 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 Texas, the rates of child obesity have decreased since 2013 from 21.3% to 17.3% during 2018-2019.

Medicaid, CHIP, and the Uninsured Children of our Community

The number of Bexar County children enrolled in Medicaid has decreased from 229,751 in 2015 to 214,508 in 2020, with a rate decrease from 43.6% to 40.8%. Children in Texas are eligible for either Medicaid or CHIP if their household incomes are up to 201 percent of poverty. Texas has refused to expand Medicaid and instead has been negotiating with CMS to secure funding to cover uncompensated care. Bexar County moved from Traditional Medicaid to STAR or Managed Medicaid in 2016.

Exhibit 10

Children Enrolled in Medicaid Comparison

	Enrollment		% of all children		Change between 2015 and 2020	
Area	2015	2020	2015	2020	Enrollment	Percentage points
Bexar County	229,751	214,508	43.6%	40.8%	-6.6%	-2.8%
Comal County	8,249	8,808	27.4%	27.9%	6.8%	0.5%
Texas	3,486,765	3,707,183	40.7%	49.8%	6.3%	9.1%
U.S.	29,843,607	37,581,693	40.7%	47.1%	25.9%	6.5%

Source: Source: Annie E. Casey Foundation

Rates of uninsured children have grown at a high rate between 2015 and 2018, and Texas is one the state with one of the highest rates in the nation. While the uninsured rate in Bexar County is lower than the rate in Texas overall (8.5% vs. 11.1%), the growth in number during this period was 16.6% and we had almost 45,000 uninsured children in 2018.

Exhibit 11

Uninsured Children Rates Comparison (aged 17 and under)

	Number of uninsured children		% rate of all children		Change between 2015 and 2018	
Area	2015	2018	2015	2018	in # of uninsured	in % rate
Bexar County	38,574	44,973	7.5%	8.5%	16.6%	1.0%
Comal County	3,411	3,700	11.0%	10.4%	8.5%	-0.6%
Texas	747,567	855,304	10.0%	11.1%	14.4%	1.1%

Source: Source: Annie E. Casey Foundation

Health Status of the Community

This section of the assessment reviews national mental health statistics and the mental health status of Bexar County residents, as available.

Prevalence of Mental Illness and Treatment Rates

Almost one in five young people 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.

Mental Health America's 2020 data reveals that:

- 13.01% of youth ages 12 to 17 reported suffering from at least one major depressive episode in the last year, an increase of 99,000 from 2019.
- 9.2% of youth cope with severe major depression; 59% did not receive any mental health treatment.
- Texas ranks #43 in the nation for untreated mental illness in youth, with 65.4% (180,000) youth untreated in 2020[1].

Athena Health's 2017 Behavioral Health In America survey, which represents 100 million patient encounters and 80,000 providers nationwide, indicates that 7.8% of children under the age of 13 were diagnosed with ADHD; 8.9% were diagnosed with anxiety[2].

[1] mhanational.org/issues/2020/mental-health-america-youth-data
[2]athenahealth.com/knowledge-hub/clinical-trends/visualizing-behavioral-health-america#adhd;age;patients

The Rep. Four Price House Select Committee on Mental Health Interim Report 2016[3] provides an overview of the Texas State of Mental Health statistics:

- Half of mental health conditions begin by age fourteen, and 75% of mental health conditions develop by age twenty-four
- Nearly 250,000 children have a serious emotional disturbance (SED);
- About one-half of these persons are below the 200 percent poverty level;
- Approximately 26,300 Texas students are receiving special education services with a primary diagnosis of emotional disturbance;
- Approximately 32,000 children are in Department of Family Protective Services (DFPS) conservatorship, and it is estimated that over fifty percent of those children have a diagnosed mental illness;
- Approximately 50 percent of youth in the juvenile justice system have been identified with need for mental health treatment; and
- Approximately 80 percent of state committed youth have a need for alcohol or drug use treatment.

According to the 2019 American Community Survey, 25.3% (506,899) of Bexar County's population is under the age of 18. Applying the one in five ratio, this results in an estimated 101,380 children 0-18 suffering from MEB problems in our county today.

According to the Texas Statewide Behavioral Health Strategic Plan for 2017-2021, over 500,000 Texas children are diagnosed with a SED. The Meadows Mental Health Policy Institute 2017 study of needs in Bexar County reports that only 22% of the children with SED and in poverty are being helped by the two main community / public mental health providers for such services.

"While a very low level of service overall, of equal concern is the fact that relatively few children receive the intensity and level of care necessary in the community, with less than 5% of children in need of intensive, community-based supports able to receive such care through CHCS or community providers, leading to an overreliance on juvenile justice, child welfare, and specialty school placements."

[3] https://house.texas.gov/_media/pdf/committees/reports/84interim/Mental-Health-Select-Committee-Interim-Report-2016.pdf

Lack of Education and Awareness

In a 2015 presentation, the Meadows Mental Health Policy Institute[4] reported that 9 in 10 people they interviewed were not comfortable discussing mental health, and 31% would not know where to turn to. The stigma and lack of awareness is even greater for children's mental health. Notable differences exist between ethnic / race groups and education levels. Access to care among low-income families and those at highest risk of trauma is much lower than other groups.

Recognizing this issue, the American Psychology Association writes: "It is imperative that we improve efforts around early recognition of mental health needs among children and adolescents and foster greater awareness of early warning signs. Early identification of mental health problems needs to be encouraged in preschool, childcare, K-12 education, health, child welfare, juvenile justice and substance use settings. Staff in these settings require additional training and technical assistance to understand the early warning signs of mental health problems, what to do about them and where to make referrals for further assistance."

One in Five Minds, a prevention and awareness program of Clarity Child Guidance Center, is on the fore front of this issue and has reached thousands of families through online education and through multiple events in the past 8 years.

State of Texas Funding for Children's Mental Health

While Texas spending on children's mental health has nearly doubled between 2009 and 2013 to reach $40 per capita[5], it still lagged behind most other US States which spend on average $119 per capita in 2018. During the last 2 sessions (2019 and 2021), the legislature increased the Behavioral Health spending significantly as a result of the Four Price Select Committee Report and Recommendations.

Despite these improvements, funding remains a major issue for providers like Clarity CGC. There is a lot of pressure on payers to cut costs while still providing parity. It results in low reimbursement rates and shorter stays or denied days which put a lot of financial pressure on hospitals.

Funding is not only an issue for children in low-income families. The parity requirement brought by ACA insured an increase of funding for families who have public insurance. However, while private insurances are required to provide parity if they offer a mental health coverage, they are not

[4] The Mental Health Landscape of Texas: Key Finding from 2015 survey
[5] Source: Henry Kaiser Family Foundation State Mental Health Agency (SMHA) Per Capita Mental Health Services Expenditures

required to offer a mental health plan. Further, the rates they pay providers are often much lower than Medicaid rates and insufficient to cover the costs of critical services.

Two pieces of Federal legislation in 2019 and 2021 attempt to correct the rather inconsistent application of the parity laws. One issue reported by NAMI in 2019[6] was how "mental health providers are being reimbursed by insurance companies at a significantly lower rate than other providers — even if they are offering the same service. This inequity in reimbursement rates is a contributing factor to the vast number of mental health providers who do not accept any insurance and only see patients on an out-of-network basis." A 2017 study reported in Health Affairs found that "participation in mental health networks was low, with only 42.7 percent of psychiatrists and 19.3 percent of nonphysician mental health care providers participating in any network."[7]

Outpatient Treatment

In 2019, there were 2,280 actively licensed psychiatrists providing direct patient care in Texas[8]. This number represented a 15.7% increase since 2014 and a 39.5% increase since 2009. Relative to population growth, the size of the psychiatrist workforce has improved by 15.9% over the past 10 years. Despite these improvements, Texas still had fewer psychiatrists than the national average, and the majority of the state was federally designated as a Mental Health Professional Shortage Area.

Thanks to the efforts of UT Health and other local institutions, the number of child and adolescent psychiatrists in Bexar County has grown from 7.53 for every 100,000 to almost 15 in 2016. However, this masks a critical lack of services in neighboring counties and especially the continued scarcity in rural areas and in South Texas.

In addition, in 2016, only half of Texas psychiatrists accepted private insurance (compared to nearly 90 percent of other physician types), and only 21 percent of Texas psychiatrists accepted Medicaid patients, according to the Texas Medical Association[9].

For providers like Clarity CGC, the reimbursement rate of outpatient services for Medicaid patients is below the cost of services, which limits their ability to expand services.

[6] https://www.nami.org/About-NAMI/NAMI-News/2019/Even-with-Insurance-It-s-Getting-Harder-to-Access-Care
[7] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0325 (using data for 2016 from 531 unique provider networks in the Affordable Care Act Marketplaces)
[8] Health Professions Resource Center, Trends Distribution and Demographics, Statewide Health Coordinating Council, Feb 2020.
[9] Quoted by Hogg Foundation Blog article : http://hogg.utexas.edu/the-shame-of-texas

Emergency Room "Boarding"

Another unintended consequence of the lack of care in our community is the increase of emergency room (ER) visits by children and teens with an MEB diagnosis. This is the most expensive and ineffective option for the children of our community.

An ER setting is particularly not suited for such patients. Diagnosis and intervention must wait for a specialist's arrival following an initial general physician's evaluation. ER staff may be undertrained in mental health treatment resulting in more complications. The emergency setting is likely to extend the problems as it is not offering the nurturing, calming setting required for such patients.

A scoping review of previous studies published in Pediatrics reported that: "among youth requiring inpatient psychiatric care, 23% to 58% experienced boarding and 26% to 49% boarded on inpatient medical units. Average boarding durations ranged from 5 to 41 hours in EDs and 2 to 3 days in inpatient units. Risk factors included younger age, suicidal or homicidal ideation, and presentation to a hospital during non-summer months. Care processes and outcomes were infrequently described. When reported, provision of psychosocial services varied widely."[10]

According to a study published in the February 2012 Journal of the American Academy of Child & Adolescent Psychiatry, "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 were discharged in the community
- 39% of the discharged patients received an assessment in the ER
- 43% received follow-up outpatient mental healthcare

Data provided by Healthcare Access San Antonio (HASA), the local Health Information Exchange, reveals a high number of ER visits for mental health in three Bexar County Health Systems between July 2013 and June 2014[11]. It reported 457 ER visits for children 0 to 12 and 1,448 for the 13- to 17-year-old group. Among the older group, the length of stay analysis showed that 82% of them

[10] https://pediatrics.aappublications.org/content/146/4/e20201174

[11] The data is comprised of ER admissions to Baptist Health System (BHS), Methodist Health System (MHS) and Christus Santa Rosa (CSR). The data compares admissions for a primary diagnosis of mental health versus all admissions and includes length of stay (LOS) information. There has been some discussion amongst various groups that HASA data may be incomplete, or contain only unfunded patients. If that is indeed correct, then the numbers being shared in this report are low and would only rise if funded patients were included.

spent more than an hour in the ER. The median stay was 4 hours. Overall, 48% were discharged before 3 hours, but 34% stayed between 4 and 7 hours and 18% stayed over 8 hours.

Acute Treatment – Few Facilities, High Utilization

Only one in three mental health facilities in the state provide 24-hour inpatient hospitalization, and the utilization rate for inpatient treatment is 91%[12]. The shortage of beds for individuals in need of 20–90-day inpatient treatment also continues to be a major problem[13].

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. Since then, the following happened:

- Clarity added 14 inpatient beds and 6 crisis and observation beds
- The Nix closed its doors, causing a negative impact of 31 child beds
- Other privately funded hospitals added beds prior to 2018 (Laurel Ridge and San Antonio Behavioral Hospital) but not since.

San Antonio State Hospital (SASH) is in the midst of constructing a 300-bed facility which will open in 2024 but right now it only admits adults.

Because the needs are high, the community often experiences bed shortages. For instance, between April 2020 and April 2021, Clarity CGC was on diversion an average 11% to 28% of the time, depending on gender and age group (Females under 12: 14%, Males under 12: 15%, Females 12-17: 28%, Males 12-17: 11%).

[12] Substance Abuse and Mental Health Services Administration (SAMHSA) 2018 Texas National Mental Health Services Survey.
[13] City of San Antonio and Bexar County 2021 Behavioral Health System's Gap Analysis Progress Report.

Exhibit 12
Number of Children Acute Care Beds in Bexar County in 2021

Hospital	Acute care beds
Clarity CGC	66
Laurel Ridge	40-60
San Antonio Behavioral Hospital	122
Total	***228-248***

Factors Impacting Health Outcomes

Risk and Protective Factors

According to the American Mental Wellness Association, a variety of life experiences may put a child at risk of mental illness. Risk factors for mental illness include, but are not limited to:

- Familial history of mental illness
- Chronic medical conditions and traumatic brain injuries
- Alcohol or substance use
- Chronic stress
- Traumatic life experiences
- Childhood abuse or neglect
- Living in persistent poverty
- Discrimination

While these experiences may put a child at risk of mental illness, it is important to note that lived experiences contribute to the development of resilience. Each child will respond to life experiences differently due to their personal resilience and protective factors. Protective factors decrease the risk of mental illness and include:

- Secure attachment
- Adequate nutrition and exercise
- Reliable caregivers
- Emotional self-regulation and positive coping skills
- Positive self-regard
- Good peer relationships and familial support
- Financial security
- Achievement motivation and optimism
- Moral beliefs

Ripple Effects of Non-Treatment

Absence of treatment harms children and their families, often leading to a higher risk of failure at school, substance abuse, contact with the criminal justice system, dependence on social services, and suicide.

- Young people who do not get treatment for mental illness are at higher risk for incarceration as adults; 60% of Texas youth entering state juvenile justice facilities have a moderate to severe mental health issue[14].
- High school students with significant symptoms of depression are twice as likely to drop out of school[15].
- Half of people who experience a mental illness during their lives also experience a substance use disorder[16]; the onset for substance use disorders is 15 years old[17].

There Is Hope: Treatment Works

With the right treatment, the response rate for psychiatric disorders is high. Prevention programs and parental participation in treatment can reduce symptoms by as much as 60% in school age children; 81% of children with anxiety respond in as little as 12 weeks, and 86% of children experiencing depression improve within 36 weeks[18].

Considerations During COVID-19

The COVID-19 pandemic resulted in a variety of stressors for the globe. The effects of social isolation, unemployment and economic instability, the load of working from home while caring for children who are out of school, fears of virus exposure, grief from the passing of loved ones, and burnout have led to increased anxiety, depression, and posttraumatic stress disorder in children and families worldwide[19]. A survey conducted in August 2020 by Pew Research Center revealed just how much COVID-19 has shaped Americans, and while the results largely pointed toward the negative effects of the pandemic, we experienced positives, too. Social distancing and

[14] Texas Juvenile Justice Department 2022-2023 Legislative Appropriations Request.
[15]The Journal of Adolescent Health. "Revisiting the Link Between Depression Symptoms and High School Dropout: Timing of Exposure Matters".
[16]Common Comorbidities with Substance Use Disorders Research Report" by National Institute on Drug Abuse.
[17]Merikangas, K., Hep, J., Burstein, M., Swanson, S., Avenevoli, S., Cui, L., Benejet, C…Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). Journal of American Academy of Child and Adolescent Psychiatry.
[18]"2015 Children's Mental Health Report" by Child Mind Institute.
[19]"Post-COVID Stress Disorder: Another Emerging Consequence of the Global Pandemic" by the Psychiatric Times, January 2021.

isolation weighed heavily on the shoulders of most survey respondents, stating they missed friends and family and were struggling with new living situations. However, a third of respondents described a positive impact to their relationships with members of the home, better connections with distant family via video chats, and the enjoyment of a lack of social obligations. A third of Americans also saw their hobbies and routines disrupted, while a quarter enjoyed the slower pace of their lives and additional time for self-care. Physical and mental health impacts were more markedly negative, with 28% of respondents mourning a loss to COVID-19, suffering from increased stress and depression, and undesired weight gain; women were more likely to experience these negative effects than men (33% as compared to 21%). Work-life balance received polarizing responses; one in five described more stressful work conditions due to the loss of employment, additional work stress, and frustrations with telework, while 13% saw working from home as a positive change.

Children's lives were especially disrupted during the pandemic. A survey conducted by the Kaiser Family Foundation noted that:

- Parents with children ages 5-12 reported their children showed elevated symptoms of depression (4%), anxiety (6%), and psychological stress (9%); and experienced overall worsened mental or emotional health (22%).
- More than 25% of high school students reported worsened emotional and cognitive health. Only one-third of high school students felt they were able to cope with their sources of stress.
- LGBTQ adolescent respondents ages 13-17 reported symptoms of anxiety (73%) and depression (67%), and serious thoughts of suicide (48%) during the pandemic.
- The most frequently diagnosed mental health conditions in 2020 were depression, anxiety, and adjustment disorder[20].

Health Care Resources

Other Mental Health Care Facilities and Providers

The Bexar County Mental Health Consortium publishes the resources available to the community and specifies children's resources, which are noted in Exhibit 13.

[20] kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/

Exhibit 13

Source: Bexar County Mental Health Publication of Resources

Organization	Non-profit	Assessments	Case Management	Outpatient Therapy (with Therapist, Psychologist or Psychiatrist)	Partial Hospital	Acute Care Hospitalization (Mental Health)
Any Baby Can	X		X			
BCFS	X	X	X	X		
Boys Town Texas	X	X	X	X		
Catholic Charities	X	X	X	X		
Center for Health Care Services	X	X	X	X		
Centro Med	X	X		X		
Children Hospital of San Antonio	X	X		X		
Children's Bereavement Center	X	X		X		
Childsafe	X	X	X	X		
CHOSA	X	X	X	X		
Clarity CGC	X	X	X	X	X	X
CommuniCare Health	X	X	X	X		
Endeavors/Cohen Clinic	X	X	X	X		
Laurel Ridge Treatment Center		X	X	X (IOP)	X	X
Pathways Youth & Family Services	X	X	X	X		
Presa Community Center	X	X	X	X		
Rape Crisis Center for Children & Adults	X	X	X	X		
Roy Mass' Youth Alternatives	X	X	X	X		
San Antonio Behavioral Hospital		X	X	X (IOP)	X	X
San Antonio Youth Mental Health Assoc	X		X			
St. Peter St. Joseph Children's Home	X		X	X		
Unversity Health System San Antonio	X	X	X	X		

Observations

The two largest providers of outpatient therapy are Clarity CGC with over 30,000 therapy and psychiatry visits annually and the Center for Healthcare Services. The three main providers of acute inpatient care are Clarity CGC, with over 16,000 inpatient days annually, Laurel Ridge, who treats both adults and children and have the capability to flex beds to either population, based on need, and San Antonio Behavioral Hospital with also the ability to flex beds for capacity. Rural access in counties adjacent to Bexar are not listed because there are literally no acute care services and few outpatient services available, forcing this population to access care in the San Antonio area.

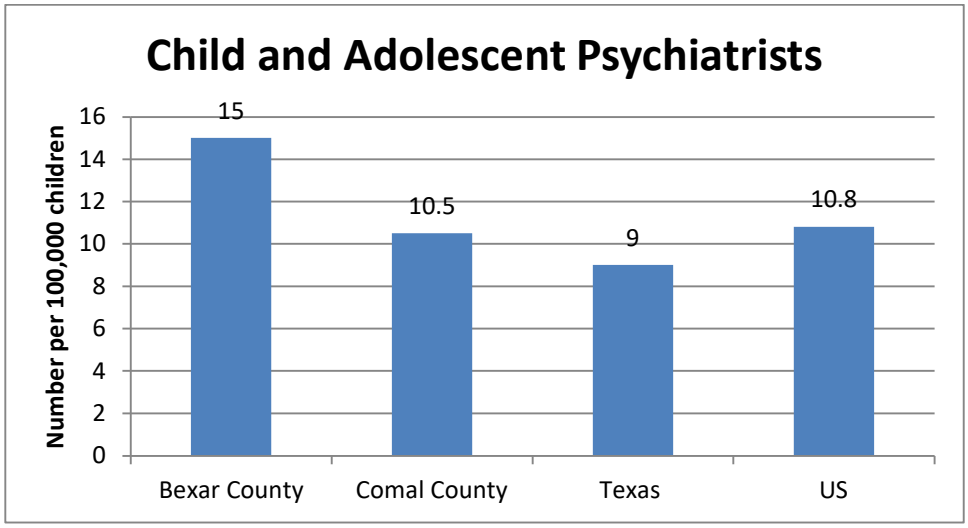
Demand for Mental Health Care

As noted, there are significant delays in obtaining an outpatient therapy appointment and a lack of beds for acute care in our community. Not only are there not enough facilities to accommodate demand, but there is a shortage of child and adolescent psychiatrists. Clarity CGC is proud to be affiliated with UT Health San Antonio, where residents and fellows from the Division of Child and Adolescent Psychiatry receive their training onsite at our campus. This affiliation has helped Bexar County to improve upon its per capita rates of providers and we are now above the US and

Texas. However, Bexar County is surrounded by counties with very few psychiatrists, and as noted above, many physicians do not take insurance.

Exhibit 14

The supply of Mental Health Professional in Texas 2015



Source: American Academy of Child and Adolescent Psychiatry, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

Community Input

Community input was collected from three main sources:

- The Bexar County Children and Youth Rapid Behavioral Health Assessment produced by the Meadows Mental Health Policy Institute.
- Youth Voices - Report on Behavioral Health from The Center for Young Minds at the Ecumenical Center in San Antonio (November 2020).
- The Center for Young Minds' survey and report of Prioritizing Factors & Strategies conducted in 2020.

Bexar County Children and Youth Rapid Behavioral Health Assessment

In November 2018, the Meadows Mental Health Policy Institute (MMHPI) organized a focus group with 6 members of Young Minds Matter (YMM), a program of the Health Collaborative. The participants ranged in age from 14 to 23 years. Participants were asked to "discuss both what is currently going well and what needs to be improved for youth mental health in their communities". The report from MMHPI outlines 4 most relevant themes from the discussion. The 4 themes are listed and explained below directly from the report:

Top Theme: Trauma Broadly Defined

The participants shared their insight and perceptions regarding trauma and how they perceive it manifests at young ages. The participants defined it broadly across a range of situations, and several recalled being surprised when they encountered narratives of trauma from elementary and middle school-aged children, agreeing that these young children and youth also need to be included in conversations surrounding mental health.

Top Theme: Substance Use As a Way to Cope

Substance use was also seen as important, and several of the participants linked it to trauma and social pressures, noting that these factors, when left unaddressed, can and have led to substance use among people they know. One participant summarized it particularly clearly: "Dealing with bullying, self-image, self-worth, and fitting in, all of these can turn into substance abuse and violence. High schools are full of cliques and gangs. And if you don't fit into one, you are an outcast. Trying to fit in and find your group of people is hard. If you are an outcast, then you might turn to peer pressure. There are a lot of good kids, but there is substance abuse – it is around. I have friends in jail and dead because of substance use. Once you get caught up, it is hard to get out." (Male Participant, Age 17)

Top Theme: Fear of Not Being Taken Seriously

Participants vocalized that much of the time they feel pressure from their parents and teachers to present as "fine," noting that they fear not being taken seriously if they develop issues that may affect their emotional and mental health. In the words of one participant "When I was in school, people wouldn't believe me. They would say, 'she is fine,' but because of that I couldn't tell people that is not how it is. I didn't know how to ask for help because I thought people would say that I was having a bad day." (Female Participant, Age 23)

Top Theme: Peer Support Helps

Participants described the importance of support from their peers, and some noted how YMM empowers youth to help each other when dealing with issues of mental and emotional health. In particular, participants agreed that the peer aspect of the program is what drives its success. (Female Participant, Age 14) "When YMM meets, we all start talking and it helps us to process what we are going through, especially when you can't talk to your parents." More broadly, participants also discussed how helpful peer support can be outside of formal peer supports such as YMM meetings. Participants discussed how important it can be to have at least one peer who cares about you and what an impact it can make when you feel worthless. "I opened up to my

friend over text messages . . . it was easy to talk about things that way. She assured me, "you are awesome, you know who you are." I wasn't suicidal, but you do feel worthless, you feel you can't talk to anyone. Her telling me to look in the mirror and have some confidence worked." (Male Participant, Age 17)

Additional Insights
Focus group participants and community partners also voiced the importance of and need for peer supports in the community, especially in schools. Participants stated they appreciated when teachers and coaches at school recognized a change in their emotional well-being and took the initiative to engage with them regarding the change. "I was always energetic and bubbly. My coach noticed I wasn't the same. I am [involved in a sports] team. When a lot of people know you, they can tell something is not right. I was glad he had seen it. It meant a lot to me." (Male Participant, Age 17)

In addition to the youth, YMM program staff described a gap in connecting children and youth in need to the appropriate mental health services. YMM staff stated that while they have identified child and youth pre-diagnostic tools and self-assessments for attention deficit / hyperactivity disorder, depression, and anxiety through the help of pediatricians, it has been difficult to implement the tools in a school or community setting with adequate handoff to a medical professional, if needed[21]*.*

Youth Voices - Report on Behavioral Health from The Center for Young Minds

The Center for Young Minds at the Ecumenical Center in San Antonio conducted a series of zoom or in-person discussion group sessions: 14 sessions were held, encompassing 40 youth during September and October of 2020. Like with the MMPHI focus group, they collected emerging themes, which we are reporting below verbatim from their report, but removed the names:

> ***Most youth indicated a desire to be with peers in a casual setting that creates a sense of shared connection.***

- *"Can we start a children of divorce support group? I think this would be really helpful." female, age 12*
- *"We need a club where we can share our feelings, so we don't feel like outcasts." female, age 11*

[21] https://saafdn.org/wp-content/uploads/2020/09/Bexar-County-Children-and-Youth-Rapid-Behavioral-Health-Assessment-Reduced-File.pdf

- *"My school counselor put together a group for new students. That's where I gained real friends and felt supported." male, age 19*
- *"We do a wellness check in my immediate family. We are open with what we are experiencing, and we don't pretend to know everything or have all the answers. We research and find resources." male, age 20*
- *"My teachers have been helpful. I go to talk to them, and it's calming. They are an outside source giving me coping skills for everyday situations. I feel better getting another point of view from my teachers. I sometimes get trapped in my own thoughts, and their objective feedback helps. I have anxiety and ADHD, which play a role in how I feel from moment to moment." female, age 17*

Many youths shared positive experiences with adults, whether the adult was a parent, extended family member, teacher, counselor, or therapist.

- *When youth experienced disconnection or a negative experience with an adult figure in their life, the common thread centered around the adult discounting the young person's feelings and/or not listening. The young person did not feel seen and heard.*
- *Most youth have asked for school systems to be more attentive to mental health needs. Youth feel schools are not resourced to provide help, with the term "resourced" meaning lacking education, awareness, tools, staffing, and empathy.*

Youth expressed that they do not desire clinical settings to manage their mental health. Casual settings are indicated, and aspects are outlined in the verbatims.

- *"We need education and information on mental health. Every student should have this information. It reduces stigma and gives us a pathway to manage our own health." Male, age 19*
- *"I don't want to go to a clinic and see a doctor. No 'name badge' type people are needed. I just need a real, human connection with someone I feel safe with and can trust. Female, age 14*
- *"Adults don't understand your situation. They blame you instead of just listening. Can you just listen, not judge and hear our perspective? My friends help more, because they are going through the same thing." Male, age 13*
- *"Youth have plenty of authority figures in their lives; we don't need more. We need people we can trust and talk to." Female, age 18*

Some youth have embraced coping mechanisms, yet caution that it's not a one-size-fits-all approach. Youth who do not have coping mechanisms voiced a desire to gain those skills.

- *"I like creating collages, but not painting or drawing. Each person is different in what may work for their particular needs." Female, age 16*
- *"I can be sitting next to three people my age with the same issues, and we all experience it differently and have different needs. You can't use the same, cookie-cutter approaches with kids. Our needs are unique. Everyone's struggle is different; everyone's trauma is different." Female, age 17*
- *"I can't meditate – it doesn't work for me. I need to create and keep busy. I like to spray paint as an art form." Female, age 14*
- *"I'm in therapy to deal with my grandmother's death. I learned about what triggers me and how meditation and breathing exercises can help." Female, age 15*[22]

The Center for Young Minds' survey and report of Prioritizing Factors & Strategies

The Center for Young Minds also conducted a series of workshops with nearly 90 community leaders from 45 organizations in order to develop and prioritize strategies to improve youth mental health in our community. The group identified 5 key indicators that mattered in determining ways to measure improvement. Then they identified and prioritized key factors that would have an impact (positive or negative) on these indicators. The resulting lists below is a good reflection of the needs perceived by key community players who are engaged in providing a variety of services, from education (schools) to mental health or social services agencies.

INDICATOR 1 - Utilization Rate. Factors listed from most important to least important:

- Access to care is limited, siloed, and determined by levels of crisis, resources and institutional constraints rather than being universal and leveraging community assets.
- Family and youth-interfacing systems and mental health professionals lack capacity to adequately respond to needs as they are identified and lack structures to grow community-based support systems
- Systems are ineffective because they are not built to hear youth and family voice or value and invest in peer-led supports due to stigma, cultural narratives and misinformation

INDICATOR 2 - School Absenteeism. Factors listed from most important to least important:

- There are significant barriers to accessing MH services which create delays in treatment systems
- A lack of familial/system support and effective coping skills that mitigate external/internal factors impacting MH, substance use, and absenteeism

[22] https://www.ecrh.org/wp-content/uploads/2020/11/youth-voice-report-2020-compressed.02.pdf

- There is a lack of resources, data, tools and training of evidence-based practices to build positive school/family/peer relationships
- There is a lack of MH support (education) resources, training and tools

INDICATOR 3 - School Discipline. Factors listed from most important to least important:

- Schools and communities with positive cultures foster awareness of behavioral health and engagement in interventions, reduce school disciplinary issues
- While making great strides, school-wide systems struggle with limited, disparate and siloed resources to support youth with behavioral health and school disciplinary issues
- Data-driven collaboration of schools, communities and families fosters engagement and support in addressing the unique needs of children with behavioral health and school discipline issues

INDICATOR 4 - System Capacity. Factors listed from most important to least important:

- Sustainability is limited by inadequate funding and billing structures that do not support integrated care and early identification/prevention
- Access to care is limited by location of services, transportation, and other barriers
- Workforce capacity is limited by the shortage of specialty providers and school based BH professionals along with the discomfort of general providers with treating BH issues
- Youth-facing organizations and providers and caregivers have experience and collective commitment to improve children and youths' behavioral health with the use of evidence-based practices

INDICATOR 5 - Duration of Symptoms. Factors listed from most important to least important:

- Awareness and education of behavioral symptoms and contributing factors across community leads to early identification and treatment
- Complexity and lack of understanding of BH diagnoses leads to fear, denial, and/or stigma and delays treatment
- Lack of comprehensive, effective and responsive family-based system of care leads to delayed treatment
- Lack of insurance is a contributing factor to the affordability of care, leading to delayed treatment

Prioritization of Identified Health Needs

Clarity CGC has been the premier resource for children's mental health care in South Texas. Much work remains to be done and steps are being taken by Clarity CGC Leadership and its Board of Directors to close as many gaps as is feasible. In evaluating the results of our document research as well as survey respondents, we ranked the opportunities identified in the following manner:

- Does the opportunity align with our values, our mission, and our vision?
- Is it a core competency currently? If not, is it a complementary core competency that strengthens our value proposition?
- Is there another organization or entity that would be better served to address the opportunity versus Clarity CGC?
- Is there a viable funding stream for sustainability purposes?
- Does the opportunity impact improvements in other areas of need, if implemented?
- What are the benefits in quantifiable terms of implementing the opportunity?

Clarity Child Guidance Center's leadership evaluated the opportunities revealed in the Community Health Needs Assessment and with the guidance of the Board of Directors, developed a strategic plan to address gaps in the community. Items prioritized were the following:

1. Continue investing in development to enable systemic and repeatable funding streams to our existing business model of billing insurance companies.

2. Explore methods to increase access to care, knowing that a severe shortage of psychiatrists and other mental health professionals has been an ongoing societal issue.

3. Expand levels of care and types of care in the community with family friendly access points.

    a. Expand traditional longer-term outpatient therapy to include a brief psychotherapy model.

    b. Include medication management at the clinic, when feasible.

    c. Offer day treatment (partial hospitalization) when feasible.

    d. Evaluate non-medical based levels of care, such as intensive outpatient, respite beds, etc.

    e. Evaluate home and school-based partnerships for services.

4. Deepen the relationships and outreach related to One in Five Minds, Clarity CGC's signature campaign to end the stigma of mental illness.

5. Implement care coordination to create more effective utilization of health services for children at high-risk.

6. Explore the need for additional inpatient beds, specifically for youth with serious symptoms requiring intensive intervention.

From our last published CHNA in 2015, we have implemented the following initiatives:

- Opening of a Crisis Assessment Center on our main campus which includes six observation beds for extended assessments and crisis stabilization (November 2015) and 24-hour staffing.
- Implementation of a telepsychiatry relationship with a Houston-based organization to add additional psychiatry support to our assessment and admitting processes.
- We also added several nurse practitioners to continue addressing the severe psychiatrist shortage.