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June 29, 2022

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Via E-Mail Correspondence
John Kniery, Administrator
Illinois Health Facilities and Services Review Board ("HFSRB")
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Methodist Medical Center of Illinois d/b/a Young Minds Institute
Project No. 22-017

Dear Mr. Kniery:

Our firm represents the applicants for the above-referenced project. The applicants remain sincerely appreciative of the HFSRB's approval of their request for expedited review and look forward to presenting the project to the HFSRB at its July 19th meeting.

There exists today an unprecedented mental health crisis among people of all ages, and youth have been particularly impacted. In 2019, one in three high school students and half of female students reported persistent feelings of sadness or hopelessness (an overall increase of 40% from 2009), and emergency department visits for attempted suicide have risen 51% among adolescent girls.[1] Half of all mental disorders begin before the age of 14.[2]

NAMI Illinois recently published a fact sheet reporting that 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year.[3] In Illinois, almost 5 million people live in a community that does not have enough mental health professionals, and 61.8% of Illinoisans age 12-17 who have depression did not receive any care in the last year.[4]

The White House recently announced and outlined its national mental health strategy to effectively address the crisis by strengthening system capacity, connecting more Americans to care, and creating a continuum of support. The White House noted that "when systems act to promote well-being at early developmental stages, youth reap the mental and emotional benefits for years to

[1] Attachment 1, March 1, 2022 White House Fact Sheet/Statement.
[2] Id.
[3] Attachment 2, NAMI Illinois Fact Sheet.
[4] Id.

come."[5] Many of the features and goals of the White House's strategy are at the heart of the applicants' project, including, among others, (1) expanding the supply, diversity, and cultural competency of behavioral health workers; (2) increasing access to quality, affordable behavioral health care; (3) offering a full continuum of care in a convenient setting; (4) increasing behavioral health navigation resources; and (5) expanding early childhood and school-based intervention services and supports.[6]

Inpatient behavioral health services are in short supply across the nation, especially for children and adolescents. A recent New York Times article (previously submitted to the HFSRB on May 10, 2022) highlighted the devastating realities lack of ready access to local, essential inpatient services has on youth and their families.[7] As noted in the article, when an inpatient bed is necessary, but not immediately available, children and adolescents in a mental health crisis often must be boarded in a hospital's emergency department (with a national average stay of 48 hours) while they wait for an available hospital bed.[8] In other situations, parents may feel compelled to bring their child home to wait for an available bed (which poses safety considerations), and, often, children must be transported great distances away from their home and loved ones to another inpatient facility.

The emergency department is often the entry point for patients seeking care for a behavioral health crisis. The total number of children and adolescents presenting to the emergency department at UnityPoint Health - Methodist Hospital ("Methodist Hospital") in Peoria who required a behavioral health crisis evaluation has risen 32% since 2019.[9] In 2021, Methodist Hospital had to turn away approximately 46% of patients requiring inpatient care due to a lack of available beds.[10] Because Methodist Hospital is the only provider that offers inpatient child and adolescent behavioral health services in the planning area, children and adolescents often must wait in the emergency department before a hospital bed at Methodist Hospital is available or until they can be transferred to another inpatient facility outside the planning area. In the most extreme case to date, over 36 patients had to be boarded in Methodist Hospital's emergency department for more than 24 hours (with the longest boarded for 58 hours) before appropriate placement could be made.[11]

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[5] Attachment 1.
[6] Id.
[7] Attachment 3, May 8, 2022 New York Times article.
[8] Id.
[9] Application for Project No. 22-017, p. 63.
[10] Id.
[11] Id.

In the last 12 months alone, over 4,400 patients entered the Methodist Hospital emergency department in crisis, and, of those, 1,185 were children and adolescents.[12]

The proposed state-of-the art child and adolescent behavioral health campus (the Young Minds Institute) will effectively address unmet behavioral health needs in the community and transform the delivery of behavioral health care services. This project has overwhelming community support, as evidenced by the powerful comments in the Young Minds Project video submitted to the HFSRB (posted on the HFSRB's website) and by the more than 30 letters submitted to the HFSRB in support of the project from family members of patients, elected officials, community organizations, employees of the applicants, and other behavioral health care providers in the planning area.

To assist the HFSRB in its review of the project, the applicants prepared the attached preliminary renderings and updated floor plans of the proposed campus, attached as **Attachment 4.**[13] As noted in the application, if approved by the HFSRB, the applicants will purchase and renovate an existing building (former long-term care facility called Heddington Oaks) located approximately 2 miles from Methodist Hospital's main campus. Side-by-side comparisons depicting the renovation of certain rooms/areas of the existing building are included in Attachment 4. The applicants plan to use the visuals included in Attachment 4 during its presentation to the HFSRB.

The applicants appreciate the HFSRB's consideration of this important project and look forward to presenting the project at the July 19, 2022 meeting. In the meantime, if you have any questions, please do not hesitate to contact me.

Sincerely,

/s/Rebecca Lindstrom

Rebecca M. Lindstrom

Enclosures – Attachments 1 – 4

cc: Mike Constantino and George Roate

[12] Id., p. 64.
[13] The updated floor plans reflect minor, mostly stylistic changes to the floor plans the applicants submitted with the application. The layout and square footage has not changed.

BRIEFING ROOM

FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union

MARCH 01, 2022 • STATEMENTS AND RELEASES

In his first State of the Union, the President will outline a unity agenda consisting of policy where there has historically been support from both Republicans and Democrats, and call on Congress to send bills to his desk to deliver progress for the American people. As part of this unity agenda, he will announce a strategy to address our national mental health crisis.

Our country faces an unprecedented mental health crisis among people of all ages. Two out of five adults report symptoms of anxiety or depression. And, Black and Brown communities are disproportionately undertreated – even as their burden of mental illness has continued to rise. Even before the pandemic, rates of depression and anxiety were inching higher. But the grief, trauma, and physical isolation of the last two years have driven Americans to a breaking point.

Our youth have been particularly impacted as losses from COVID and disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. More than half of parents express concern over their children's mental well-being. An early study has found that students are about five months behind in math and four months behind in reading, compared with students prior to the pandemic. In 2019, one in three high school students and half of female students reported persistent feelings of sadness or hopelessness, an overall increase of 40 percent from 2009. Emergency department visits for attempted suicide have risen 51 percent among adolescent girls.

This youth mental health crisis has been accentuated by large social media platforms, which for years have been conducting a national experiment on our children and using their data to keep them clicking—with enormous consequences. While technology platforms have improved our lives in some ways, there is mounting evidence that social media is harmful to many kids' and teens' mental health, well-being, and development. As the Surgeon-General has said, "when not deployed responsibly and safely, these tools can pit us against each other, reinforce negative behaviors like bullying and exclusion, and undermine the safe and supportive

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environments young people need and deserve." In the State of the Union, the President will call on Congress to strengthen privacy protections, ban targeted advertising to children, and demand technology companies stop collecting personal data on our children.

President Biden is laying out a vision to transform how mental health is understood, perceived, accessed, treated, and integrated – in and out of health care settings. The American Rescue Plan laid the groundwork, providing critical investments to expand access to mental health services. Now, far more is needed to ensure that everyone who needs help can access care when and where they seek it.

The President is announcing a national mental health strategy to strengthen system capacity, connect more Americans to care, and create a continuum of support –transforming our health and social services infrastructure to address mental health holistically and equitably.

Strengthen System Capacity

At the center of our national mental health crisis is a severe shortage of behavioral health providers. More than one-third of Americans live in designated Mental Health Professional Shortage Areas, communities that have fewer mental health providers than the minimum their level of population would need. Even outside of these shortage areas, the fragmentation of the current system makes it hard for mental health providers to meet people where they are. We must dramatically expand the supply, diversity, and cultural competency of our mental health and substance use disorder workforce – from psychiatrists to psychologists, peers to paraprofessionals – and increase both opportunity and incentive for them to practice in areas of highest need. Our crisis response infrastructure must also be strengthened to ensure that those facing acute behavioral health challenges can be seamlessly connected to necessary services. We will:

- **Invest in proven programs that bring providers into behavioral health.** The President's FY23 budget will invest $700 million in programs – like the National Health Service Corps, Behavioral Health Workforce Education and Training Program, and the Minority Fellowship Program – that provide training, access to scholarships and loan repayment to mental health and substance use disorder clinicians committed to practicing in rural and other underserved communities. These major new investments will both expand the pipeline of behavioral health providers and improve their geographic distribution to target areas with the greatest unmet need.

- **Pilot new approaches to train a diverse group of paraprofessionals**. Doctors, nurses, and other clinicians cannot do this work alone. In the fall of 2022, HHS expects to award over $225 million in training programs to increase the number of community health

workers and other health support workers providing services, including behavioral health support, in underserved communities. The President's FY23 budget will also propose major new multi-year funding to develop provider capacity and support mental health transformation.

- **Build a national certification program for peer specialists.** The Biden-Harris Administration will convene stakeholders, launch development, and support implementation of a national certified peer specialist certification program, which will accelerate universal adoption, recognition, and integration of the peer mental health workforce across all elements of the health care system.

- **Promote the mental well-being of our frontline health workforce.** Three-quarters of frontline health care workers report burnout, while more than half say they lack adequate supports to cope. The Administration has already dedicated $103 million in American Rescue Plan funding to address burnout and strengthen resiliency among health care workers. The President will strengthen this commitment by signing the bipartisan Dr. Lorna Breen Health Care Provider Protection Act into law, which will invest $135 million over three years into training health care providers on suicide prevention and behavioral health while launching an awareness campaign to address stigmatization, promote help-seeking and self-care among this workforce. In addition, HHS will continue grant programs to support health systems and provider groups to prevent burnout, relieve workplace stressors, administer stress first aid, and increase access to high-quality mental health care for the frontline health care workforce.

- **Launch the "988" crisis response line and strengthen community-based crisis response.** This summer, HHS will launch the 988 mental health crisis service hotline, which will create a national network of local crisis centers fortified by national back up centers to answer calls and texts. Through the American Rescue Plan, the Administration has provided $180 million to support local capacity to answer crisis calls, and establish more community-based mobile crisis response and crisis stabilizing facilities to minimize unnecessary emergency department visits. The President's FY23 budget will build on this investment with an additional nearly $700 million to staff up and shore up local crisis centers while also building out the broader crisis care continuum: someone to call, someone to respond, and somewhere for every American in crisis to go.

- **Expand the availability of evidence-based community mental health services.** The American Rescue Plan invested millions of dollars to expand Certified Community Behavioral Health Clinics (CCBHCs), a proven model of care that has been shown to improve health outcomes while lowering costs, by delivering 24/7 mental health and

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substance use care to millions of Americans, no matter who they are or whether they're able to pay. The President's FY23 budget will build on this down payment, by proposing to make this program permanent while granting states funding to expand CCBHCs for the communities that need them most. The President's budget will also permanently extend funding for Community Mental Health Centers, which provide essential mental health services to vulnerable communities that would otherwise lack access.

- **Invest in research on new practice models**. New scientific and technological innovation has the opportunity to expand our capacity to meet American's mental health needs, but there is a pressing need for research to validate what works and build a robust evidence base. The President's FY23 budget will call for investing $5 million in research into promising models for treating mental health conditions.

Connect Americans to Care

Less than half of Americans with mental health conditions receive treatment. The average delay from the onset of mental health symptoms to treatment is 11 years. Too often, costs prevent people from accessing care far. At the same time, those with mental illness are often misunderstood, mistreated, mislabeled, and misdirected to services. It is imperative that we promote better pathways to care and make it as easy as possible for all Americans with behavioral health needs – including common and pervasive conditions like anxiety and depression – to access the resources that will improve their well-being. We must fight to ensure that every American can access mental health and substance use disorder care through their insurance coverage, while integrating mental health services and supports into a variety of other settings, online and in the community. The Biden-Harris Administration will:

- **Expand and strengthen parity**. The 2008 Mental Health Parity and Addiction Equity Act called for mental health care benefits to be covered at the same level as physical health care benefits. The President's fiscal year 2023 (FY23) budget will propose that all health plans cover robust behavioral health services with an adequate network of providers, including three behavioral health visits each year without cost-sharing.

- **Integrate mental health and substance use treatment into primary care settings**. Equipping primary care providers with the tools to identify, treat, and manage behavioral health conditions is a proven approach for delivering quality mental health and substance use care, particularly for individuals with depression. To facilitate adoption of these models, the President's FY23 budget will double funding for primary and behavioral health integration programs. In addition, using existing authority, the Department of Health and Human Services (HHS) will test payment models that support the delivery of whole-person care through behavioral health integration and authorize Medicaid reimbursement

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of inter-professional consultations so that primary care providers can consult with a specialist and provide needed care for patients.

- **Improve veterans' access to same-day mental health care.** Veterans are at higher risk for mental health and substance use challenges than the general population. Increasing their access to quality mental health care is the first step to closing this disparity. The Department of Veterans Affairs (VA) will reduce barriers to mental health access by fully implementing their Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program, which connect veterans to same-day mental health care and improve the integration of these services into primary care settings.

- **Expand access to tele- and virtual mental health care options.** The use of telehealth to address mental health and substance use needs rose dramatically during the height of the pandemic and has remained above pre-pandemic levels even where COVID has waned. These tele-mental health services have proven both safe and effective, while reducing barriers to care. To maintain continuity of access, the Administration will work with Congress to ensure coverage of tele-behavioral health across health plans, and support appropriate delivery of telemedicine across state lines. At the same time, the HHS will create a learning collaborative with state insurance departments to identify and address state-based barriers, like telehealth limitations, to behavioral health access. And the United States Office of Personnel Management will facilitate widespread, confidential, and easy access to telehealth services, in part by strongly encouraging Federal Employees Health Benefits Program carriers to sufficiently reimburse providers for telehealth services, and to eliminate or reduce co-payments for consumers seeking tele-mental service.

- **Expand access to mental health support in schools and colleges and universities.** The President has committed to doubling the number of school-based mental health professionals. The Department of Education (ED) will continue to support states, school districts, colleges and universities, in using relief funds – including the more than $160 billion invested by the American Rescue Plan in the Elementary and Secondary School Emergency Relief (ESSER) and Higher Education Emergency Relief Fund (HEERF) – to address the mental health needs of students, including by training, recruiting, and retaining more school- and college and university-based mental health professionals. With the help of ESSER funds, schools have already seen a 65% increase in social workers, and a 17% increase in counselors. To help schools sustain these roles, the Department of Health and Human Services will make it easier for school-based mental health professionals to seek reimbursement from Medicaid, and the President's FY23 budget will propose $1

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billion to help schools hire additional counselors and school psychologists and other health professionals.

- **Embed and co-locate mental health and substance use providers into community-based settings**. Expanding pathways to care also means creating new, low-barrier access points, in settings where Americans already live, work, and play. To that end, the President's FY23 budget will include $50 million to pilot models that embed and co-locate mental health services into non-traditional settings like libraries, community centers, schools, and homeless shelters.

- **Increase behavioral health navigation resources.** Finding the right care or an available provider can be a frustrating experience. We need to make it easier for Americans both to find help, and to receive it. To meet this need, the Administration will build new easy-to-access, user-friendly online treatment locator tools – starting with a redesigned and refurbished mentalhealth.gov – so Americans can find care when they need it, where they need it, with the click of a button. The Department of Defense will also create a one-stop online resources for service members and their families to access mental health information and locate mental health providers.

Support Americans by Creating Healthy Environments

We cannot transform mental health solely through the health care system. We must also address the determinants of behavioral health, invest in community services, and foster a culture and environment that broadly promotes mental wellness and recovery. This crisis is not a medical one, but a societal one. In December 2021, the Surgeon-General released an Advisory on Protecting Youth Mental Health that outlined a wide range of causes for the national youth mental health crisis and underscored growing concern about the harms of digital technologies, particularly social media, to the mental health and well-being of young people, as well as calling for practical action from technology companies to address these concerns.

We need a whole-of-society effort to address these concerns: to expand prevention programs and actions that improve mental health at every age and across settings; and to enhance programs that support recovery, especially for populations at increased risk during vulnerable transition periods. The Biden-Harris Administration will:

- **Strengthen children's privacy and ban targeted advertising for children online.** The online platforms have billions of users worldwide, many of whom use the platforms for hours a day. These companies know everything from where users are physically located at any moment, to how many seconds they spend reading a particular post, to

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intimate personal data like what medical symptoms they have been researching. Children are also subject to the platforms' intensive and excessive data collection vacuum, which they use to deliver sensational and harmful content and troves of paid advertising to our kids. By one estimate, online advertising firms hold 72 million data points on the average child by the time they reach the age of 13. The President is calling on Congress to ban excessive data collection on and targeted advertising online for children and young people.

- **Institute stronger online protections for young people, including prioritizing safety by design standards and practices for online platforms, products, and services.** Social media platforms are designed to be addictive, too often deliver age-inappropriate content, promote unhealthy social comparisons, and enable harassment, child sexual exploitation, stalking, and cyber-bullying. Children, adolescents and teens are uniquely vulnerable to harmful and dangerous content online. Other democratic countries have been acting to prevent and reduce the online harms to their children. The President believes not only that we should have far stronger protections for children's data and privacy, but that the platforms and other interactive digital service providers should be required to prioritize and ensure the health, safety and well-being of children and young people above profit and revenue in the design of their products and services.

- **Stop discriminatory algorithmic decision-making that limits opportunities for young Americans.** When a girl searches for jobs online, platforms will too often push her away from fields like engineering that historically have excluded women. Searches for "Black girls," "Asian girls," or "Latina girls" too often return harmful content, including pornography rather than role models, toys, or activities. Platforms shape how our kids understand what is possible and access opportunities. When young people are treated unfairly, it can have mental health impacts including anxiety and depression. We must ensure that platforms and other algorithmically-enhanced systems do not discriminatorily target our kids.

- **Invest in research on social media's mental harms.** Ample research has now emerged that social media is associated with negative mental health outcomes, particularly among young people, and that children under 18 are disproportionately vulnerable to the dangerous and harmful content that they might encounter online. More research, however, is needed to understand why and how these harms occur – and how they can be prevented and treated. To meet this need, the President's FY23 budget will dedicate at least $5 million toward advancing research on social media's harms, as well as the clinical and societal interventions we might deploy to address them. Over the next year, the Department of Health and Human Services will also launch a national Center of Excellence on Social Media and Mental Wellness, which will develop and disseminate

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information, guidance, and training on the full impact of adolescent social media use, especially the risks these services pose to their mental health.

- **Expand early childhood and school-based intervention services and supports**. Half of all mental disorders begin before the age of 14. And when systems act to promote well-being at early developmental stages, youth reap the mental and emotional benefits for years to come. The American Rescue Plan dedicated millions of dollars to youth mental health. The President's FY23 budget builds on this investment and proposes to make historic investments in youth mental health services, including more than $70 million in infant and early childhood mental health programs. For example, Project LAUNCH works to ensure that the systems that serve young children have the resources and knowledge to foster their social, emotional, cognitive, and behavioral development. The FY23 budget will also continue funding for the Maternal, Infant, and Early Childhood Home Visiting Program of the Department of Health and Human Services, which supports new families by teaching positive parenting skills, conducting developmental and mental health screenings, promoting school readiness, and linking to community resources and supports. Additionally, the President's FY23 budget will propose to dramatically expand funding for community schools by increasing funding for the Full-Service Community School program by over $400 million dollars relative to current levels – a more than ten-fold increase. Community schools provide a range of wraparound supports to students and their families, including mental health services and other integrated student supports.

- **Set students up for success.** When students struggle in school, it impacts their well-being. A comprehensive strategy to support student wellness must also include efforts to address the impact of the pandemic on student learning, particularly on students most impacted by the pandemic, and create supportive learning environments. ED will continue to help states and school districts use the $122 billion in ARP ESSER funds for this purpose. Specifically, the Department will help states and districts use the funds to provide more individual and small group instruction, hire instructional and other critical staff, launch high-impact tutoring programs, provide high-quality afterschool and summer learning and enrichment programs, and invest in other evidence-based strategies that will help our students recover from the pandemic. Districts nationwide are already using ARP ESSER funds to invest in these strategies. To support this work, we need more caring adults taking on roles supporting students. The President is calling on Americans nationwide to take on roles as tutors and mentors to help our students recover. Those looking to return to the workforce, who are just out of school, or changing careers, should consider the rich, rewarding job opportunities in our schools and with our young people. The investments the President will propose in his FY23 budget will support and sustain efforts that set up students for success. This includes more than doubling funding for Title I, a ten-fold

increase for the Full-Service Community School program, and an historic $3.3 billion increase for Individuals with Disabilities Education Act grants that support PK-12 children with disabilities and $450 million for IDEA PART C, which supports early intervention services for infants and toddlers.

- **Increase mental health resources for justice-involved populations**. In too many communities, jails and other correctional facilities have become the largest provider of mental health care. Approximately 40 percent of incarcerated individuals have a mental illness, yet merely one-third receive treatment. The President believes that we have both a moral and a public health obligation to increase access to comprehensive mental health care for the justice-involved. To this end, the Department of Justice will expand funding and technical assistance to local communities and corrections systems to provide behavioral health care, case management services, family services, and other transitional programming for adults returning from incarceration into the community.

- **Train social and human services professionals in basic mental health skills.** It's not enough to train health care providers to deliver mental health care; social and human services providers must also be equipped to identify, understand, and respond to signs of mental illness and addiction among those they serve. To this end, the Department of Housing and Urban Development will launch a national effort to train housing counselors, housing-based services coordinators, and Fair Housing grantee staff to recognize the signs of emotional distress and to connect residents with mental health resources. The U.S. Department of Agriculture will provide training on mental health resources and communication strategies to Farm Production and Conservation Mission Area field employees, who serve farmers and ranchers, as well as incorporate updated mental health information into its online resource center for State, local and clinic staff administering the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). ED will continue to highlight the effectiveness of Mental Health First Aid training for educators, so that they can better support their students and one another. And the Department of Health & Human Services will provide additional training support to Head Start, Early Head Start, and home visiting grantees to spot and address mental health challenges among children.

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Mental Health in Illinois

1 in 5 U.S. adults experience mental illness each year.

1,754,000 adults in Illinois have a mental health condition.

That's more than 15x the population of Springfield.

It is more important than ever to build a stronger mental health system that provides the care, support and services needed to help people build better lives.

NAMI
National Alliance on Mental Illness

More than half of Americans report that **COVID-19 has had a negative impact** on their mental health.

In February 2021, **38.5% of adults in Illinois** reported symptoms of **anxiety or depression.**

28% were unable to get needed counseling or therapy.

1 in 20 U.S. adults experience serious mental illness each year.

In Illinois, **403,000 adults** have a **serious mental illness.**

1 in 6 U.S. youth aged 6–17 experience a **mental health disorder** each year.

145,000 Illinoisans age 12–17 have depression.

Illinoisans struggle to get the help they need.

More than half of people with a mental health condition in the U.S. **did not receive any treatment** in the last year.

Of the **486,000 adults in Illinois who did not receive needed mental health care,** 33.2% did not because of cost.

7.3% of people in the state are uninsured.

Illinoisans are over **3x more likely to be forced out-of-network** for mental health care than for primary health care — making it more difficult to find care and less affordable due to higher out-of-pocket costs.

4,873,491 people in Illinois live in a community that **does not have enough mental health professionals.**

Attachment 2

Mental Health in Illinois

An inadequate mental health system affects individuals, families and communities.

High school students with depression are more than **2x more likely to drop out** than their peers.

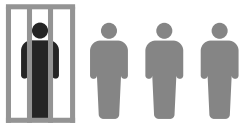
61.8% of Illinoisans age 12–17 who have depression **did not receive any care** in the last year.

10,431 people in Illinois are homeless and **1 in 5 live with a serious mental illness.**

On average, 1 person in the U.S. **dies by suicide every 11 minutes.**

In Illinois, **1,488 lives were lost to suicide** and 376,000 adults had thoughts of suicide in the last year.

1 in 4 people with a serious mental illness has been arrested by the police at some point in their lifetime –



leading to over **2 million jail bookings** of people with serious mental illness each year.

About **2 in 5 adults** in jail or prison have a history of mental illness.

7 in 10 youth in the juvenile justice system have a mental health condition.

NAMI
National Alliance on Mental Illness

NAMI Illinois is part of NAMI, National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

This fact sheet was compiled based on data available in February 2021. For full citations, visit: nami.org/mhpolicystats.

Attachment 2

The New York Times https://www.nytimes.com/2022/05/08/health/emergency-rooms-teen-mental-health.html

Hundreds of Suicidal Teens Sleep in Emergency Rooms. Every Night.

With inpatient psychiatric services in short supply, adolescents are spending days, even weeks, in hospital emergency departments awaiting the help they desperately need.

By Matt Richtel Photographs by Annie Flanagan

Matt Richtel spent more than a year interviewing adolescents and their families for this series on the mental health crisis.

Published May 8, 2022 Updated May 9, 2022, 2:10 p.m. ET

On a rainy Thursday evening last spring, a 15-year-old girl was rushed by her parents to the emergency department at Boston Children's Hospital. She had marks on both wrists from self-harm and a recent suicide attempt, and earlier that day she confided to her pediatrician that she planned to try again.

At the E.R., a doctor examined her and explained to her parents that she was not safe to go home.

"But I need to be honest with you about what's likely to unfold," the doctor added. The best place for adolescents in distress was not a hospital but an inpatient treatment center, where individual and group therapy would be provided in a calmer, communal setting, to stabilize the teens and ease them back to real life. But there were no openings in any of the treatment centers in the region, the doctor said.

Indeed, 15 other adolescents — all in precarious mental condition — were already housed in the hospital's emergency department, sleeping in exam rooms night after night, waiting for an opening. The average wait for a spot in a treatment program was 10 days.

The girl and her family resigned themselves to a stay in the emergency room while she waited. But nearly a month went by before an inpatient bed opened up.

The girl, being identified by her middle initial, G, to protect her privacy, spent the first week of her wait in a "psych-safe" room in the emergency department. Any equipment that might be used for harm had been removed. She was forbidden to use electronics — to keep her from searching the internet for ways to commit suicide or asking a friend to smuggle in a sharp object, as teens before her had done. Her door was kept open night and day so she could be monitored.

It was "padded, insane-asylum-like," she recalled recently in an interview. "Just walls — all you see is walls."

She grew "catatonic," her mother recalled. "In this process of boarding we broke her worse than ever."

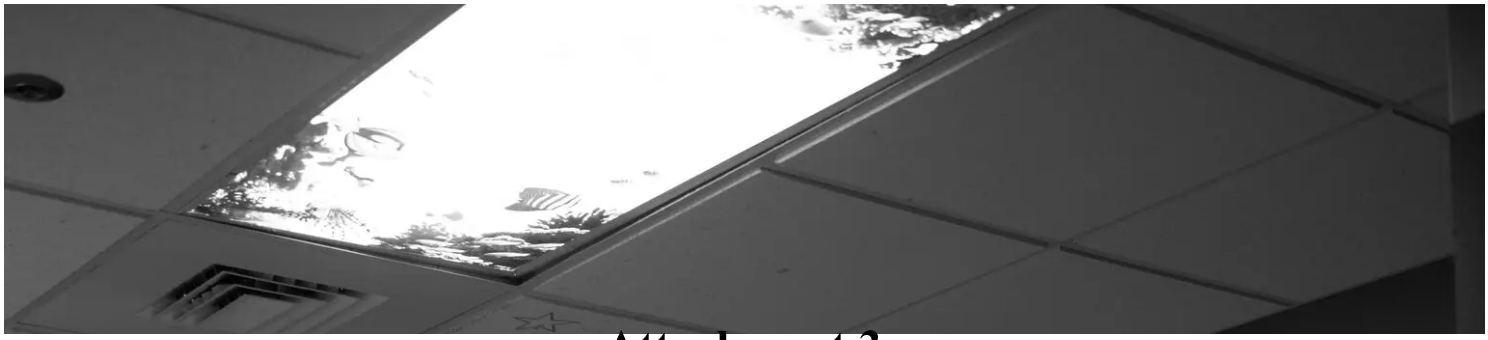
Mental health disorders are surging among adolescents: In 2019, 13 percent of adolescents reported having a major depressive episode, a 60 percent increase from 2007. Suicide rates, stable from 2000 to 2007, leaped nearly 60 percent by 2018, according to the Centers for Disease Control and Prevention.

G's story describes one of its starkest manifestations of the crisis. Across the country, hospital emergency departments have become boarding wards for teenagers who pose too great a risk to themselves or others to go home. They have nowhere else to go; even as the crisis has intensified, the medical system has failed to keep up, and options for inpatient and intensive outpatient psychiatric treatment have eroded sharply.

Nationally, the number of residential treatment facilities for people under the age of 18 fell to 592 in 2020 from 848 in 2012, a 30 percent decline, according to the most recent federal government survey. The decline is partly a result of well-intentioned policy changes that did not foresee a surge in mental-health cases. Social-distancing rules and labor shortages during the pandemic have eliminated additional treatment centers and beds, experts say.

Attachment 3

Dr. Kevin Carney, a pediatric emergency-room doctor at Childen's Hospital Colorado in Aurora. "Frankly speaking, the E.D. is one of the worst places for a kid in mental health crisis to be," he said.



Attachment 3

An exam room at Children's Hospital Colorado, where fixtures and other items had been removed to prevent harm.

Absent that option, emergency rooms have taken up the slack. A recent study of 88 pediatric hospitals around the country found that 87 of them regularly board children and adolescents overnight in the E.R. On average, any given hospital saw four boarders per day, with an average stay of 48 hours.

"There is a pediatric pandemic of mental health boarding," said Dr. JoAnna K. Leyenaar, a pediatrician at Dartmouth-Hitchcock Medical Center and the study's lead author. In an interview, she extrapolated from her research and other data to estimate that at least 1,000 young people, and perhaps as many as 5,000, board each night in the nation's 4,000 emergency departments.

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“We have a national crisis,” Dr. Leyenaar said.

This trend runs far afoul of the recommended best practices established by the Joint Commission, a nonprofit organization that helps set national health care policy. According to the standard, adolescents who come to the E.R. for mental health reasons should stay there no longer than four hours, as an extended stay can risk patient safety, delay treatment and divert resources from other emergencies.

Yet in 2021, the average adolescent boarding in the E.R. at Boston Children’s Hospital spent nine days waiting for an inpatient bed, up from three and a half days in 2019; at Children’s Hospital Colorado in Aurora in 2021, the average wait was eight days, and at Connecticut Children’s Medical Center in Hartford, it was six.

Emergency-department boarding has risen at small, rural hospitals, too, with “no pediatric or mental health specialists,” said Dr. Christian Pulcini, a pediatrician in Vermont who has studied the trend in the state. “There is one clear conclusion,” he told the Vermont legislature recently. “The E.D. is not the appropriate setting for children to get comprehensive, acute mental health services.”

Doctors and hospital officials emphasize that adolescents should absolutely continue to come to the E.R. in a psychiatric emergency. Still, many emergency-room doctors and nurses, trained to treat broken bones, pneumonia and other corporeal challenges, said the ideal solution was more preventive care and community treatment programs.

“Frankly speaking, the E.D. is one of the worst places for a kid in mental health crisis to be,” said Dr. Kevin Carney, a pediatric emergency room doctor at Children’s Hospital Colorado. “I feel at a loss for how to help these kids.”

‘Actually a good day’

Dr. Carney on his rounds at Children’s Hospital Colorado in Aurora last month.

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The challenge was evident one day in late February when Dr. Carney arrived for his shift at 3 p.m. The children's hospital has 50 exam rooms in its emergency department, which fill with patients who have gone through an initial screening and need further evaluation. By midafternoon, 43 of the rooms were full, 17 of them with mental health cases.

"It's breathtaking," Dr. Carney said as he stood in the hallway. "Forty percent."

On clocking in, Dr. Carney had inherited a block of 10 exam rooms from a doctor who was clocking out. "Seven are mental health issues," Dr. Carney said. "Six are suicidal. Three of them made attempts."

The adolescents who were deemed to be at physical risk to themselves or others could be readily identified: Their exam room doors were open so they could be monitored, and they wore maroon-colored scrubs instead of their own clothes. No shoelaces, belts or zippers.

Throughout the day, staff members at the hospital had called eight inpatient facilities in the region, looking for available slots in treatment centers where the 10 young boarders, as well as 17 other adolescents boarding at three smaller Colorado Children's Hospital campuses around the state, could be placed.

One of the adolescents waiting in Aurora, a Denver suburb, was a 16-year-old who had been stabilized after attempting suicide and who needed a residential treatment spot. "But there are no beds," Jessica Friedman, a social worker, said she had told the family.

"I have eight or nine conversations like this a day," Ms. Friedman, standing in the hallway, told a reporter; so far that day she had had only two. "This is actually a good day."

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Jessica Friedman, a social worker at Children's Hospital Colorado.

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A room at the Gary Pavilion Pediatric Mental Health Institute at Children's Hospital in Aurora, Colo., one of eight inpatient facilities in the area.

Standing nearby, Travis Justilian, a nurse and the interim clinic manager in the emergency department, said the flood of boarders "is crushing our staff." He added, "We're fixers and we're sitting here doing nothing but watching them watch TV."

Colorado is struggling with the same shortage of services that has hit hospitals nationwide. The state has lost 1,000 residential beds serving various adolescent populations since 2012, according to Heidi Baskfield, vice president of population health and advocacy for Children's Hospital Colorado. The state closed one 500-bed facility, Ridgeview, which served at-risk young people, in 2021 because of instances of poor quality and abuse. Another facility, Excelsior, closed its 200 beds in 2017 because reimbursement rates were not high enough to support ongoing operations, the chief executive officer said at the time of the closing.

A major cause, Ms. Baskfield said, was the low reimbursement rates paid by Medicaid, the state insurance program. From 2006 to 2021, the daily Medicaid rate in Colorado allotted roughly $400 for a therapeutic residential bed — "less than some families spend to send their kids for a night to sleepaway camp," Ms. Baskfield said.

The low rates also accounted for some of the quality issues, she said; it was hard to hire experienced staff. (In the past year, Colorado has raised its reimbursement to $750 per day by using money from the American Rescue Plan, but new beds have yet to open, and that source of money is temporary.)

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Travis Justilian, a nurse and interim clinic manager in the emergency department. “We’re fixers and we’re sitting here doing nothing but watching them watch TV,” he said.

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Lyndsay Gaffey, the hospital's director of patient care services. The aim of inpatient care, she said, was to stabilize patients by having them work through trauma, receive therapy and interact with peers.

Lisette Burton, chief policy and practice adviser for the Association of Children's Residential and Community Services, a nonprofit advocacy group, noted that, nationally, the closure of facilities and the loss of beds was the result of many factors, including a well-intended, decades-long effort to keep foster children and other children out of institutional settings. But the intended substitutes — more nimble and specialized treatment options — were never funded and remain largely unavailable, she said.

Then came the pandemic, amplifying labor shortages and introducing social-distancing and quarantine guidelines that reduced the capacity for patients. "Demand went up, supply went down," Ms. Burton said. "Now we're in full-blown crisis."

On that February day in Colorado, one inpatient bed finally opened up. It happened to be in the 12-bed inpatient ward of Children's Hospital Colorado, just a few minutes' walk from the E.R.

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The ward's hallways are wide, the walls painted light green and the lighting bright, to instill a feeling of comfort and calm. Each bedroom has windows looking outside and, next to the door, a glass panel enabling hospital staff to discreetly peer inside.

In a small communal room, four adolescent girls in maroon scrubs sat on blue chairs and couches. One listened to headphones and sang aloud to the soundtrack to "Encanto." Another worked on a jigsaw puzzle of the sea. Two others chatted with a counselor.

The emergency department "is just a collection of rooms where patients are expected to stay in their rooms and comply with rules," said Lyndsay Gaffey, director of patient care services at Children's Hospital Colorado. In the inpatient ward, she said, the aim instead was to stabilize patients by having them work through trauma, receive therapy and interact with peers.

But they must be closely watched here, too. When a reporter rested a pen on a countertop, a staff member swept it up. "You cannot have this here unless it is on your person," she said. "If a patient walks over and grabs it, it can basically be used as a weapon."

Is it safe to go home?

J on a neighborhood street in Denver last month. In February, he spent time in the E.R. after he was discovered searching the internet for ways to commit suicide.

In severe cases of mental distress, emergency-room doctors can compel an adolescent to board in the E.R. until inpatient services become available, however long that takes. Often, parents opt to return home with their child, to try to manage there while waiting for a treatment opening. But that option requires family and doctors alike to work through a difficult question: Is the adolescent safe to go home?

In early February, a 12-year-old boy, J, was struggling toward an answer at the emergency room of the Highlands Ranch campus of Children's Hospital Colorado. (He is being identified by his first initial for privacy reasons.)

He had arrived that morning with his mother, after she discovered that he had been searching the internet for ways to commit suicide. Over the course of his day in the E.R., he was asked several times how safe he felt to go home. The mother recounted one exchange:

Attachment 3

“Do you think you can go home?” the doctor asked.

“What’s the other option?” J asked.

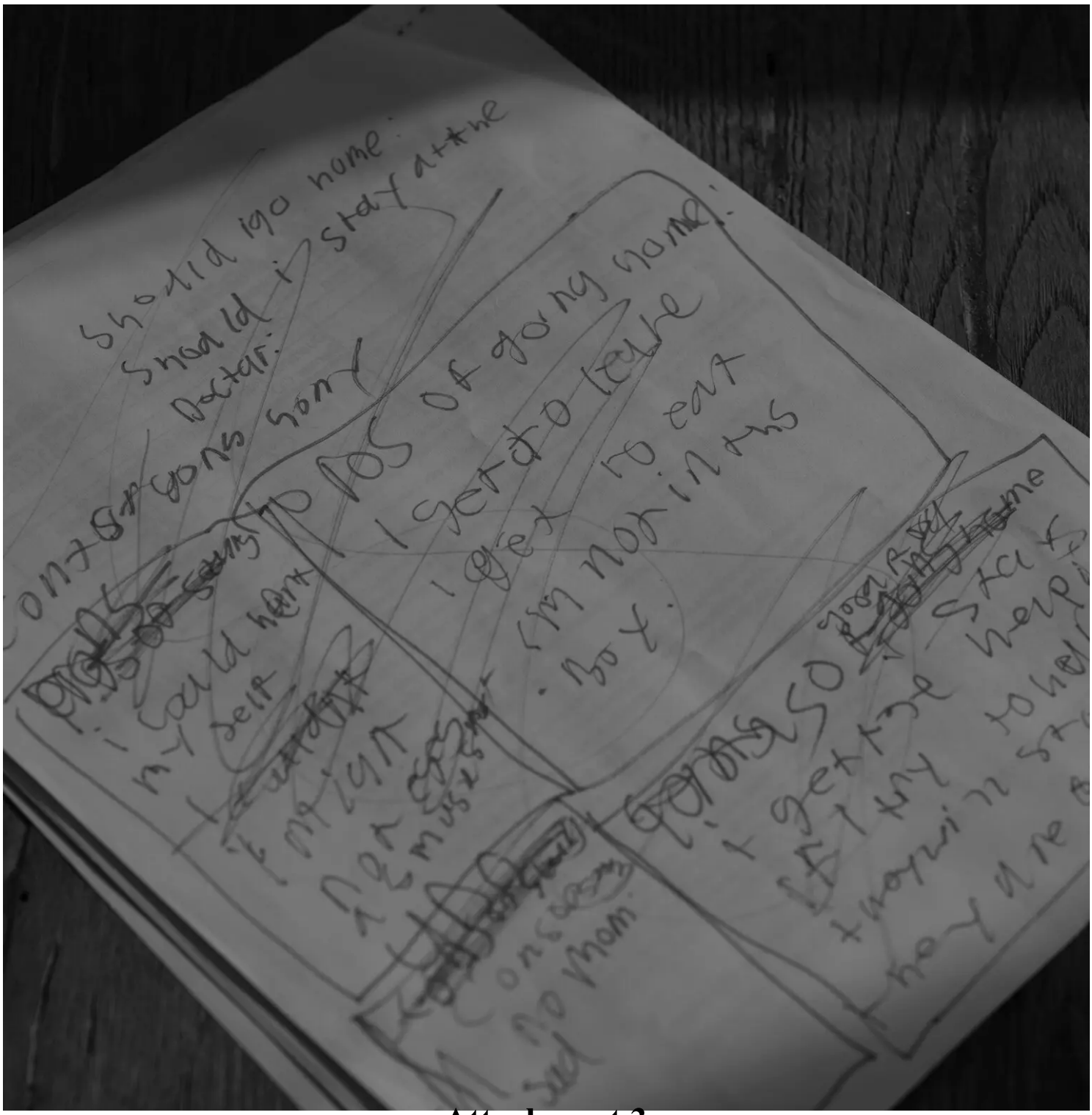
“You’d be in the emergency room.”

“I can go home with my mom,” J said. “But if I feel like I’m going to kill myself, what do I do?’”

“You’ll come back to the emergency room,” the doctor replied.

J’s mother took him home and “hid every medicine and every knife,” she said. J wanted to get help and asked her that first night: “So can I start tomorrow?”

No, his mother told him, he’d have to wait. Sixteen days went by before a spot for J opened in an intensive treatment program. She watched her son around the clock. “It was the scariest two weeks of my life,” she said.



Attachment 3

A page of J's safety plan, outlining J's pros and cons for leaving or staying in the hospital.

Attachment 3

J and his mother at home.

The longest wait

For adolescents like G, who stayed in the emergency room of Boston Children's Hospital last spring, the experience can be wrenching.

G lives in a Boston suburb with a teenage brother, father and mother. The family has a history of anxiety and depression, the mother said, but G had been a happy and adventurous child. In middle school she started talking back and acting somewhat obsessively, behavior that her mother figured was typical for a teenager.

What G's mother did not know was that her daughter had been cutting herself for two years, since seventh grade, before the pandemic began. "I cut with literally anything I could find — hockey cards, pipe cleaners, paper clips, anything," G said. She described the self-harm as a "coping mechanism" to deal with inner pain. She hid the activity "with sweaters, hoodies, foundation."

As the pandemic set in, G withdrew, and her grades fell. "Then came April 29," her mother said. "We had a life before April 29 and a life after April 29."

That day, she picked up G at school for a routine visit to the pediatrician. As G got into the car, her mother saw the marks on her wrists.

At the emergency room, G told the medical team she had tried to overdose a few weeks earlier and had regretted the next morning that she was still alive. In the exam room, she noticed a container of hand sanitizer. "I told them, 'I'm thinking about drinking this,'" G recalled.

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Boston Children's Hospital.

Admitting to her pain and self-harm provided her "with kind of a little bit of relief," she said. "After two years of cutting and trying to kill myself, I was finally going to get some help. But I didn't really get help."

That first night, she was moved for safety reasons to a room that contained just a bed and, for her mother, a rollaway. With the door open, sleeping was difficult. "A sitter was literally staring at my kid," G's mother said. "It felt demoralizing."

Mother and daughter played Uno, Go Fish, checkers and Connect Four. G, anxious and awake, received Ativan on three of the next four nights, then was prescribed Trazodone for chronic anxiety.

Boarding night after night in an emergency department can overwhelm some adolescents, said Dr. Amanda Stewart, an emergency room pediatrician at Boston Children's. One day this February, she was treating an infant with a respiratory infection when she heard screaming. It came from a 12-year-old boy with attention-deficit disorder and autism who had threatened suicide and was boarding down the hall.

"Other patients started escalating," Dr. Stewart recalled. "One of them, across the hall, started hitting her head against the wall." The girl, 15, had entered the E.R. after a suicide attempt and had been calm until that point.

Dr. Stewart said that some teens tell her that boarding in the emergency department intensified their suicidal urges. "I've heard that from kids many times," she said, recalling that they will say: "'I'm not going to tell you next time, because it means I'm going to have to come here again.'"

Dr. Patricia Ibeziako, a child psychiatrist at Boston Children's Hospital, said that adolescents do, in fact, receive some treatment while boarding in the emergency department, including basic counsel aimed at "crisis stabilization" that is "all geared to safety."

"Boarding is not a great thing, but it's still care," Dr. Ibeziako said. "We're not just putting a kid in a bed."

Attachment 3

Attachment 3

Dr. Amanda Stewart, an emergency-room pediatrician at Boston Children's. She said that some teens tell her that boarding in the emergency department intensified their suicidal urges.

Attachment 3

Dr. Patricia Ibeziako, a child psychiatrist at Boston Children's. "Boarding is not a great thing, but it's still care," she said.

Kid on fire

May 7 arrived — G's eighth day in the emergency ward — and still no inpatient beds were available in the region. But a bed did open in the hospital, upstairs in the pediatric medical unit; this room had a window and a private bathroom, and a caregiver who watched G around the clock.

She "was very, very, very depressed and dejected," her mother recalled. "She didn't even cry anymore."

Finally, 29 days after G arrived, a bed was located for her at an inpatient facility in an outlying suburb. She spent a week there but did not find the experience all that helpful.

"We learned the same coping skills over and over," she said. Over the summer, she worked a fast-food job, but she continued cutting herself, she said, and did a better job of hiding it.

In the fall, she told a counselor at school that she planned to kill herself; she was quickly re-admitted to the same inpatient unit, given priority as a former patient, and spent two weeks there. When her stay ended, G went into an intensive outpatient program. But a counselor there told her mother that G needed more intensive care because she had described a plan to kill herself.

"They told me, 'This kid is on fire, she's too acute to be here,'" G's mother recalled. This time, the family went to the emergency room at a different Boston-area hospital, Salem Hospital, where G boarded only one night and, this time, was lucky to get a bed in that hospital's inpatient unit, where she spent three weeks, until mid-October.

G's mood these days is "better than it was, but it still sucks," she said recently. And, she added, "I'm better at covering things up more."

"Once people ask you a question, 'Do you feel suicidal,' you have to say nope," she said. "You can't tell them anything or they'll send you to the hospital."

How Matt Richtel spoke to adolescents and their parents for this series

In mid-April, I was speaking to the mother of a suicidal teenager whose struggles I've been closely following. I asked how her daughter was doing.

Not well, the mother said: "If we can't find something drastic to help this kid, this kid will not be here long term." She started to cry. "It's out of our hands, it's out of our control," she said. "We're trying everything."

She added: "It's like waiting for the end."

Over nearly 18 months of reporting, I got to know many adolescents and their families and interviewed dozens of doctors, therapists and experts in the science of adolescence. I heard wrenching stories of pain and uncertainty. From the outset, my editors and I discussed how best to handle the identities of people in crisis.

The Times sets a high bar for granting sources anonymity; our stylebook calls it "a last resort" for situations where important information can't be published any other way. Often, the sources might face a threat to their career or even their safety, whether from a vindictive boss or a hostile government.

In this case, the need for anonymity had a different imperative: to protect the privacy of young, vulnerable adolescents. They have harmed themselves and attempted suicide, and some have threatened to try again. In recounting their stories, we had to be mindful that our first duty was to their safety.

If The Times published the names of these adolescents, they could be easily identified years later. Would that harm their employment opportunities? Would a teen — a legal minor — later regret having exposed his or her identity during a period of pain and struggle? Would seeing the story published amplify ongoing crises?

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As a result, some teenagers are identified by first initial only; some of their parents are identified by first name or initial. Over months, I got to know M, J and C, and in Kentucky, I came to know struggling adolescents I identified only by their ages, 12, 13 and 15. In some stories, we did not publish precisely where the families lived.

Everyone I interviewed gave their own consent, and parents were typically present for the interviews with their adolescents. On a few occasions, a parent offered to leave the room, or an adolescent asked for privacy and the parent agreed.

In these articles, I heard grief, confusion and a desperate search for answers. The voices of adolescents and their parents, while shielded by anonymity, deepen an understanding of this mental health crisis.

Attachment 3

UnityPoint Health
Methodist

INTEGRATED PROJECT
SOLUTIONS

Architectural
Design Group
INCORPORATED

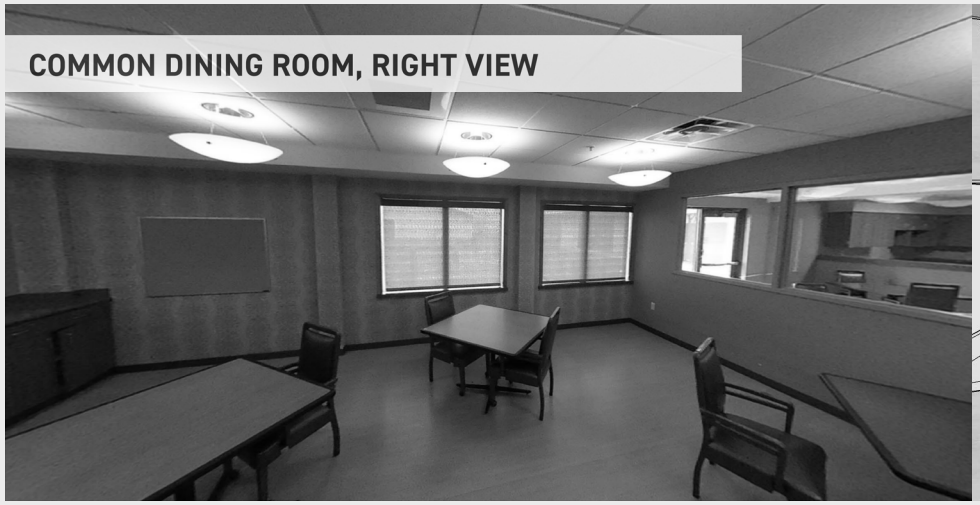
Young Minds Institute

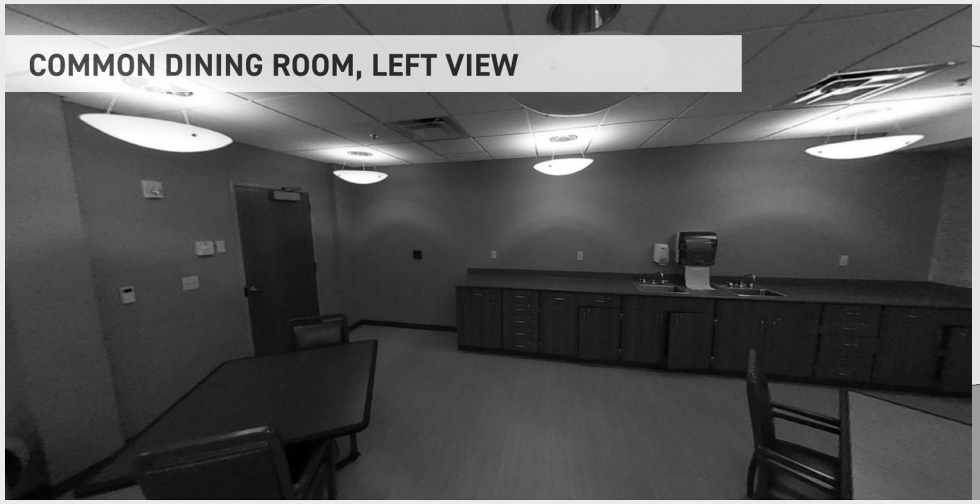
ROOM DESIGNS

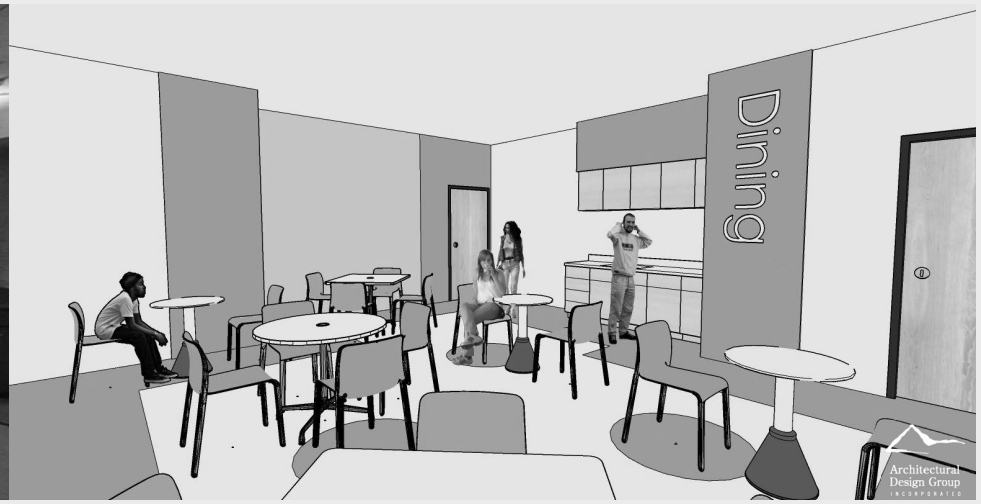
June 2022

Attachment 4

ROOM Design







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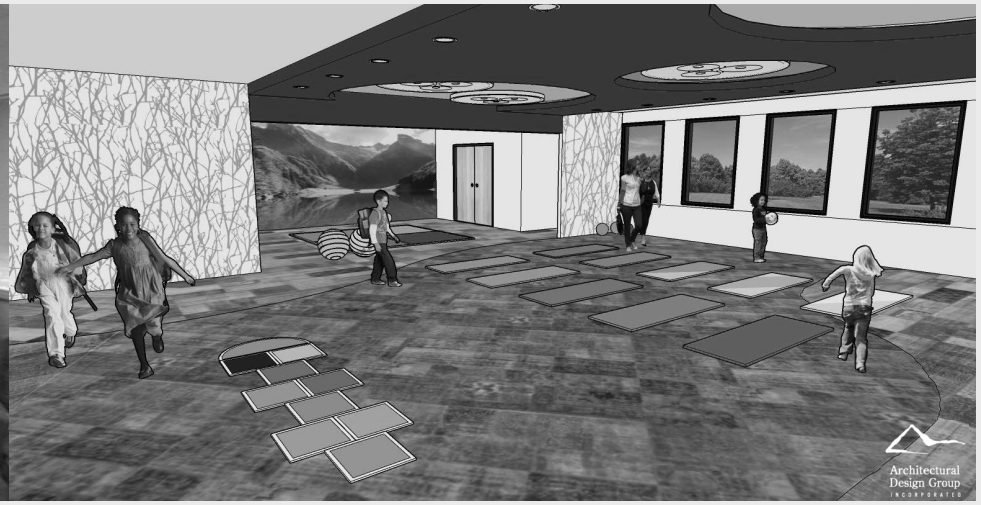
Attachment 4

ROOM Design



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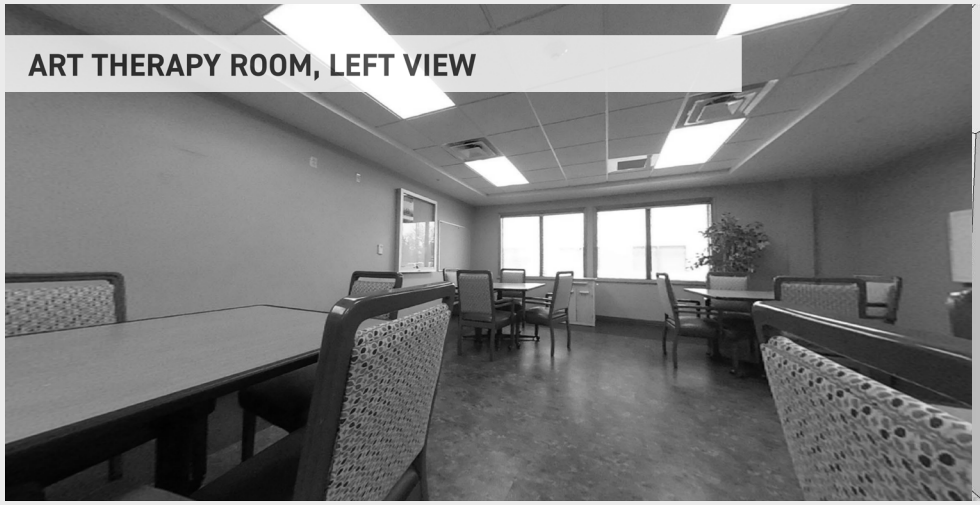

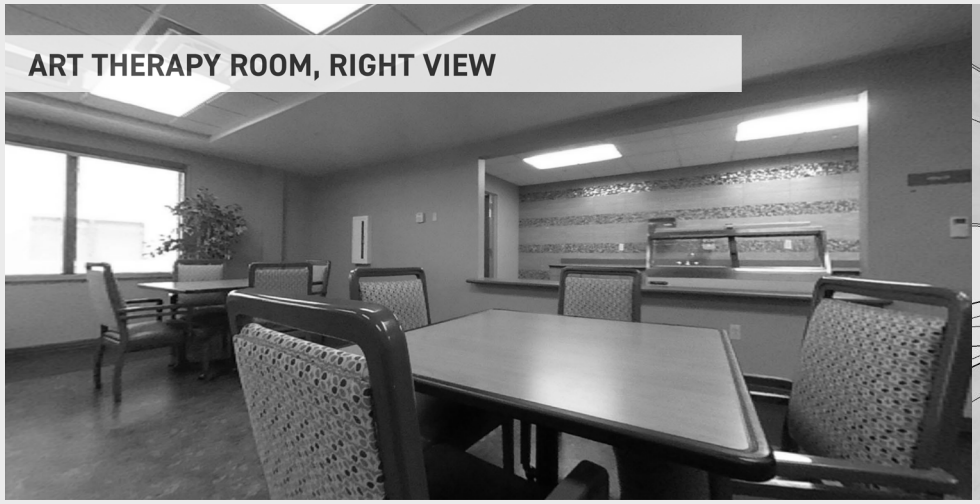

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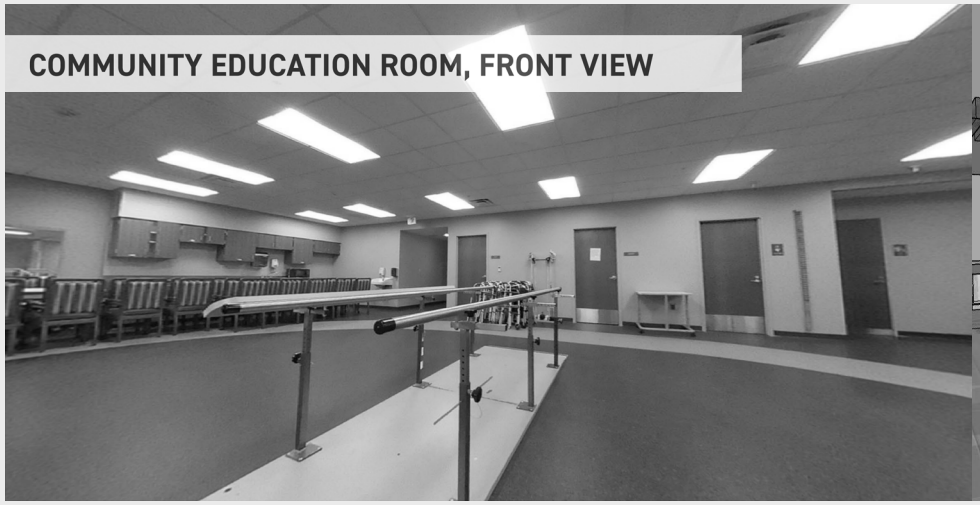

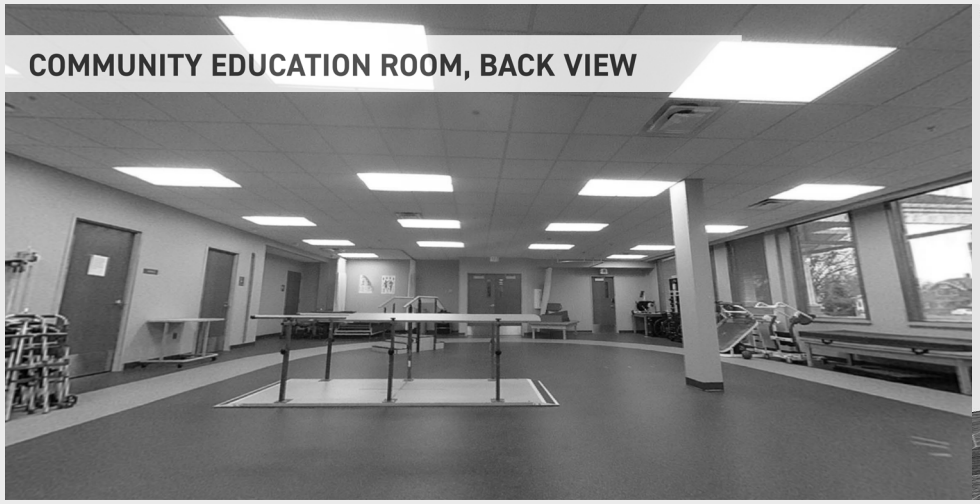

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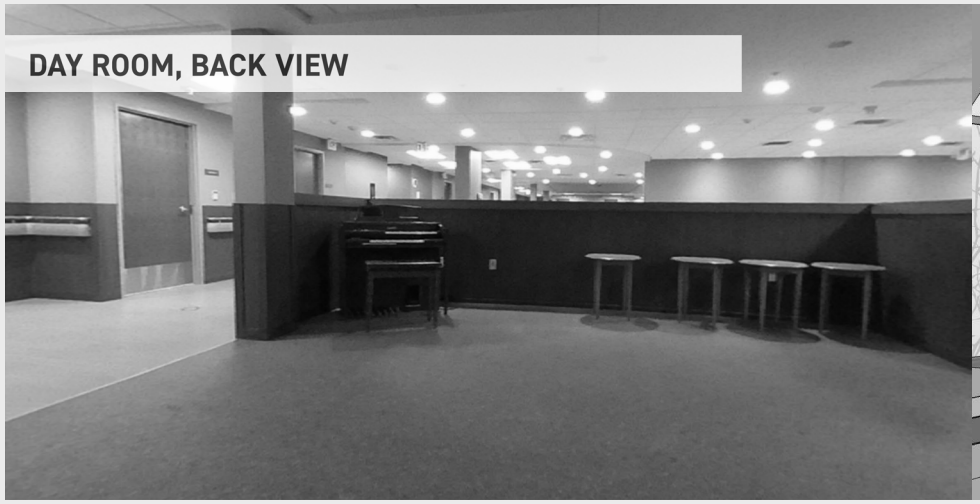

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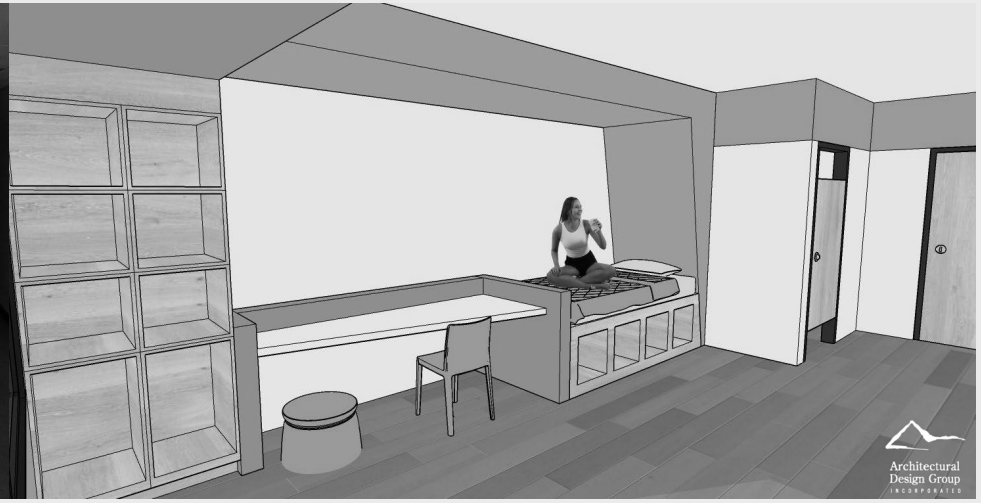

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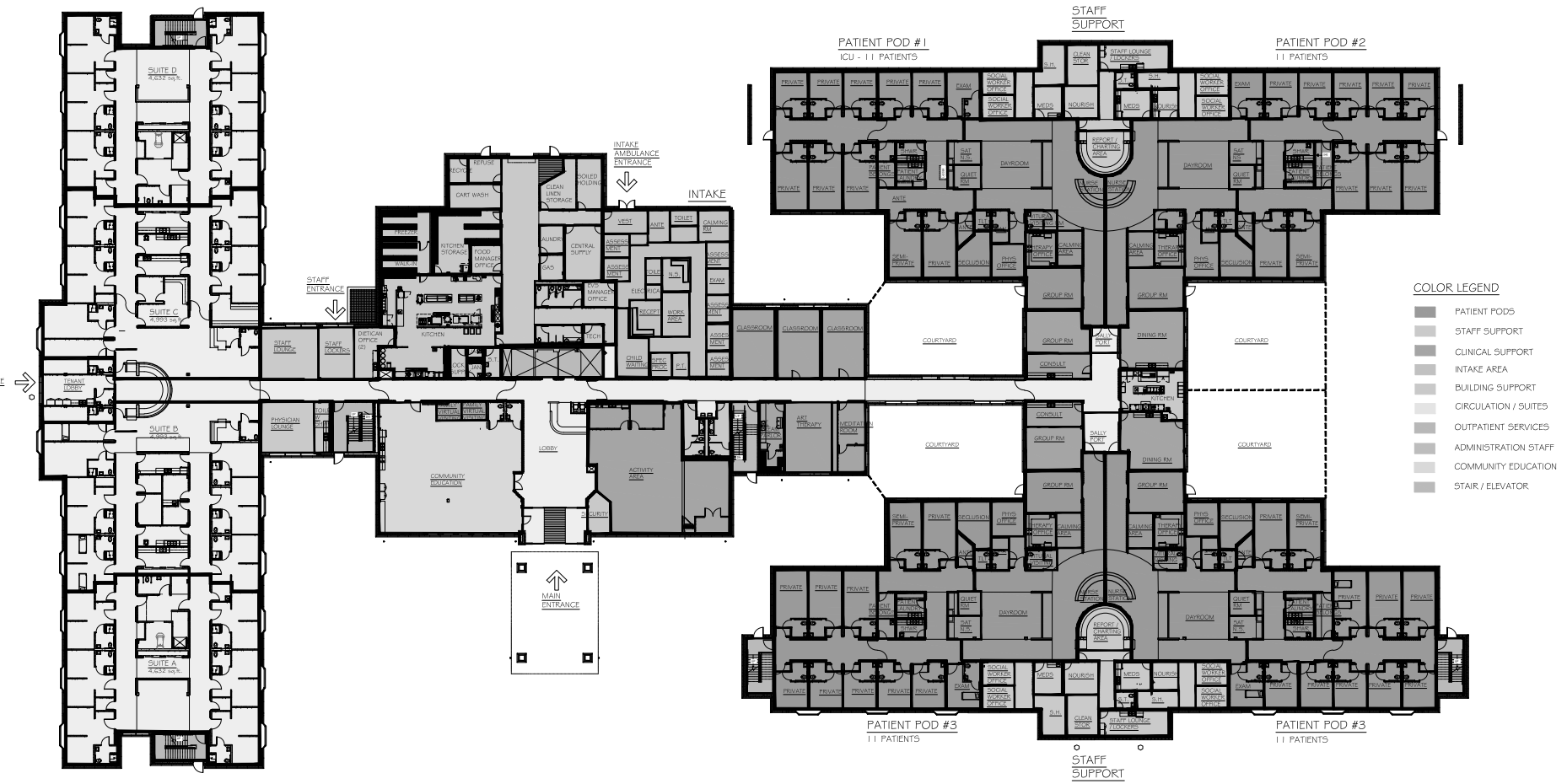


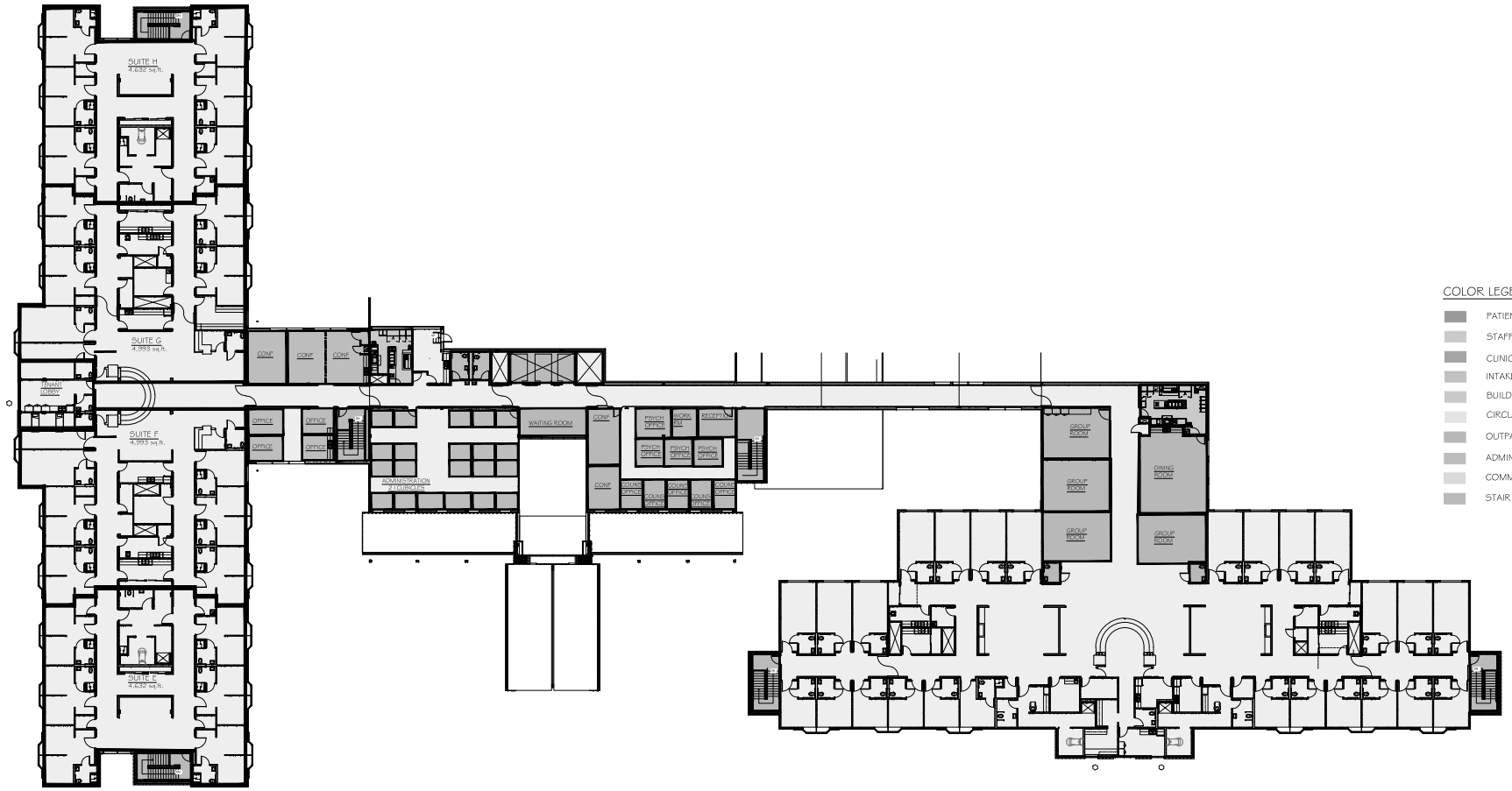
1 OVERALL FIRST FLOOR PLAN
1/16" = 1'-0"

UnityPoint Health BEHAVIORAL HEALTH FACILITY CONCEPTUAL PLANNING

Architectural Design Group INCORPORATED

JUNE 29, 2022

Attachment 4



1 OVERALL SECOND FLOOR PLAN
1/16" = 1'-0"

UnityPoint Health BEHAVIORAL HEALTH FACILITY CONCEPTUAL PLANNING

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JUNE 29, 2022