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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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January 23, 2024

VIA EMAIL (shpda.online@shpda.alabama.gov)

Hon. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: North Alabama Shoal Hospital's Proposed Adjustment to the Alabama State Health Plan

Dear Ms. Marsal:

On behalf of North Alabama Shoals Hospital, an Alabama licensed acute care hospital ("Shoals Hospital"), I am e-filing an electronic copy of the above-referenced Proposed Adjustment to the State Health Plan today. Enclosed, please find the receipt for the filing fee in the amount of $3,500 paid via the SHPDA online payment portal in connection with such filing.

Thank you for your assistance with this matter. Please feel free to contact me with any questions or if you need any additional information.

Best regards,

HOLLAND & KNIGHT LLP

Kristen Larremore

Kristen Larremore

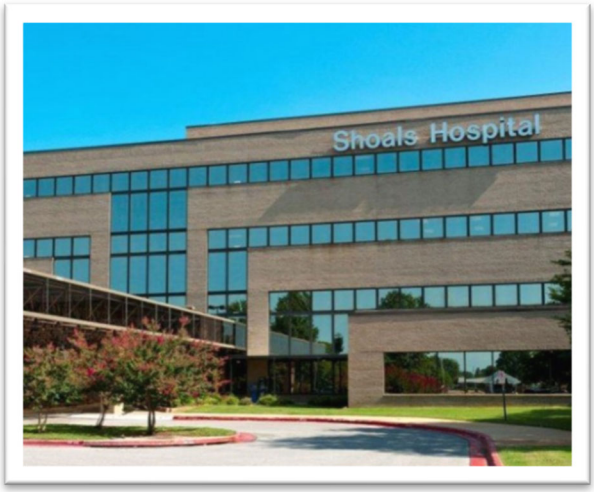
Enclosures

Application for State Health Plan Adjustment

North Alabama Shoals Hospital

Colbert County

Adult and Child/Adolescent Psychiatric Beds



To support a Psychiatric Residency Program and meet the needs of the North Psychiatric Planning Region

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Exhibits

Applicant Identification. An application for a Plan Adjustment must be filed in accordance with SHPDA Rule 410-1-3-.09 and accompanied by the administrative fee specified in Rule 410-2-5-.04(c)(5). The application must include the name of the applicant, physical address, telephone number, the contact person and mailing address, telephone number, and e-mail address.

Name of Applicant:

North Alabama Shoals Hospital

Physical Address:
201 W. Avalon Ave
Muscle Shoals, AL 35661

Telephone number:
(256) 386-1701

Contact Person:
Doug Holzbog
201 W Avalon Ave
Muscle Shoals, AL 35661
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doug.holzbog@shoalshospital.com

Project Description. Provide a narrative statement explaining the nature of the request, with details of the plan adjustment desired. (If the request is for additional beds, indicate the number and type, i.e., Psychiatric, Rehabilitation, Pediatric, Nursing Home, etc.) The narrative should address availability, accessibility, cost, quality of the health care in question, and state with specificity the proposed language of the adjustment.

North Alabama Shoals Hospital ("Shoals Hospital") submits this State Health Plan Adjustment Application (the "Adjustment") to address the overwhelming, unmet need for inpatient Adult and Child/Adolescent psychiatric beds within Colbert County and the North Psychiatric Planning Region of Alabama (the "North Region"). Shoals Hospital is a 157-bed licensed acute care hospital located in Muscle Shoals, Colbert County, Alabama that features a newly established Psychiatric Residency Program. Additionally, Shoals Hospital is affiliated with the North Alabama Medical Center ("NAMC") located in Florence, Lauderdale County, Alabama. As NAMC lacks a psychiatric program of its own to provide in-patient psychiatric care services, Shoals Hospital

regularly receives patient referrals from NAMC. For this reason, this Application includes relevant patient data from both facilities.

Shoals Hospital faithfully serves the residents and communities of Colbert County, as well as neighboring areas in Northwest Alabama, by providing extensive geriatric and adult psychiatric care through its 20-bed Adult Behavioral Health Unit and 30-bed Geriatric Behavioral Health Unit. From January to October of 2023, the facility averaged seventeen (17) occupied adult beds out of the twenty (20) available beds and thirteen (13) occupied geriatric beds out of the available thirty (30) beds. See **Exhibit 1** (Shoals Hospital data of bed occupancy for January-October of 2023). Both psychiatric units are overseen by a Medical Director, Dr. Narahari, and staffed by highly trained and qualified healthcare personnel. See **Exhibit 2** (Dr. Narahari's CV).

Shoals Hospital proposes to add an additional ten (10) adult psychiatric beds to the hospital and create an additional sixteen (16) bed adolescent unit (the "Project"). To do so, the Shoals is seeking approval of this Adjustment to create these additional beds in the North Region to allow Shoals Hospital the opportunity to then apply to the Certificate of New Review Board as a second step for approval of such Project to add psychiatric beds at its hospital and to remodel the facility's current Geriatric and Adult Behavioral Health units to add a Child/Adolescent Unit and expand the Adult Behavioral Health unit.

Colbert County is one of the ten counties comprising the North Region, in which there are six (6) total providers with psychiatric beds who provide various types of psychiatric services. Of these providers, there are five (5) providers of adult psychiatric services and **only one (1) facility––Decatur Morgan West—that provides access to adolescent psychiatric beds**. See **Exhibit 3** (2022 SHPDA data of Psychiatric Beds by Category in the North Region). Decatur Morgan West is often at capacity and cannot alone meet the full North Region demand for adolescent psychiatric

services through its limited number of beds. This lack of adolescent beds poses a detrimental risk not only to individuals seeking care, but to Shoals Hospital staff and other emergent patients at the hospital. For example, the lack of adolescent beds recently forced Shoals Hospital to hold an adolescent patient in the hospital's emergency department ("ED") for over three (3) days due to the lack of available adult beds or nearby adolescent beds at the unit in Decatur. The patient became increasingly anxious to the point of tearing a room apart in the emergency department. The patient then assaulted a police officer and was placed under arrest. Instead of receiving the care the teen so desperately needed, the patient was moved to the juvenile detention center. These cases are unfortunately not uncommon at Shoals Hospital where psychiatric patients must be held in the emergency department for extended periods of time until they can be placed in an inpatient psychiatric bed. Not only do these events compromise care to other emergent patients by taking emergency department rooms out of service, but they disrupt the attention of staff and upset the overall health delivery system. An emergency department is far less than an optimal setting to provide care to a psychiatric patient for such extended periods of time.

There are many factors contributing to the lack of available psychiatric beds in Colbert County. Due to closures of the state psychiatric hospitals in recent years, individuals suffering from debilitating mental illnesses have limited resources to turn to for treatment. An overwhelming number have been forced into the Alabama penitentiary system or are temporarily housed in hospital emergency departments. Shoals Hospital and NAMC regularly hold adolescent and adult psychiatric patients in their emergency department rooms due to such lack of available beds. See **Exhibit 4**. From January 1st, 2023 to August 30th, 2023, Shoals Hospital had fifteen (15) cases where an adolescent patient could not receive a psychiatric bed for needed treatment; twenty-four (24) cases where there were long wait times due to the lack of availability of a psychiatric bed;

and twelve (12) cases where the patient had an elopement event and left the facility against medical advice ("AMA") due to lack of timely placement and access to necessary psychiatric care. See the excerpt from **Exhibit 4A** below.

Excerpt of Exhibit 4A
Shoals Hospital Adolescent Patient Data, *January-August 2023*

SHOALS 01.01.23 - 08.30.23 - Adolescent Psych Patients				
D#	Date	AGE	Total LOS	Dispo
639321	1/9/2023	14	4.55	AMA
639404	1/10/2023	14	16.29	TXF
639483	1/12/2023	17	6.09	HOME
640602	1/26/2023	18	25.34	TXF
640675	1/27/2023	18	87.24	TXF
640940	1/31/2023	18	17.53	TXF
641262	2/3/2023	16	83.55	TXF
641553	2/7/2023	14	0.55	AMA
641706	2/9/2023	15	2.08	AMA
641828	2/10/2023	18	19.16	AMA
642386	2/18/2023	18	2.4	HOME
642814	2/23/2023	14	18.51	TXF
642873	2/24/2023	16	39.56	TXF
643948	3/14/2023	18	19.53	TXF
644130	3/16/2023	14	17.32	HOME
644669	3/25/2023	18	26.29	AMA
645594	4/9/2023	13	21.25	TXF
646006	4/15/2023	17	42.25	TXF
646039	4/16/2023	18	36.45	TXF
647080	5/1/2023	18	30.25	TXF
647429	5/6/2023	18	0.48	HOME
647861	5/12/2023	14	8.3	AMA
647868	5/13/2023	12	0.26	AMA
647934	5/14/2023	13	2.19	AMA

Case who could not receive beds, lack of beds

Elopements due to lack of Care

Long Wait times, could not be placed quickly

Comparison LWOT/AMA/Stay > 6 Hours 01.01.23 - 08.30.23	
AMA	28%
LWOT	3%
Stay > 6 Hrs	60%
08.31.23-11.28.23	
AMA	19%
LWOT	4%
Stay > 6 Hrs	33%

648222	5/17/2023	18	4.22	HOME
648454	5/22/2023	15	4.39	HOME
648789	5/26/2023	12	26.37	AMA
648823	5/26/2023	11	36.13	TXF
648923	5/30/2023	8	3.32	HOME
649031	5/31/2023	16	6.54	TXF
649807	6/10/2023	13	0.1	LWOBSPTT
650112	6/14/2023	18	10.3	TXF
650175	6/15/2023	18	11.21	TXF
650278	6/17/2023	18	90.51	TXF
650601	6/21/2023	15	18.24	TXF
650679	6/23/2023	15	1.08	HOME
652540	7/21/2023	18	22.22	HOME
653541	8/6/2023	17	4.27	HOME
653777	8/9/2023	18	8.35	AMA
654622	8/22/2023	17	0.36	AMA
655226	8/30/2023	8	20.22	HOME
		TOTAL TIME	795.25	
		AVERAGE TIME	19.4	

Additionally, from August 31st, 2023, to November 28th, 2023, alone, Shoals Hospital had eleven (11) cases where an adolescent patient could not receive a psychiatric bed for needed treatment; seven (7) cases where there were long wait times due to the lack of availability of a psychiatric bed; and five (5) cases where the patient had an elopement event and left the facility AMA due to lack of timely placement and access to necessary psychiatric care. See the excerpt from **Exhibit 4A** below.

Excerpt of Exhibit 4A
Shoals Hospital Adolescent Patient Data, *August-November 2023*

SHOALS HOSPITAL 08.31.23 - 11.28.23 - Adolescent Psych Patients				
D#	Date	AGE	Total LOS	Dispo
655433	9.01.23	18	14.3	AMA
655618	9.05.23	18	2.04	AMA

655644	9.06.23	18	8.55	AMA	Case who could not receive beds, lack of beds
661044	11.23.23	18	2.1	AMA	Elopements due to lack of Care
655532	9.03.23	16	3.08	Home	Long Wait times, could not be placed quickly
655637	9.05.23	16	4.45	Home	
657430	9.30.23	18	2.59	Home	
659621	11.1.23	15	2.44	Home	
659794	11.4.23	18	7.37	Home	
660180	11.9.23	12	3.29	Home	
660293	11.11.23	15	13.52	Home	
660318	11.12.3	15	2.44	Home	
660350	11.12.23	18	1.49	Home	
660603	11.15.23	15	1.09	Home	
660626	11.16.23	16	2.34	Home	
660776	11.17.23	17	3.17	Home	
660789	11.18.23	7	5.34	Home	
660835	11.19.23	18	2.37	Home	
656569	9.19.23	13	0.08	LWOT	
656369	9.15.23	13	38.35	TXF	
658238	10.12.23	14	18.52		
	Total		138.92		
	Average		6.62		

This crisis in psychiatric care is further evidenced by North Alabama Medical Center's 2023 data for the period of January 1st, 2023 to August 30th, 2023, where twelve (12) adolescent psychiatric patients could not receive beds; twenty-one (21) adolescent psychiatric patients suffered long wait times due to lack of beds before finally being placed to receive psychiatric

treatment; and three (3) adolescent patients had an elopement event and left the facility against medical advice due to the inability to timely place the patient in a psychiatric in-patient bed. See excerpt from **Exhibit 4B** below.

Excerpt from Exhibit 4B
NAMC Adolescent Patient Data, *January-August 2023*

NAMC 01.01.23 - 08.30.23 - Adolescent Psych Patients									
E#	Date	AGE	Total LOS	Dispo	E#	Date	AGE	Total LOS	Dispo
2107145	01.01.23	15	23.01	TXF	2136750	04.07.23	15	26.57	TXF
2107640	01.03.23	16	2.22	HOM	2136949	04.08.23	14	17.24	TXF
2108958	01.07.23	13	4.01	HOM	2137453	04.10.23	14	18.02	TXF
2109056	01.08.23	18	3.54	HOM	2137696	04.11.23	16	6.08	HOM
2111220	01.16.23	13	5	HOM	2137349	04.12.23	16	7.37	HOM
2112157	01.18.23	13	18.52	TXF	2138944	04.14.23	18	9.03	HOM
2112918	01.20.23	17	0	LWOT	2138987	04.14.23	17	9.34	HOM
2113177	01.22.23	16	21	TXF	2141467	04.23.23	14	4.15	HOM
2113954	01.24.23	12	2.18	HOM	2141468	04.23.23	14	17.4	TXF
2114310	01.25.23	15	7.39	HOM	2144238	05.01.23	13	3.16	HOM
2115107	01.28.23	16	1.11	HOM	2144376	05.01.23	14	3.27	HOM
2115674	01.31.23	17	4.47	HOM	2146841	05.09.23	12	5.29	HOM
2115678	01.31.23	14	3.46	HOM	2147637	05.12.23	13	24.4	TXF
2115747	01.31.23	15	1.58	HOM	2148010	05.13.23	14	7.12	HOM
2115887	01.31.23	17	3.09	HOM	2148216	05.14.23	11	5.18	HOM
2116889	02.02.23	7	25.38	TXF	2152568	05.29.23	11	12.58	TXF
2117206	02.03.23	18	3.22	HOM	2154020	06.01.23	13	7.17	TXF
2117899	02.07.23	15	19.33	TXF	2154975	06.05.23	10	3.49	AMA
2118269	02.07.23	13	6.52	HOM	2156998	06.12.2	8	19.16	TXF
2118443	02.08.23	13	9.53	HOM	2158448	06.16.23	17	4.26	HOM
2121370	02.16.23	16	5.21	HOM	2159214	06.19.23	14	12.05	TXF
2121980	02.20.23	16	3.57	HOM	2161134	06.27.23	15	2.46	HOM
2122656	02.21.23	17	6.17	TXF	2161524	06.27.23	6	12.24	HOM

Case who could not receive beds, lack of beds

Elopements due to lack of Care

Long Wait times, could not be placed quickly

2122731	02.21.23	14	2.37	HOM	2162364	06.29.23	14	1.37	HOM
2123595	02.24.23	16	5.34	HOM	2164316	07.06.23	13	3.39	HOM
2124911	02.28.23	16	18.05	TXF	2165696	07.11.23	17	14.22	TXF
2125412	03.01.23	12	4	HOM	2171296	07.30.23	15	1.37	HOM
2127026	03.06.23	17	5.58	HOM	2172731	08.02.23	15	2.16	HOM
2127760	03.08.23	14	28.02	TXF	2173061	08.03.23	15	3.09	HOM
2131026	03.20.23	14	0	LWOT	2173451	08.05.23	13	5.12	TXF
2131228	03.21.23	17	2.45	HOM	2173991	08.08.23	17	3.3	HOM
2131110	03.20.23	13	16.26	TXF	2175147	08.10.23	8	16.27	TXF
2132258	03.24.23	14	16.51	TXF	2175506	08.11.23	13	2.41	HOM
2138492	03.24.23	12	68.42	TXF	2175527	08.11.23	17	9.09	HOM
2132783	03.26.23	15	1.45	HOM	2175648	08.12.23	14	17.27	HOM
2133727	03.29.23	11	43.7	HOM	2176240	08.15.23	12	17.01	HOM
2133825	03.29.23	8	5.18	HOM	2176925	08.16.23	16	1.3	HOM
2134983	04.03.23	13	53.57	HOM	2178442	08.21.23	13	9.4	HOM
2136172	04.06.23	15	3.55	TXF	2178850	08.22.23	7	11.07	TXF
2136237	04.06.23	16	3.19	HOM	2179925	08.25.23	5	19.01	HOM
		TOTAL	457.15				TOTAL	373.88	
				TOTAL	831.03				
				AVERAGE	10.6542307				

Further, from August 31st, 2023 to November 28th, 2023, NAMC had instances where eighteen (18) adolescent psychiatric patients could not receive beds; fifteen (15) adolescent psychiatric patients suffered long wait times due to lack of beds before finally being placed to receive psychiatric treatment; and three (3) adolescent patients had an elopement event and left the facility against medical advice due to the inability to timely place the patient in a psychiatric in-patient bed. See excerpt from **Exhibit 4B** below.

Excerpt from Exhibit 4B
NAMC Adolescent Patient Data, *August-November 2023*

NAMC 08.31.23 - 11.28.23 - Adolescent Psych Patients					
E#	Date	Age	Total LOS	Dispo	
2184527	9/10/2023	18	3.05	AMA	
2190468	9/28/2023	18	1.1	AMA	
2183283	9/6/2023	12	3.07	Home	
2184531	9/10/2023	18	1.15	Home	
2186269	9/14/2023	18	2.41	Home	
2187542	9/19/2023	16	5.28	Home	Case who could not receive beds, lack of beds
2187557	9/19/2023	15	6.11	Home	Elopements due to lack of Care
2188767	9/23/2023	15	3.35	Home	Long Wait times, could not be placed quickly
2195934	10/17/2023	17	34.41	Home	
2208376	11/26/2023	15	43.48	Home	
2182537	11/2/2023	15	4.14	Home	
2190802	9/29/2023	18	0.02	LWOT	
2182470	9/1/2023	8	15.09	TXF	
2184471	9/9/2023	17	6.39	TXF	
2187184	9/18/2023	8	16.12	TXF	
2187901	9/20/2023	12	58.48	TXF	
2187669	9/20/2023	16	18.49	TXF	
2188801	9/23/2023	8	4.38	TXF	
2189591	9/26/2023	11	29.35	TXF	
2190032	9/27/2023	8	20.51	TXF	
2192422	10/4/2026	13	44.42	TXF	
2193068	10/6/2023	16	27.36	TXF	

2193191	10/7/2023	13	35.06	TXF
2195246	10/14/2023	13	29.48	TXF
2196216	10/17/2023	11	22.25	TXF
2201424	11/2/2023	12	12.33	TXF
2205074	11/13/2023	17	25.37	TXF
		TOTAL TIME	472.65	
		AVERAGE TIME	17.51	

Additionally, NAMC adult patient ER data for the period of January 1st, 2023 to November 30th, 2023 indicates that a total of sixty-one (61) adult patients had elopement events and left the NAMC emergency department. Of these adult patients, thirty-two (32) left the ED against medical advice and twenty-nine (29) adult patients left the ED without treatment. See excerpt from **Exhibit 13** below. Typically, AMA and LWOT elopement events occur due to the inability to timely place the patient in a psychiatric in-patient bed. This Project seeks to remedy these issues by filling the existing gap in adolescent and adult psychiatric services for Colbert County and surrounding areas within the North Region.

Excerpt from Exhibit 13
NAMC Adult and Geriatric Patient ER Data, *January-November 2023*

01.01.23 - 11.30.23 NAMC ER Adult Psych Patients LOG													
DATA	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Totals	
Total Patients	107	78	84	86	67	76	56	93	97	69	83	896	Total
Male Patients	56	35	47	41	28	38	28	48	55	29	34	439	Total
Female Patients	51	43	37	45	39	38	28	45	42	40	49	457	Total
Pediatrics	16	12	11	13	7	9	3	15	8	5	3	102	Total
Adult	86	60	65	64	56	56	47	68	73	56	70	701	Total
Geri	5	6	8	10	4	11	6	10	7	6	9	82	Total
AMA	5	3	4	0	2	3	2	3	7	1	2	32	Total
LWOT	9	2	4	1	0	0	0	3	7	2	1	29	Total
Greater than 5 HRS LOS	33	31	29	34	33	40	19	49	39	25	30	362	Total
Average LOS	5.08	8.35	8.15	6.43	8.10	7.06	6.23	6.37	7.17	7.33	7.55	7.07	(Average)
TXFR OUT	17	24	9	10	14	11	5	13	19	12	17	151	Total

A lack of access to necessary psychiatric care is especially concerning given the state of mental health in our country for the adult and adolescent populations. According to the Centers for Disease Control and Prevention (the "CDC"), more than 1 in 5 adults live with a mental illness and over 1 in 5 youth (ages 13-18) either currently, or at some point during their life, have dealt with a seriously debilitating mental illness. See **Exhibit 5**. As the conversation regarding mental health in our nation evolves, the increasing need for psychiatric services and lack of availability of treatment to address those needs has become abundantly apparent and such is expected to continue for the foreseeable future.

According to the U.S. Census Bureau, the total population of those nineteen (19) years old and younger in Colbert County was estimated to be 13,263 in 2022 and 170,716 for the North Region for 2022. This is a vulnerable age demographic that is facing unprecedented mental health challenges as reflected in the recent U.S. Surgeon General's Public Health Advisory, Protecting Youth Mental Health. See **Exhibit 6**. According to the advisory, the COVID-19 pandemic dramatically changed the world of young adults, shifting the trajectory of how they attend school, interact with friends, and receive healthcare. *Id*. Since the start of the pandemic, rates of physiological distress among young people have increased, including symptoms such as anxiety, depression, and other mental health disorders. *Id*. Most disturbing of all, suicide is now the **second** leading cause of death for youth and young adults aged 10-24 years-old. See **Exhibit 5**. The U.S. Surgeon General's advisory reports that in early 2021, emergency department visits in the U.S. for suspected suicide attempts had increased by 51% for adolescent girls and by 4% for adolescent boys compared to the same time frame in 2019. See **Exhibit 6**. Overall, the suicide rates for the 10–24-year-old age group have increased 52.2% between 2000-2021. See **Exhibit 5**.

The crisis is not just limited to adolescents. In the state of Alabama, the Substance Abuse and Mental Health Services Administration ("SAMHSA") reports an estimated 41% of Alabama adults sought medical treatment for a mental health issue between 2017–2019 (See Alabama Department of Public Health, Mental Health and Substance Abuse, available at https://www.alabamapublichealth.gov/healthrankings/mental-health-and-substance-abuse.html). For severe mental illnesses ("SMI") in Alabama—which includes illnesses such as schizophrenia spectrum disorders, severe bipolar disorder, and major depression with psychotic features—the Treatment Advocacy Center estimates that 134,875 individuals are currently suffering from SMI in 2024 (See Treatment Advocacy Center, available at: https://www.treatmentadvocacycenter.org/map_directory/alabama/#alabama).

Further, lack of access to mental health poses enhanced risks to a patient's overall health. As explained by the CDC, depression has the potential to not only lead to suicide, but also increases the risk for many types of physical health problems, "particularly long-lasting conditions like diabetes, heart disease, and stroke." See **Exhibit 5**. Likewise, the presence of such chronic conditions can increase the risk for mental illness. *Id*.

While the Alabama State Health Plan for 2020-2023 does not show a need for additional psychiatric beds, many children, adolescents, and adults are in dire need of mental health treatment in Colbert County and the surrounding areas of the North Region, yet are unable to access these services. Creating a sixteen (16) bed child/adolescent psychiatric unit in Colbert County is projected to enhance and expand the availability and accessibility of care that is critical to the well-being of the most vulnerable populations—children and adolescents under the age of eighteen (18). Additionally, the proposal to add ten (10) adult psychiatric beds to the North Region will help to meet the needs of the ever-expanding demand for such services in the area and allow for timelier

placement of such patients in an inpatient psychiatric bed and allow hospitals, such as NAMC and Shoals Hospital, to have use of their ER rooms for truly emergent patients rather than housing psychiatric patients in critical emergency department space not designed for such purposes.

The quality of healthcare for adults and adolescents in Colbert County and surrounding counties in the North Region will be improved due to the increased access to adult and adolescent mental health treatment services. This increased access to adolescent psychiatric services will offer such patients the opportunity to receive psychiatric care in Colbert County and thereby keep such patients closer to home. There is a high-stress level for families dealing with issues in the adolescent psychiatric population and providing a location for quality psychiatric care in closer proximity to home will allow an enhanced experience for both the patients and their families.

Shoals Hospital has the staffing capabilities for this Project and is currently employing and/or contracting with several psychiatrists. See **Exhibit 7** for a listing of Shoals Hospital's mental health services providers. Further, Shoals Hospital has recently enhanced its future access to psychiatric resources through the addition of a Psychiatric Residency Program in July of 2023––overseen by Dr. Narahari as the Program Director. See **Exhibit 2** (Dr. Narahari's CV). This four-year program is highly unique and only the third of its kind in the state of Alabama. Each year, the program will accept five (5) residents. In July of 2023, five (5) first and lateral second year residents began the program. In total, there will be twenty (20) psychiatric residents working at both Shoals Hospital and NAMC as of July 1, 2025. The first class of residents will graduate in June of 2026. This program will provide a vital staffing pipeline for Shoals Hospital and attract young physicians to Muscle Shoals and the Colbert County area. Expansion of adult and child/adolescent psychiatric beds at Shoals Hospital, and such increased access in the service area,

will complement the much-needed access to training that these young psychiatrist residents will need as they prepare for their careers and evaluate where they will start their practice.

Service Area. Describe the geographical area to be served. (Provide an 8 ½ ″ x 11″ map of the service area. The map should indicate the location of other similar health care facilities in the area.)

As mentioned, this Adjustment request is for an increase in adult and adolescent psychiatric beds specifically for Colbert County, within the North Region, so as to provide the necessary increased capacity to meet current demands within this area and also to support the psychiatric residency program at Shoals Hospital. Currently, Shoals Hospital is the **only provider** of adult psychiatric beds in not only Colbert County, but the surrounding counties of Lauderdale County and Franklin County as well, and there are **no providers** of child/adolescent psychiatric inpatient services in Colbert County, Lauderdale County, or Franklin County. Notably, the closest provider of child/adolescent inpatient psychiatric services is a fifty-minute drive away in Morgan County.

A map reflecting all current providers of Adult and Child/Adolescent inpatient treatment services in the North Region is included with this application. See **Exhibit 8**. Since Colbert County is in the North Region for psychiatric planning purposes, the map includes the locations of all psychiatric providers within the planning region.

Also, attached as **Exhibit 9** is the existing Alabama Department of Public Health ("ADPH") facility directory for Hospitals and Related Facilities with hospitals in the North Region that reported psychiatric beds for 2022 highlighted. Within the ten (10) counties making up the North Region, there are only four (4) providers of adult psychiatric beds and one (1) provider of child/adolescent beds in the North Region for a total of eighty-three (83) adult psychiatric beds and thirty-eight (38) child/adolescent psychiatric beds to serve the entire northern portion of the State. *Id*. As reflected herein, this has been insufficient to provide much-needed access to these services for psychiatric patients presenting in the Shoals Hospital and NAMC emergency departments—as reflected by the psychiatric patient statistics included in **Exhibits 5, 4,** and **13**.

Population Projections. Provide population projections for the service area. In the case of beds for a specific age group, such as pediatric beds or nursing home beds, document the existence of the affected population. An example for nursing home beds is the number of persons 65 and older. The applicant must include the source of all information provided.

The latest CBER projections indicate that Colbert County is a growing county with a population of 57,227 residents as of 2020. By 2040, it is projected that the population of Colbert County will **increase 4.0 percent** to a population of 59,532.

Within the North Region, the total population of the region was 1,069,178 in 2020. By 2040, it is projected that the population of the region will be 1,256,264, an **increase of 17.49 percent**. This data is provided below and attached to the Application as **Exhibit 10**.

North Psychiatric Care Region Population 2000-2020 and Projections 2025-2040

County	Census 2000	Census 2010	Census 2020	2025	2030	2035	2040	Change 2020-2040 Number	Change 2020-2040 Percent
Alabama	*4,447,100*	*4,779,736*	*5,024,279*	*5,165,416*	*5,306,554*	*5,447,691*	*5,588,829*	*564,550*	*11.2*
Colbert	54,984	54,428	57,227	57,803	58,380	58,956	59,532	*2,305*	*4.0*
Cullman	77,483	80,406	87,866	90,403	92,940	95,477	98,014	*10,148*	*11.5*
Franklin	31,223	31,704	32,113	32,349	32,584	32,820	33,056	*943*	*2.9*
Jackson	53,926	53,227	52,579	52,297	52,015	51,733	51,452	*-1,127*	*-2.1*
Lauderdale	87,966	92,709	93,564	94,966	96,368	97,770	99,172	*5,608*	*6.0*
Lawrence	34,803	34,339	33,073	32,686	32,298	31,911	31,523	*-1,550*	*-4.7*
Limestone	65,676	82,782	103,570	112,669	121,768	130,867	139,966	*36,396*	*35.1*
Madison	276,700	334,811	388,153	414,976	441,800	468,623	495,446	*107,293*	*27.6*
Marshall	82,231	93,019	97,612	101,346	105,081	108,815	112,549	*14,937*	*15.3*
Morgan	111,064	119,490	123,421	126,454	129,488	132,521	135,554	*12,133*	*9.8*

Source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, August 2022

Further, the U.S. Census Bureau estimates that the total population of adolescents in Colbert County 19-years-old and younger was 13,263 as of 2022, which is a steady increase as compared to the agency estimate of 12,695 in 2020. For the North Region, the Census Bureau estimated the area had a population of 170,716 for adolescents 19-years-old and younger in 2022. The rapidly increasing population in the North Region overall, as well as the increasing adolescent population for Colbert County, will only further exacerbate the challenges that currently exist in providing adult and adolescent patients timely access to life saving psychiatric services.

Need for the Adjustment. Address the current need methodology. If the application is to increase beds or services in a planning area, give evidence that those beds or services have not been available and/or accessible to the population of the area.

The current need methodology for psychiatric beds, found in Ala. Admin Code 410-2-4-.10, provides a calculation based on the category of bed and designated region in which the facility's county is located. There are three (3) categories of psychiatric beds: (1) child/adolescent, (2) adult, and (3) geriatric. Muscle Shoals, where Shoals Hospital is located, is located in Colbert

County, which is one of ten counties included in the North Psychiatric Planning Region. As stated in the need methodology, "any region that shows an occupancy rate of 75 percent (75%) or greater in any one of the three (3) bed categories shall be eligible for additional beds in that category."

The following table reflects the currently licensed psychiatric beds in the North Region.

North Region Psychiatric Care Beds

County	Number of Facilities	Number of Adult Beds	Number of Child/Adolescent Beds
Colbert	1	20	0
Cullman	2	20	0
Franklin	0	0	0
Jackson	0	0	0
Lauderdale	0	0	0
Lawrence	0	0	0
Limestone	0	0	0
Madison	2	23	0
Marshall	1	10	0
Morgan	1	0	38

Based on SHPDA data from the 2022 Hospital Annual Reports, the occupancy rate for the adult psychiatric category in the North Region is currently 60.96%.

As there is only one (1) provider of adolescent psychiatric beds in the North Region, there is only one occupancy rate to calculate for the child adolescent category. In 2022, Decatur Morgan West had an occupancy rate of 65.49%. See **Exhibit 3**.

However, as noted, the current methodology does not account for the unfortunate fact that there is only **one (1)** provider with **thirty-eight (38)** available child/adolescent psychiatric beds serving a region with a total population of well over 1,000,000 people that is projected to grow by over 17% by 2040 per the available CBER data. It has also not been the experience of Shoals Hospital and NAMC that adult patients have ready and timely access to an adult inpatient

psychiatric bed as reflected in the Emergency Department statistics contained in **Exhibit 13**, which reflect significant issues experienced by these facilities in being able to provide timely access to care and to avoid AMA and LWOT events.[1] Timely access to inpatient psychiatric care can literally be the difference between life and death for psychiatric patients.[2]

The lack of available psychiatric care options in Alabama has severely exacerbated the mental health crisis in the state. According to UnitedHealthcare, recent findings by Forbes identify Alabama as one of the top ten (10) worst states for behavioral health care based on a variety of measures, including: (i) prevalence of unmet behavioral health needs, (ii) the lack of nearby behavioral health facilities, and (iii) the number of individuals who are currently uninsured and living with mental illness (See UnitedHealthcare*, 5 ways to help employees in Alabama find the behavioral health care they need,* (June 2, 2023)) (Attached as **Exhibit 11**).

Further, the children and adolescents of our state are still feeling the repercussions of the COVID-19 pandemic, which created a surge in demand for child/adolescent psychiatric services. According to a 2023 Trends Report from the American Psychological Association ("APA"), not only did nearly all children and teens faced social isolation and academic disruption during the pandemic, but many also lost caregivers, had parents lose jobs, or were victims of physical or emotional abuse at home. See **Exhibit 12**. The CDC provides statistics for these pandemic stressors, estimating that 29% of all U.S. high school students had a parent or caregiver lose their job, 55% suffered emotional abuse by a parent or caregiver, and 11% were physically abused. See **Exhibit 5**. These difficulties felt by our nation's youth have materialized in statistically higher rates of suicide and depression among the teen demographic. However, struggles faced during this

[1] Patients leaving against medical advice ("AMA") and/or leaving without treatment.
[2] Instances of AMA and LWOT are typically due to the inability to promptly move a psychiatric patient from the ER to an inpatient psychiatric bed.

time period are only a few of the contributing factors to the current care dilemma. Other instrumental components include negative messages, such as online bullying and unrealistic beauty standards, and structural issues such as poverty, food insecurity, homelessness and lack of educational opportunities and healthcare access, which can lead to stress-response patterns known to underlie mental health struggles. See **Exhibit 12**.

For the greater part of the calendar year 2023, Shoals Hospital was forced to deny two hundred and forty-two (242) individuals, a majority of which were adults, access to psychiatric services and mental health treatment due to lack of available beds. See **Exhibits 4** and **13**. Twenty-six (26) of those individuals were adolescents—from the time periods of January 1st, 2023 to August 30th, 2023 and August 31st, 2023 to November 28th, 2023—and two hundred and sixteen (216) were adults—all of which were seeking the currently existing services offered by Shoals Hospital. *Id*. This access issue is further evidenced by NAMC data. In 2023, NAMC was forced to deny access to psychiatric services to sixty-one (61) individuals, at least thirty (30) of which were adolescents. *Id*. Further, Shoals Hospital and NAMC had a combined total of twenty-nine (29) adolescent patients who could not receive psychiatric services due to lack of bed availability from August 31st, 2023, to November 28th, 2023, and a combined total of fifty-six (56) adolescent patients who could not receive psychiatric services due to lack of an available bed in the majority of 2023—from January 1st, 2023 to November 28th, 2023. *Id*.

Of the adult patients who were denied psychiatric treatment due to lack of timely access to an available bed, some left against medical advice and left without treatment after waiting hours or days in the emergency department because they were forced to wait in the emergency department until an adult or adolescent inpatient psychiatric bed became available. Others were eventually transferred out to other facilities with psychiatric beds. However, due to lack of

available beds in nearby facilities, Shoals Hospital and NAMC have been forced to transfer a significant portion of these patients to out-of-state facilities in Mississippi.

In addition, Shoals Hospital receives numerous requests for referrals that they are unable to accommodate. Once the adult psychiatric beds at Shoals Hospital are full, the hospital will not take referrals. For example, Shoals Hospital consistently receives referrals from nearby hospitals and the Colbert County Probate Court. Individuals needing psychiatric care are then forced to wait in jail or in the emergency departments of referring hospitals until an available adult psychiatric bed opens up at Shoals Hospital. With an expansion of the Adult Behavioral Unit and creation of a Child/Adolescent Behavioral Unit, Shoals Hospital could provide much-needed additional access to high-quality psychiatric care for the individuals in its service area and surrounding counties.

In addition, from 2020-2040, per data from CBER, Colbert County is projected to increase in population by 4 percent and the North Region will increase in population by nearly 18 percent. As the population grows, the need and demand for inpatient psychiatric services will continue to increase as well.

Current and Projected Utilization. Provide current and projected utilization of similar facilities or services within the proposed service area.

As illustrated below, the current utilization of adult psychiatric staffed beds in Colbert County averaged 76.6% from 2018 to 2022.

		2018			2019			2020			2021			2022		
County	Hospital	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate
COLBERT	NORTH ALABAMA SHOALS HOSPITAL	20	5,818	79.70%	20	5,958	81.62%	20	5,748	78.74%	20	5,290	72.47%	20	5,146	70.49%

Source: SHPDA Annual Reports, 2018-2022

Based on internal Shoals Hospital data, the utilization rate for adult psychiatric staffed beds has shown rapid growth for 2023. As illustrated below, Shoals Hospital presented a utilization rate of 84.03% for this past calendar year.

		2023		
County	**Hospital**	Adult Psych Beds Reported	Patient Days	Occupancy Rate
COLBERT	NORTH ALABAMA SHOALS HOSPITAL	20	6,134	84.03%

Source: Internal Shoals Hospital data

As for the North Region, the current utilization of adult psychiatric staffed beds in the averaged 69.43% from 2020 to 2022 as illustrated below.

		2020			2021			2022		
County	**Hospital**	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate
COLBERT	NORTH ALABAMA SHOALS HOSPITAL	20	5,748	78.74%	20	5,290	72.47%	20	5,146	70.49%
CULLMAN	SANCTUARY AT THE WOODLANDS, THE	20	1,193	16.34%	N/A	N/A	N/A	20	68	0.93%
MADISON	HUNTSVILLE HOSPITAL, THE	23	6,422	76.50%	23	6,484	77.24%	23	7,625	90.83%
MADISON	UNITY PSYCHIATRIC CARE - HUNTSVILLE	0	0	N/A	0	0	N/A	0	0	N/A
MARSHALL	MARSHALL MEDICAL CENTER NORTH	10	3,276	89.75%	10	2,910	79.73%	10	2,477	67.86%
MORGAN	DECATUR MORGAN WEST	10	2,754	75.45%	10	2,960	81.10%	10	3,152	86.36%
Regional Totals		**83**	**19,393**	**67.36%**	**63**	**17,644**	**77.63%**	**83**	**18,468**	**63.29%**

Source: SHPDA Annual Reports, 2020-2022

For adolescent psychiatric beds, the current utilization for the one (1) provider in the North Region averaged 56.11% from 2020 to 2022 as shown below.

		2020			2021			2022		
County	**Hospital**	Adolescent Psych Beds Reported	Patient Days	Occupancy Rate	Adolescent Psych Beds Reported	Patient Days	Occupancy Rate	Adolescent Psych Beds Reported	Patient Days	Occupancy Rate
COLBERT	NORTH ALABAMA SHOALS HOSPITAL	0	0	N/A	0	0	0	0	0	N/A
CULLMAN	SANCTUARY AT THE WOODLANDS , THE	0	0	N/A	N/A	N/A	N/A	0	0	N/A
MADISON	HUNTSVILLE HOSPITAL, THE	0	0	N/A	0	0	0	0	0	N/A
MADISON	UNITY PSYCHIATRIC CARE - HUNTSVILLE	0	0	N/A	0	0	N/A	0	0	N/A
MARSHALL	MARSHALL MEDICAL CENTER NORTH	0	0	N/A	0	0	0	0	0	N/A
MORGAN	DECATUR MORGAN WEST	38	6,886	49.65%	38	7,377	53.19%	38	9,083	65.49%
Regional Totals		**38**	**6,886**	**49.65%**	**38**	**7,377**	**53.19%**	**38**	**9,083**	**65.49%**

Source: SHPDA Annual Reports, 2020-2022

Based upon the increasing rate of adults and adolescents requiring psychiatric care, escalating population, and current utilization in Colbert County and the North Region as a whole, the projected utilization and demand for both adult and child/adolescent mental health treatment can be expected to continue to grow.

If additional staffing will be required to support the additional need, indicate the availability of such staffing.

Shoals Hospital believes that there is readily available staffing for the Project based upon its existing relationships and access to staff for its current Adult Behavioral Unit and Geriatric Behavioral Unit. See **Exhibit 7** reflecting psychiatrists already engaged to provide services at

Shoals Hospital. Further, Shoals expects the recent introduction of the Psychiatry Residency Program to generate additional, talented young providers that will be more likely to stay in Colbert County and the North Region.

Effect on Existing Facilities or Services. Address the impact this plan adjustment will have on other facilities in the area both in occupancy and manpower.

The proposed Plan Adjustment anticipates little to no impact on other existing providers of adult and child/adolescent psychiatric services given the demonstrated geographic and access challenges, particularly for child/adolescent patients, from Colbert County to Decatur, Morgan County where the sole provider of adolescent psychiatric services, Decatur Morgan West, is located. In addition, the nationwide mental health crisis which is impacting Alabama as well as the current utilization rates combined with the population growth projections for adults and adolescents in both Colbert County and the North Region is anticipated to further exacerbate the existing access issues and result in continuing higher demand at all facilities for the foreseeable future.

Community Reaction. Give evidence of project support demonstrated by local community, civic and other organizations. (Testimony and/or comments regarding plan adjustment provided by community leaders, health care professionals, and other interested citizens.)

See **Exhibit 14** to this Application for the numerous letters of support provided for the Project. Representative excerpts are displayed below:

"The lack of sufficient psychiatric resources often leads to delays in treatment, impacting the overall well-being and rehabilitation prospects of youth within our system. By expanding these services, we can work together to ensure that our adolescents receive the specialized care they require."

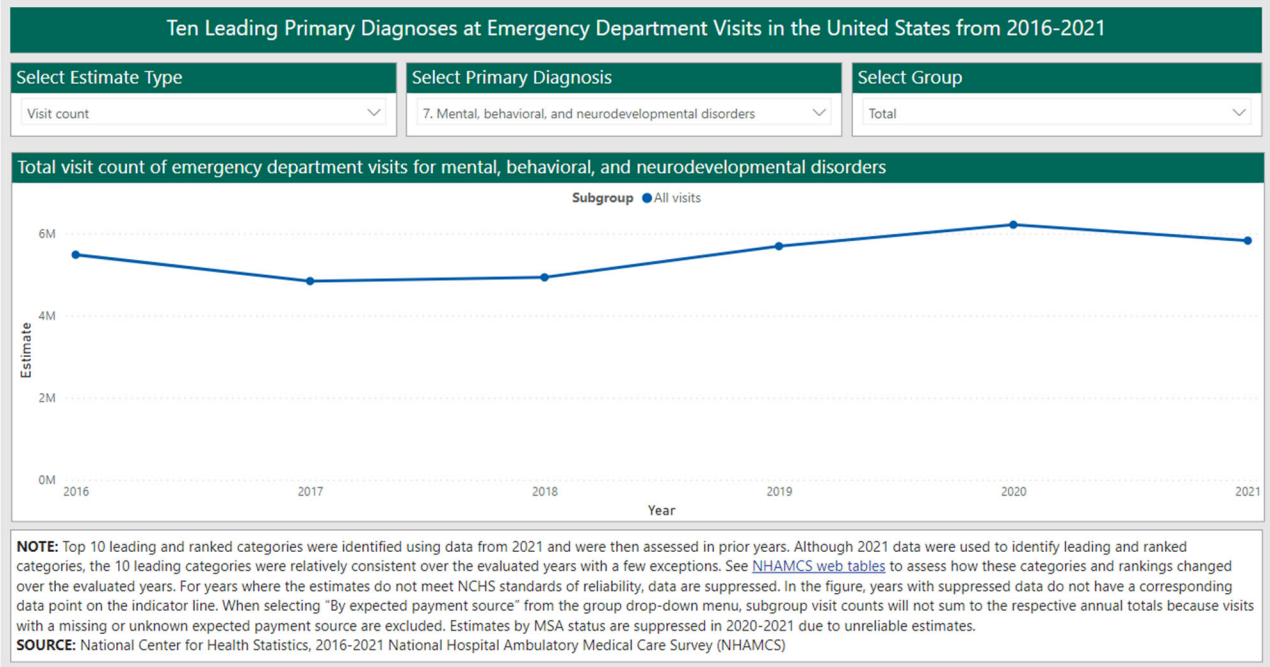
- The Honorable M. Chad Smith
Colbert County District/Juvenile Court Judge

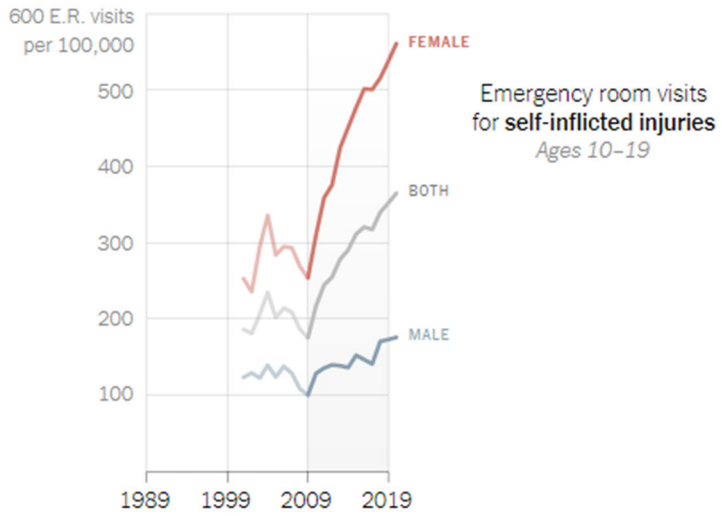
"The proposed Adjustment will provide much-needed increased access to high-quality adult and youth psychiatric treatment in Colbert County and surrounding counties. I see this as a benefit for our entire community."

- Jeff Johnson
Chairman of the Board of Trustees for
North Alabama Shoals Hospital & North Alabama Medical Center

Provide any other information or data available in justification of the plan adjustment request.

The recent struggles of our nation's youth and necessity of additional access to mental health treatment for adolescents and adults is urgent. Emergency room visits by children, adolescents, and adults requiring mental health services, are on the rise nationwide as evidenced by **Exhibit 15** and the charts below.





By The New York Times | Source: Centers for Disease Control and Prevention

In some cases, whether an individual receives care could make the difference between life or death. See **Exhibit 15.** By increasing available adult psychiatric beds and creating the opportunity for a new unit for adolescents in Colbert County, the proposed Adjustment will ease the intensive burden currently placed on the community's first responders and emergency department medical professionals in their role in providing life-saving treatment to the youth and adults of Colbert County.

Proposed Adjustment

In order to provide the necessary adult and child/adolescent psychiatric beds for this proposed Project, Shoals Hospital respectfully requests the below language be added as an adjustment to the psychiatric care section of the State Health Plan as Ala. Admin. Code § 410-2-4-.10(5):

> *Notwithstanding anything to the contrary in the State Health Plan, recognizing the significant and unmet need for additional adult and child/adolescent beds and in conjunction with the implementation of a psychiatry residency program in Colbert County, the Statewide Health Coordinating Council (SHCC), through the adjustment process, adjusted the planning policy to recognize the need for* ***twenty-six (26)*** *additional inpatient psychiatric beds –* ***ten (10)*** *beds for adult psychiatric services and* ***sixteen (16)*** *beds for child/adolescent psychiatric services – to be located in Colbert County, with consideration given to facilities with a psychiatric residency program that can address the specialized needs of children and adolescents.*

The Proposed Adjustment to the State Health Plan presented to the Statewide Health Coordinating Council and Committee is consistent with the following guidelines:

410-2-4-.10 Psychiatric Care

(4) Plan Adjustments

The psychiatric bed need for each region as determined by the methodology is subject to adjustments by the SHCC. The psychiatric bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a target population are not being met by the current bed need methodology.

410-2-5-.04 Plan Revision Procedures

(2) There are three types of plan revisions:

(a) Plan Adjustment. In addition to such other criteria that may be set out in the SHP, a requested modification or exception to the SHP of limited duration, to permit additional facilities, beds, services, or equipment to address circumstances

and meet the identified needs of a specific planning area, or part thereof, that is less than statewide and identified in the State Health Plan. A Plan Adjustment is not of general applicability and is thus not subject to the AAPA's rulemaking requirements. Unless otherwise provided by the SHCC, a Plan Adjustment shall be valid for only one (1) year from the date the Plan Adjustment becomes effective, subject to the exceptions provided in this paragraph. If an Application is not filed with SHPDA seeking a Certificate of Need for all or part of the additional facilities, beds, services or equipment identified in the Plan Adjustment within one (1) year of the Governor's approval of the Plan Adjustment, the Plan Adjustment shall expire and be null and void. If an Application(s) seeking a Certificate of Need for all or part of the additional facilities, beds, services or equipment identified in the Plan Adjustment is filed prior to the expiration of the one (1) year period, the Plan Adjustment shall remain effective for purposes of such pending Certificate of Need Application(s). Such one (1) year period shall be further extended for the duration of any deadline provided by SHPDA for the filing of applications as part of a batching schedule established in response to a letter of intent filed within nine (9) months of the effective date of the adjustment. Upon the expiration of such deadlines, no Certificate of Need Applications shall be accepted by SHPDA which are based, in whole or in part, upon the expired Plan Adjustment.

(3) Application Procedures

(a) Application Procedure for Plan Adjustment. Any person may propose an adjustment to the SHP, which will be considered in accordance with the provisions of SHPDA Rule 410-2-5-.04(4). The proposal will state with specificity the proposed language of the adjustment and shall meet the electronic filing requirements of SHPDA Rule 410-1-3-.09 (Electronic Filing).

The undersigned, being first duly sworn, hereby makes oath or affirms that he is the authorized representative for North Alabama Shoals Hospital, has knowledge of the facts in this request, and to the best of his information, knowledge and belief, such facts are true and correct.

Affiant: _____
Russell Pigg
Chief Executive Officer

SUBSCRIBED AND SWORN to before me December 14, 2023.

_____
Notary Public
My commission expires: 03-27-2027

EMILY HARLESS
My Commission Expires
March 27, 2027
(SEAL)

Exhibit 1

Shoals Hospital Data of Psychiatric Bed Occupancy, *January-October 2023*

	2023 Adult Census (MHCU) - 20 Licensed Beds										
	January	February	March	April	May	June	July**	August	September	October	Average
Average	15	16	15	15	16	17	19	18	17	18	17

Geriatric Psych - 30 Licensed Beds

	2023										
	January	February	March	April	May	June	July**	August	September	October	Average
Average	13	13	13	14	14	12	14	14	12	8	13

** Started Psychiatric Residency

Exhibit 2

Dr. Narahari CV

NAME: Praveen Narahari, MS, MD, FAPA

ADDRESS: 201 West Avalon Avenue
Muscle Shoals, Al 35661
Phone: 256-386-1701
Fax: 256-386-1575
pnarahari@shoalshopital.com

EDUCATION:

NTR University of health Sciences
Kakatiya Medical College
Warangal, Telangana, India.
M.B.B.S. (Bachelor of Medicine and Bachelor of Surgery) May 2005

Eastern Kentucky University
Richmond, Kentucky
M.S. Community Nutrition, May 2009

RESIDENCY:

Psychiatry, University of South Alabama College of Medicine, July 2009-June 2013

Chief Resident, July 2012-June 2013

HONORS:

- Phi Kappa Phi, 2008
- Best Community Service Award, 2011
- Distinguished Performance Award, 2011-2012
- Best Poster Presentation Award (Alabama Psychiatric Physicians Association state conferences), 2012, 2013, 2018
- Faculty Teacher of the Year, Department of Psychiatry, University of South Alabama College of Medicine, 2018
- Red Sash Award, University of South Alabama College of Medicine, 2015, 2017, 2018, and 2019
- Fellow, American Psychiatric Association, 2020
- President of Mobile Bay Psychiatric Society, 2020-2021.

BOARD CERTIFICATIONS:

ECFMG, Education Commission for Foreign Medical Graduates, September 2008

Diplomate, Psychiatry, American Board of Psychiatry and Neurology, November 2013
Diplomate, Addiction Medicine, American Board of Preventive Medicine, August 2018

CURRENT MEDICAL LICENSURE:

State: Alabama, Number: MD 31852, Issued: January 2013 (active)

ACADEMIC APPOINTMENTS:

Assistant Professor, Department of Psychiatry, University of South Alabama College of Medicine, June2013-2020

Associate Professor, Department of Psychiatry, University of South Alabama College of Medicine, June2020-2023

Program Director, North Alabama Shoals Hospital Psychiatry Residency Program, June 2022- Present.

COMMITTEES AND OFFICES HELD:

Chief Resident 2012-2013
Graduate Medical Education Committee Resident Representative, 2012-2013
Treasurer – Indian Association of Greater Mobile, 2014-2015
Member, Psychiatry Residency Evaluation Committee, University of South Alabama College of Medicine, 2015-present
Scientific Review Committee, Alabama Psychiatric Physicians Association, 2018-present
Chairperson, Clinical Competency Committee, 2019- present
Assistant Medical Director, Eastpointe Hospital, 2019- present
President of Mobile Bay Psychiatric Society, 2020-2021
Associate Program Director, University of South Alabama Department Psychiatry, 2019- 2022.
Program Director, North Alabama Shoals Hospital Psychiatry Residency Program, June 2022- Present.
Medical Director , Wellstone Emergency Services June 2023- present

PRACTICE EXPERIENCE:

Psychiatrist, AltaPointe Health, Mobile, AL, July 2013- April 2023
Psychiatrist, Lakeview Center Baptist Healthcare, Pensacola, FL, October 2012-2021.
Psychiatrist, Shoals Hospital, Muscle shoals, AL , April 2023- present
Psychiatrist, Wellstone, Huntsville, AL , June 2023- present.

TEACHING:

- Psychiatry residents, inpatient psychiatry rotation, University of South Alabama College of Medicine, 2014-2023.
- M3 and M4 medical students, inpatient psychiatry rotation, University of South Alabama College of Medicine, 2014-2023
- Sleep Disorder lecture during Psychiatry core rotation, University of South Alabama College of Medicine, 2015-2023.
- Psychopharmacology lecture during Psychiatry core rotation, University of South Alabama College of Medicine, 2016 - April 2023
- Substance Use Disorders lecture during Psychiatry core rotation, University of South Alabama College of Medicine, 2016- 2023
- Psychiatry residents, PRITE review course, University of South Alabama, Department of Psychiatry, 2017- April 2023.
- Psychiatry residents, inpatient psychiatry rotation, Shoals Psychiatry Hospital, July 1, 2023 – present .

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JS. Cheek, JC. Moore, P. Narahari. Sertraline induced severe hyponatremia: a case report. Alabama Psychiatric Physicians Association Spring Conference; 2014 Apr 25; Montgomery, AL. Abstract no. 14-1-08.

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Alisa T. Trinh, M3 student, P. Narahari, M.D.M.S., Can Uncontrolled Diabetes Mellitus Counteract Antipsychotics In patients with Schizophrenia? Abstract, Alabama Psychiatric Physician Association Semi-Annual Conference, Birmingham, AL.2017.

Bradly Harris, M3 Student, P. Narahari M.D. M.S.; Acute Psychosis, Alopecia, and Edentulism in a Narcoleptic Patient who is on Adderal X.R., Abstract, Alabama psychiatry physician Association semi- Annual conference, Destine, FL.2019.

Mistaken Affect — not a laughing matter: A case report pseudobulbar affect misidentified as worsening depression, Brad Brooks, D.O., P Narahari, MD. APPA 2019 Spring Meeting, 2019.

Clinical Course of a Patient Undergoing Delayed Withdrawal from Alprazolam (Xanax), Jazmin Scott, BS, P. Narahari, MD. APPA 2019 Spring Meeting,2019.

Medication Madness: Aripiprazole-Induced Psychosis, Taylor Ousley, MS 3; Jazmín Scott, MS 3; P. Narahari, MD, Psych Congress, Annual Meeting, Sandie ago, 2019.

Efficacy and Cost Analysis of Assisted Outpatient Treatment Program for Severely Mentally Ill Patients in a Small Alabama Community. P. Narahari MD1,2, M. Marshall MD1, B. Brooks DO1, E. Chavers MS1, C Gipson PhD2, S Parker MD1,2,1: University of South Alabama College of Medicine 2: AltaPointe Health Systems, Psych Congress, Annual Meeting, Sandie ago, 2019

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P. Narahari Invited Speaker, Team-based learning: Synthetic Cannabinoids and other synthetic drug use review, Alabama Psychiatric Physicians Association Annual Spring Meeting. 2013 April 19, Montgomery, AL.

P. Narahari Invited Speaker, Sleep disorders, and common myth about normal sleep and insomnia, treatment options for insomnia. National Alliance on Mental Illness, Mobile, AL, August 2013.

P. Narahari Invited speaker. Differences in psychiatric treatment in the United States and India and the newer psychotropics: their efficacy and affordability. Warangal Psychiatric Association. April 2014 Warangal, India.

P. Narahari Invited speaker. Major psychiatric illnesses: their diagnosis and treatment recommendation for probated court proceedings. Mobile County Probate Court. August 2014; Mobile, AL.

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P.Narahari, Invited Speaker, Creative-Methods-for-AOT-Evaluation-and-Program-Improvement , National Assisted Out-patient Treatment Annual Symposium , October, 2022.

P.Narahari, Inivited Speaker, Alabama Metal Health code and involuntary psychiatric evaluation process , what you need to know as a physician , sept 15,2023 , Grand Rounds presentation , NAMC Department of Internal Medicine.

Exhibit 3

SHPDA Psychiatric Beds and Occupancy Rates for North Region, *FY2022*

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

May 5, 2021

Notice

TO: Recipients of Unpublished/Unverified raw reports

FROM: Bradford L. Williams, Health Planning Administrator

SUBJECT: Regarding purchase of raw annual reports

These copies are being provided as per your request for this information. These reports have not been verified for accuracy or completeness in reporting. This data may change after all reports of this type have been received and verified by SHPDA staff. Due to the preliminary nature of this data, it is the recipients' responsibility to verify their findings against the final published data. SHPDA assumes no responsibility for the use of this data.

BLW

MAILING ADDRESS: P.O. BOX 303025, MONTGOMERY, ALABAMA 36130-3025
PHONE: (334) 242-4103 FAX: (334) 242-4113

Physical County	FacID	FacName	Adolescent Psych Beds Reported	Patient Days	Occupancy Rate	Adult Psych Beds Reported	Patient Days	Occupancy Rate	Geriatric Psych Beds Reported	Patient Days	Occupancy Rate	Total Psych Beds Reported	Patient Days	Occupancy Rate
COLBERT	033-653090A	NORTH ALABAMA SHOALS HOSPITAL	0	0	N/A	20	5,146	70.49%	30	4,478	40.89%	50	9,624	52.73%
CULLMAN	043-6532203	SANCTUARY AT THE WOODLANDS, THE	0	0	N/A	20	68	0.93%	20	2,409	33.00%	40	2,477	16.97%
MADISON	089-6530510	HUNTSVILLE HOSPITAL, THE	0	0	N/A	23	7,625	90.83%	12	1,876	42.83%	35	9,501	74.37%
MADISON	089-6534505	UNITY PSYCHIATRIC CARE - HUNTSVILLE	0	0	N/A	0	0	N/A	20	5,008	68.60%	20	5,008	68.60%
MARSHALL	095-6530511	MARSHALL MEDICAL CENTER NORTH	0	0	N/A	10	2,477	67.86%	0	0	N/A	10	2,477	67.86%
MORGAN	103-6530335	DECATUR MORGAN WEST	38	9,083	65.49%	10	3,152	86.36%	16	1,607	27.52%	64	13,842	59.26%
Regional Totals			38	9,083	65.49%	83	18,468	60.96%	98	15,378	42.99%	219	42,929	53.70%

Exhibit 4

Shoals Hospital and NAMC Adolescent Psychiatric Patient Data

Exhibit 4A

Shoals Hospital Adolescent Psychiatric Patient Data, *1.01.23-8.30.23* *and* *8.31.23-11.28.23*

SHOALS 01.01.23 - 08.30.23 - Adolescent Psych Patients				
D#	Date	AGE	Total LOS	Dispo
639321	1/9/2023	14	4.55	AMA
639404	1/10/2023	14	16.29	TXF
639483	1/12/2023	17	6.09	HOME
640602	1/26/2023	18	25.34	TXF
640675	1/27/2023	18	87.24	TXF
640940	1/31/2023	18	17.53	TXF
641262	2/3/2023	16	83.55	TXF
641553	2/7/2023	14	0.55	AMA
641706	2/9/2023	15	2.08	AMA
641828	2/10/2023	18	19.16	AMA
642386	2/18/2023	18	2.4	HOME
642814	2/23/2023	14	18.51	TXF
642873	2/24/2023	16	39.56	TXF
643948	3/14/2023	18	19.53	TXF
644130	3/16/2023	14	17.32	HOME
644669	3/25/2023	18	26.29	AMA
645594	4/9/2023	13	21.25	TXF
646006	4/15/2023	17	42.25	TXF
646039	4/16/2023	18	36.45	TXF
647080	5/1/2023	18	30.25	TXF
647429	5/6/2023	18	0.48	HOME
647861	5/12/2023	14	8.3	AMA
647868	5/13/2023	12	0.26	AMA
647934	5/14/2023	13	2.19	AMA
648222	5/17/2023	18	4.22	HOME
648454	5/22/2023	15	4.39	HOME
648789	5/26/2023	12	26.37	AMA
648823	5/26/2023	11	36.13	TXF
648923	5/30/2023	8	3.32	HOME
649031	5/31/2023	16	6.54	TXF
649807	6/10/2023	13	0.1	LWOBSPTT
650112	6/14/2023	18	10.3	TXF
650175	6/15/2023	18	11.21	TXF
650278	6/17/2023	18	90.51	TXF
650601	6/21/2023	15	18.24	TXF
650679	6/23/2023	15	1.08	HOME
652540	7/21/2023	18	22.22	HOME
653541	8/6/2023	17	4.27	HOME
653777	8/9/2023	18	8.35	AMA
654622	8/22/2023	17	0.36	AMA
655226	8/30/2023	8	20.22	HOME
		TOTAL TIME	795.25	
		AVERAGE TIME	19.4	

Case who could not receive beds, lack of beds
Elopments due to lack of Care
Long Wait times, could not be placed quickly

Comparsion LWOT/AMA/Stay > 6 Hours	
01.01.23 - 08.30.23	
AMA	28%
LWOT	3%
Stay > 6 Hrs	60%
08.31.23-11.28.23	
AMA	19%
LWOT	4%
Stay > 6 Hrs	33%

SHOALS 08.31.23 - 11.28.23 - Adolescent Psych Patients				
D#	Date	AGE	Total LOS	Dispo
655433	9.01.23	18	14.3	AMA
655618	9.05.23	18	2.04	AMA
655644	9.06.23	18	8.55	AMA
661044	11.23.23	18	2.10	AMA
655532	9.03.23	16	3.08	Home
655637	9.05.23	16	4.45	Home
657430	9.30.23	18	2.59	Home
659621	11.1.23	15	2.44	Home
659794	11.4.23	18	7.37	Home
660180	11.9.23	12	3.29	Home
660293	11.11.23	15	13.52	Home
660318	11.12.3	15	2.44	Home
660350	11.12.23	18	1.49	Home
660603	11.15.23	15	1.09	Home
660626	11.16.23	16	2.34	Home
660776	11.17.23	17	3.17	Home
660789	11.18.23	7	5.34	Home
660835	11.19.23	18	2.37	Home
656569	9.19.23	13	0.08	LWOT
656369	9.15.23	13	38.35	TXF
658238	10.12.23	14	18.52	TXF
	Total		138.92	
	Average		6.62	

Case who could not receive beds, lack of beds
Elopments due to lack of Care
Long Wait times, could not be placed quickly

Exhibit 4B

NAMC Hospital Adolescent Psychiatric Patient Data, *1.01.23-8.30.23* *and* *8.31.23-11.28.23*

NAMC 01.01.23 - 08.30.23 - Adolescent Psych Patients									
E#	Date	AGE	Total LOS	Dispo	E#	Date	AGE	Total LOS	Dispo
2107145	01.01.23	15	23.01	TXF	2136750	04.07.23	15	26.57	TXF
2107640	01.03.23	16	2.22	HOM	2136949	04.08.23	14	17.24	TXF
2108958	01.07.23	13	4.01	HOM	2137453	04.10.23	14	18.02	TXF
2109056	01.08.23	18	3.54	HOM	2137696	04.11.23	16	6.08	HOM
2111220	01.16.23	13	5	HOM	2137349	04.12.23	16	7.37	HOM
2112157	01.18.23	13	18.52	TXF	2138944	04.14.23	18	9.03	HOM
2112918	01.20.23	17	0	LWOT	2138987	04.14.23	17	9.34	HOM
2113177	01.22.23	16	21	TXF	2141467	04.23.23	14	4.15	HOM
2113954	01.24.23	12	2.18	HOM	2141468	04.23.23	14	17.4	TXF
2114310	01.25.23	15	7.39	HOM	2144238	05.01.23	13	3.16	HOM
2115107	01.28.23	16	1.11	HOM	2144376	05.01.23	14	3.27	HOM
2115674	01.31.23	17	4.47	HOM	2146841	05.09.23	12	5.29	HOM
2115678	01.31.23	14	3.46	HOM	2147637	05.12.23	13	24.4	TXF
2115747	01.31.23	15	1.58	HOM	2148010	05.13.23	14	7.12	HOM
2115887	01.31.23	17	3.09	HOM	2148216	05.14.23	11	5.18	HOM
2116889	02.02.23	7	25.38	TXF	2152568	05.29.23	11	12.58	TXF
2117206	02.03.23	18	3.22	HOM	2154020	06.01.23	13	7.17	TXF
2117899	02.07.23	15	19.33	TXF	2154975	06.05.23	10	3.49	AMA
2118269	02.07.23	13	6.52	HOM	2156998	06.12.2	8	19.16	TXF
2118443	02.08.23	13	9.53	HOM	2158448	06.16.23	17	4.26	HOM
2121370	02.16.23	16	5.21	HOM	2159214	06.19.23	14	12.05	TXF
2121980	02.20.23	16	3.57	HOM	2161134	06.27.23	15	2.46	HOM
2122656	02.21.23	17	6.17	TXF	2161524	06.27.23	6	12.24	HOM
2122731	02.21.23	14	2.37	HOM	2162364	06.29.23	14	1.37	HOM
2123595	02.24.23	16	5.34	HOM	2164316	07.06.23	13	3.39	HOM
2124911	02.28.23	16	18.05	TXF	2165696	07.11.23	17	14.22	TXF
2125412	03.01.23	12	4	HOM	2171296	07.30.23	15	1.37	HOM
2127026	03.06.23	17	5.58	HOM	2172731	08.02.23	15	2.16	HOM
2127760	03.08.23	14	28.02	TXF	2173061	08.03.23	15	3.09	HOM
2131026	03.20.23	14	0	LWOT	2173451	08.05.23	13	5.12	TXF
2131228	03.21.23	17	2.45	HOM	2173991	08.08.23	17	3.3	HOM
2131110	03.20.23	13	16.26	TXF	2175147	08.10.23	8	16.27	TXF
2132258	03.24.23	14	16.51	TXF	2175506	08.11.23	13	2.41	HOM
2138492	03.24.23	12	68.42	TXF	2175527	08.11.23	17	9.09	HOM
2132783	03.26.23	15	1.45	HOM	2175648	08.12.23	14	17.27	HOM
2133727	03.29.23	11	43.7	HOM	2176240	08.15.23	12	17.01	HOM
2133825	03.29.23	8	5.18	HOM	2176925	08.16.23	16	1.3	HOM
2134983	04.03.23	13	53.57	HOM	2178442	08.21.23	13	9.4	HOM
2136172	04.06.23	15	3.55	TXF	2178850	08.22.23	7	11.07	TXF
2136237	04.06.23	16	3.19	HOM	2179925	08.25.23	5	19.01	HOM
		TOTAL	457.15				TOTAL	373.88	
				TOTAL	831.03				
				AVERAGE	10.65423077				

Case who could not receive beds, lack of beds

Elopments due to lack of Care

Long Wait times, could not be placed quickly

NAMC 08.31.23 - 11.28.23 - Adolescent Psych Patients				
E#	Date	Age	Total LOS	Dispo
2184527	9/10/2023	18	3.05	AMA
2190468	9/28/2023	18	1.1	AMA
2183283	9/6/2023	12	3.07	Home
2184531	9/10/2023	18	1.15	Home
2186269	9/14/2023	18	2.41	Home
2187542	9/19/2023	16	5.28	Home
2187557	9/19/2023	15	6.11	Home
2188767	9/23/2023	15	3.35	Home
2195934	10/17/2023	17	34.41	Home
2208376	11/26/2023	15	43.48	Home
2182537	11/2/2023	15	4.14	Home
2190802	9/29/2023	18	0.02	LWOT
2182470	9/1/2023	8	15.09	TXF
2184471	9/9/2023	17	6.39	TXF
2187184	9/18/2023	8	16.12	TXF
2187901	9/20/2023	12	58.48	TXF
2187669	9/20/2023	16	18.49	TXF
2188801	9/23/2023	8	4.38	TXF
2189591	9/26/2023	11	29.35	TXF
2190032	9/27/2023	8	20.51	TXF
2192422	10/4/2026	13	44.42	TXF
2193068	10/6/2023	16	27.36	TXF
2193191	10/7/2023	13	35.06	TXF
2195246	10/14/2023	13	29.48	TXF
2196216	10/17/2023	11	22.25	TXF
2201424	11/2/2023	12	12.33	TXF
2205074	11/13/2023	17	25.37	TXF
		TOTAL TIME	472.65	
		AVERAGE TIME	17.51	

Case who could not receive beds, lack of beds
Elopments due to lack of Care
Long Wait times, could not be placed quickly

Exhibit 5

Centers for Disease Control and Prevention Statistics

Centers for Disease Control and Prevention

Mental Health

Mental Health Home

About Mental Health

Mental Health Basics | Types of Mental Illness

What is mental health?

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.[1] Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Why is mental health important for overall health?

Mental and physical health are equally important components of overall health. For example, depression increases the risk for many types of physical health problems, particularly long-lasting conditions like diabetes, heart disease, and stroke. Similarly, the presence of chronic conditions can increase the risk for mental illness.[2]

Can your mental health change over time?

Yes, it's important to remember that a person's mental health can change over time, depending on many factors. When the demands placed on a person exceed their resources and coping abilities, their mental health could be impacted. For example, if someone is working long hours, caring for a relative, or experiencing economic hardship, they may experience poor mental health.

How common are mental illnesses?

Mental illnesses are among the most common health conditions in the United States.

- More than 1 in 5 US adults live with a mental illness.

- Over 1 in 5 youth (ages 13-18) either currently or at some point during their life, have had a seriously debilitating mental illness.[5]
- About 1 in 25 U.S. adults lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.[6]

What causes mental illness?

There is no single cause for mental illness. A number of factors can contribute to risk for mental illness, such as

- Adverse Childhood Experiences, such as trauma or a history of abuse (for example, child abuse, sexual assault, witnessing violence, etc.)
- Experiences related to other ongoing (chronic) medical conditions, such as cancer or diabetes
- Biological factors or chemical imbalances in the brain
- Use of alcohol or drugs
- Having feelings of loneliness or isolation

People can experience different types of mental illnesses or disorders, and they can often occur at the same time. Mental illnesses can occur over a short period of time or be episodic. This means that the mental illness comes and goes with discrete beginnings and ends. Mental illness can also be ongoing or long-lasting.

There are more than 200 types of mental illness. Some of the main types of mental illness and disorders are listed here .

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Last Reviewed: April 25, 2023

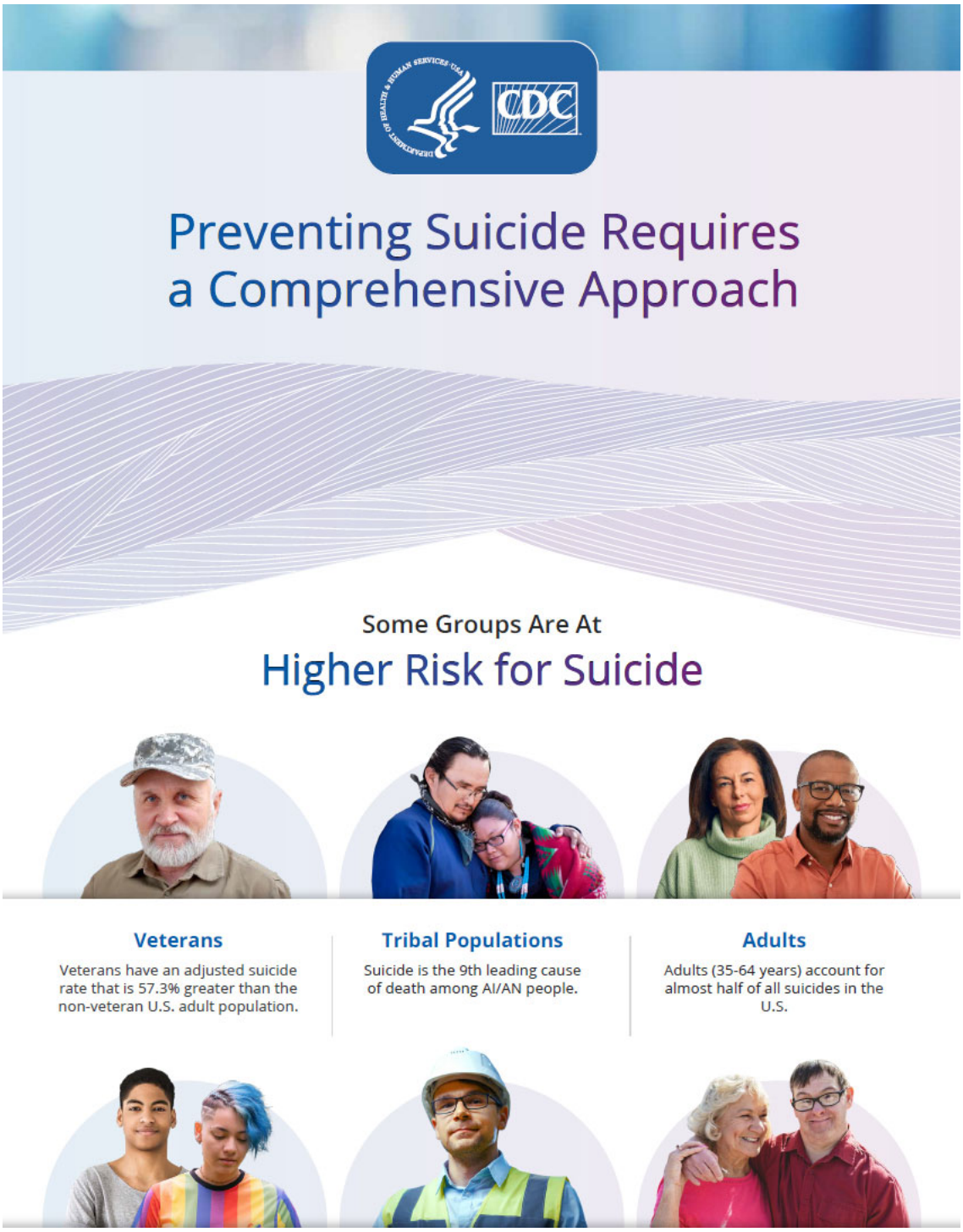
Disparities in Suicide

Suicide and suicide attempts are serious public health challenges. These events can have lasting emotional, mental, and physical health impacts, as well as economic consequences. They can also impact people who struggle with their own risk of suicide and/or mental health challenges (called lived experience).

Suicide and suicidal behavior are influenced by negative conditions in which people live, play, work, and learn. These conditions, sometimes called *social determinants of health*, can include racism and discrimination in our society, economic hardship (such as high unemployment), poverty, limited affordable housing, lack of educational opportunities, and barriers to physical and mental healthcare access, among others. Additional factors that can increase suicide risk include relationship problems or feeling a lack of connectedness to others, easy access to lethal means among people at risk, experiences of violence[1] such as child abuse and neglect, adverse childhood experiences, bullying, and serious health conditions.

Some groups experience more negative conditions or factors related to suicide. While anyone can experience suicide risk, some populations experience more negative social conditions and other factors described above and have higher rates of suicide or suicide attempts than the general U.S. population. The excess burden of suicide in some populations are called health disparities.[2] Examples of groups experiencing suicide health disparities include veterans, people who live in rural areas, sexual and gender minorities, middle-aged adults, people of color, and tribal populations.

Addressing these negative conditions and factors can help prevent suicide and suicide attempts. CDC is concerned with groups disproportionately impacted by suicide and uses a holistic, or comprehensive public health approach, to reduce suicide risk and promote resilience and well-being in communities, in order to save lives.



Click here [PDF – 1 MB] to access the Suicide Disparities infographic.

What CDC is doing to address health disparities in suicide

CDC is supporting states, tribes, territories, non-governmental organizations, and university research programs to address four strategic priority areas in suicide prevention:

- **Data:** Using new and existing data to better understand, monitor, and prevent suicide and suicidal behavior
- **Science:** Identifying risk and protective factors and effective policies, programs, and practices for suicide prevention in populations at increased risk for suicide
- **Action:** Building the foundation for CDC's National Suicide Prevention Program
- **Collaboration:** Developing and implementing wide-reaching partnership and communication strategies to raise awareness and advance suicide prevention activities

Additionally, CDC funds the Comprehensive Suicide Prevention program, which aims to reduce suicide among groups that experience health disparities in suicide. These programs use suicide prevention strategies based on the best available evidence to help states and communities prevent suicide. These strategies can be found in CDC's Suicide Prevention Resource for Action, and include:

- Strengthen economic supports
- Create protective environments
- Improve access and delivery of suicide care
- Promote healthy connections
- Teach coping and problem-solving skills
- Identify and support people at risk
- Lessen harms and prevent future risk

Suicide rates differ by age*

Adults

Adults aged 35–64 years account for 46.8% of all suicides in the United States, and suicide is the 8th leading cause of death for this age group.[3]

- Among men in this age group, suicide rates were highest for non-Hispanic American Indian or Alaska Native (AI/AN) men (41.3 suicides per 100,000), followed by non-Hispanic White men (35.7 per 100,000).[3]
- Among women in this age group, suicide rates were highest among non-Hispanic American Indian or Alaska Native women (12.8 per 100,000) and non-Hispanic White women (10.7 per 100,000).[3]

Older Adults

Adults aged 75 and older have one of the highest suicide rates (20.3 per 100,000). Men aged 75 and older have the highest rate (42.2 per 100,000) compared to other age groups. Non-Hispanic White men have the highest suicide rate compared to other racial/ethnic men in this age group (50.1 per 100,000).[3]

What CDC and funded partners are doing to prevent suicide among middle-aged adults

Massachusetts, Michigan, and Maine are working to reduce suicide disparities in middle-aged adults. Massachusetts and Maine are implementing gatekeeper training, which teaches community members how to identify people at risk for suicide and refer them to care. Massachusetts is also training providers to identify and support at-risk middle-aged adults and to use evidence-based screening and treatments.

Massachusetts also aims to reduce access to lethal means by promoting safe storage. Massachusetts is working to increase access to and education on the benefits of firearm storage safes and trigger locks, and to promote lock bags, locked cabinets, and safe disposal of over-the-counter drugs among middle-aged males.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

Youth and Young Adults

Youth and young adults ages 10–24 years account for 15% of all suicides. The suicide rate for this age group (11.0 per 100,000)** is lower than other age groups.[3] However, suicide is the second leading cause of death for this age group, accounting for 7,126 deaths.[3] Additionally, suicide rates for this age group increased 52.2% between 2000-2021.

Youth and young adults most impacted include non-Hispanic American Indian or Alaska Native, with a suicide rate of 36.3 per 100,000.[3]

Youth and young adults have high rates of emergency department (ED) visits for self-harm. In 2020, ED visits for this age group were 354.4 per 100,000, compared with 128.9 per 100,000 among middle-aged adults ages 35-64 years.[4]

- There were an estimated 224,341 ED visits for self-harm among youth and young adults.[4] Girls and young women are at particularly high risk, with their ED visit rate (514.4 per 100,000) being approximately twice the rate of ED visits among boys and young men (200.5 per 100,000).
- The rate of ED visits among girls in 2020 was approximately double compared to 2001 (244.3 per 100,000).[4]

In 2021, 9% of high school students reported attempting suicide during the previous 12 months.[5] Suicide attempts were reported most frequently among girls compared to boys (12.4% vs. 5.3%) and among non-Hispanic American Indian or Alaska Native students (20.1%).[5]

*Rates reflect 2021 data unless otherwise noted.

*All rates listed are crude, unless otherwise noted as age-adjusted rates. Age-adjusting rates refers to adjusting based on the "standard" population; this is done to ensure that the differences are not due to differences in the age distributions of the populations being compared. For example, comparing two states would usually require age-adjustments because some states may have older populations than others. Age-adjusting is not necessary when comparing age groups.

What CDC and funded partners are doing to prevent youth suicide

- Colorado, Connecticut, Massachusetts, and Tennessee are working with their states' departments of education to advance and provide social-emotional learning programs to promote coping and problem-solving skills.
- Colorado, Connecticut, North Carolina, and Vermont have implemented Counseling on Access to Lethal Means (CALM) in EDs to educate families of youth who are at increased risk for suicide on safe storage of lethal means (such as firearms, medications, and sharp objects) within the home.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

Suicide risk is higher among people who identify as lesbian, gay, or bisexual

Data are limited on the rate of suicide among people who identify as sexual minorities. However, research shows that high school students who identify as sexual minorities have higher rates of suicide attempts compared to heterosexual students.[5]

In 2021, more than a quarter (26.3%) of high school students identifying as lesbian, gay, or bisexual reported attempting suicide in the prior 12 months. This rate was five times higher than the rate reported among heterosexual students (5.2%).[5]

Data from 2020 show the rate of self-reported suicide attempts in the prior 12 months among adult sexual minorities decreased with age, from 5.5% among people ages 18-25 to 2.2% among people ages 26-49.[7]

What CDC and funded partners are doing to prevent suicide among sexual minorities

Maine is working on promoting connectedness among sexual minority youth by:

- Implementing a program to enhance resiliency among lesbian, gay, bisexual, and transgender (LGBT) youth both in and out of school.
- Promoting a training to equip youth-serving providers with skills in facilitating family connectedness and positive relationships among LGBT young people and their caregivers.

Suicide rates are higher among veterans

In 2020, 6,146 veterans died by suicide. Suicide was the 13th leading cause of death among veterans overall, and the second leading cause of death among veterans under age 45.[8] Veterans have an adjusted suicide rate that is 57.3% greater than the non-veteran U.S. adult population.[8] Veterans account for about 13.9% of suicides among adults in the United States.[8]

Additionally, in 2019, 1.6% of veteran young adults ages 18-25 reported making a suicide attempt during the previous 12 months. This was an increase from 0.9% in 2009.[9]

What CDC and funded partners are doing to prevent suicide among veterans

Massachusetts, North Carolina, Louisiana, and the University of Pittsburgh are identifying and supporting veterans at risk by implementing gatekeeper training.

- Massachusetts is requiring all staff working in Massachusetts Career Centers to complete gatekeeper training.
- North Carolina offers gatekeeper training as an option to healthcare providers.
- University of Pittsburgh provides gatekeeper trainings that teaches about risk factors and warning signs for suicide among veterans.
- Louisiana implemented gatekeeper trainings in nine local health department regions serving veterans.

Massachusetts, Louisiana, and the University of Pittsburgh are promoting connectedness among veterans.

- Massachusetts is focusing on community engagement to increase diversity, inclusion, and representation of veterans on the MassMen website. MassMen features articles, blog posts, self-assessments, and men's stories to help men find solidarity, promote wellness, and increase help-seeking.
- The University of Pittsburgh is implementing community greening projects to promote connectedness and decrease social isolation among veterans in Pennsylvania.
- Louisiana is developing peer-to-peer norm groups with veterans. Peer norm programs seek to promote connectedness and normalize protective factors for suicide such as help-seeking, reaching out, and talking to trusted friends and loved ones.

North Carolina, Louisiana, and the University of Pittsburgh are strengthening access to and delivery of suicide care. North Carolina and Louisiana are providing increased veteran access to telemental health services to reduce provider shortages. The University of Pittsburgh is working to strengthen access to and delivery of suicide care for veterans by working toward equal coverage of mental health conditions. The University of Pittsburgh is also working to raise awareness and education among healthcare providers and community members on existing mental health parity laws.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

Suicide rates vary by race and ethnicity

Age-adjusted suicide rates are highest among non-Hispanic American Indian and Alaska Native (AI/AN) people (28.1 per 100,000) and non-Hispanic White people (17.4 per 100,000).[3]

- Suicide is the 9th leading cause of death among AI/AN people.
  - Non-Hispanic AI/AN people have a higher age-adjusted rate of suicide (28.1 per 100,000) compared with Hispanic AI/AN people (2.0 per 100,000).
  - The suicide rate among non-Hispanic AI/AN males ages 15–34 is 82.1 per 100,000.
- Suicide is the 11th leading cause of death for both Hispanic and non-Hispanic people of all races.
- Between 2018-2021, suicide rates significantly increased overall among non-Hispanic AI/AN (26%) and non-Hispanic Black (19.2%) people, and declined by 3.9% among non-Hispanic White people.

What CDC and funded partners are doing to prevent suicide in tribal communities

Southern Plains Tribal Health Board and Wabanaki Public Health and Wellness are working to increase capacity to adapt, implement, and evaluate suicide prevention programs to reduce suicide-related morbidity and mortality. Each tribal organization is:

- Reviewing existing data to describe the general problem and identify a subgroup that is at increased risk for suicide compared to the general tribal population.
- Developing an inventory of existing suicide prevention programs for the general tribal population and the selected subgroup to identify gaps and opportunities that will complement existing programs.
- Selecting at least one program from CDC's Suicide Prevention Resource for Action, or another evidence-informed program, to fill prevention gaps and complement existing programs.
- Adapting the selected program to fit the cultural context of the tribe and implement and evaluate the approach or program.
- Conducting listening sessions to obtain input during the project to adapt the approach of program.
- Disseminating results, success stories, and lessons learned.

For more information on CDC's funded tribal suicide prevention program, visit: Tribal Suicide Prevention.

Suicide ideation is higher among people with disabilities

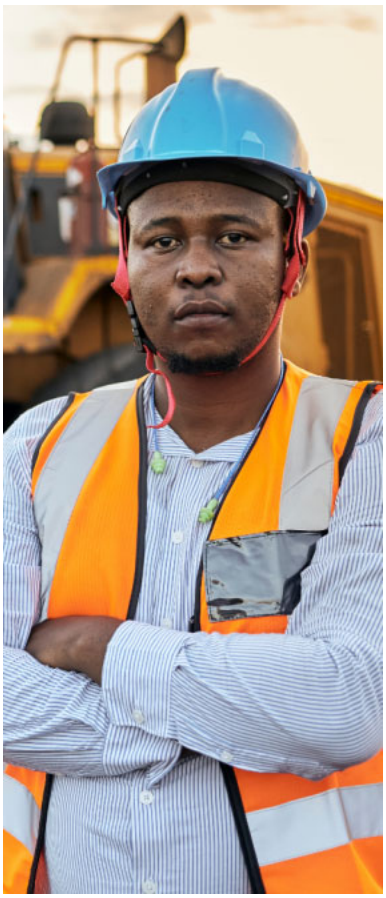
Limited data are available on suicide among people with disabilities. However, a recent survey highlighted that in 2021, adults with disabilities were three times more likely to report suicidal ideation in the past month compared to people without disabilities (30.6% versus 8.3% in the general U.S. population).[10] Prior research also shows that the prevalence of reported mental distress, which is a risk factor for suicide, was 4.6 times higher among people with disabilities (32.9%) than among people without disabilities (7.2%).[11]

What CDC and funded partners are doing to prevent suicide among people with disabilities

- Vermont is working to reduce suicide disparities among people with disabilities by providing training to primary care providers to promote safe storage among this population.
- Vermont is supplementing and scaling up the state's Zero Suicide work by engaging primary care providers serving people with disabilities.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

Suicide rates differ by industry and occupation†



Industry is the type of activity at a person's workplace and occupation is the kind of work a person does to earn a living. A CDC study examining data in 32 states found that the suicide rate among work rs in certain industries and occupations was significantly greater than the general U.S. population, particularly for males.[12]

The industry groups that had the highest suicide rates were:

1. Mining, Quarrying, and Oil and Gas Extraction (males: 54.2 per 100,000)
2. Construction (males: 45.3 per 100,000)
3. Other Services (such as automotive repair; males: 39.1 per 100,000)
4. Agriculture, Forestry, Fishing, and Hunting (males: 36.1 per 100,000)
5. Transportation and Warehousing (males: 29.8 per 100,000; females: 10.1 per 100,000)

The occupation groups that had higher suicide rates than the general population were:

1. Construction and Extraction (males: 49.4 per 100,000; females: 25.5 per 100,000)**
2. Installation, Maintenance, and Repair (males: 36.9 per 100,000)
3. Arts, Design, Entertainment, Sports, and Media (males: 32.0 per 100,000)
4. Transportation and Material Moving (males: 30.4 per 100,000; females: 12.5 per 100,000)
5. Protective Service (females: 14.0 per 100,000)
6. Healthcare Support (females: 10.6 per 100,000)

† Rates reflect 2016 data from 32 states

**Among females, no other occupation group had a rate of suicide greater than the general female population

What CDC and funded partners are doing to prevent suicide for people in at-risk occupations

Massachusetts, Colorado, and Connecticut are promoting connectedness among people working in occupations that are at greater risk for suicide.

- Massachusetts and Colorado are implementing peer norm programs for at-risk occupations, such as Signs of Suicide (S.O.S.).
- Connecticut is supporting community engagement efforts and providing workplaces for at-risk occupations with suicide prevention resources and materials.
- Massachusetts and Connecticut are identifying and supporting occupations at higher risk for suicide via healthcare provider education.
- Massachusetts, Connecticut, Michigan, and Colorado are promoting the implementation of organizational policies and culture in workplaces to create protective environments for people in at-risk occupations.

The workplace provides an important opportunity for suicide prevention efforts because it is where many adults spend a great deal of their time. Visit the National Institute for Occupational Safety and Health website for more information about workplace suicide prevention strategies.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

Suicide rates differ based on where you live

Suicide rates can vary substantially across geographic regions.* For example, suicide rates increase as population density decreases and an area becomes more rural.

2021 suicide rates based on population density:

- Large central metropolitan: 11.6 per 100,000
- Large fringe metro: 12.8 per 100,000
- Medium metro: 15.7 per 100,000
- Small metro: 17.8 per 100,000
- Micropolitan (non-metro): 19.2 per 100,000
- Noncore (non-metro): 21.7 per 100,000

Suicide rates in rural (non-metro) areas are highest among non-Hispanic AI/AN males (61.8 per 100,000) and non-Hispanic White males (36.8 per 100,000).[3]

*For information on how areas are classified, visit this page: Data Access – Urban Rural Classification Scheme for Counties (cdc.gov)

What CDC and funded partners are doing to prevent suicide in rural communities

- North Carolina and Vermont are promoting safe storage of firearms in rural areas to reduce access to lethal means.
- North Carolina and Tennessee are identifying and supporting people at risk. Both states are also implementing gatekeeper trainings in rural counties and areas. North Carolina is promoting gatekeeper trainings among staff in rural schools.

For more information on what funded states are doing to prevent suicide, visit: Comprehensive Suicide Prevention: Program Profiles.

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Last Reviewed: May 9, 2023

Centers for Disease Control and Prevention

CDC Newsroom

CDC Newsroom Home

New CDC data illuminate youth mental health threats during the COVID-19 pandemic

CDC's first nationally representative survey of high school students during the pandemic can inform effective programs

Press Release

Embargoed Until: Thursday, March 31, 2022, 1:00 p.m. ET

Contact: Media Relations
(404) 639-3286

New CDC analyses, published today, shine additional light on the mental health of U.S. high school students during the COVID-19 pandemic, including a disproportionate level of threats that some students experienced.

According to the new data, in 2021, more than a third (37%) of high school students reported they experienced poor mental health during the COVID-19 pandemic, and 44% reported they persistently felt sad or hopeless during the past year. The new analyses also describe some of the severe challenges youth encountered during the pandemic:

- More than half (55%) reported they experienced emotional abuse by a parent or other adult in the home, including swearing at, insulting, or putting down the student.
- 11% experienced physical abuse by a parent or other adult in the home, including hitting, beating, kicking, or physically hurting the student.
- More than a quarter (29%) reported a parent or other adult in their home lost a job.

Before the pandemic, mental health was getting worse among high school students, according to prior CDC data.

"These data echo a cry for help," said CDC Acting Principal Deputy Director Debra Houry, M.D., M.P.H. "The COVID-19 pandemic has created traumatic stressors that have the potential to further erode students' mental wellbeing. Our research shows that surrounding youth with the proper support can reverse these trends and help our youth now and in the future."

Lesbian, gay, and bisexual youth and female youth reported greater levels of poor mental health; emotional abuse by a parent or caregiver; and having attempted suicide than their counterparts.

In addition, over a third (36%) of students said they experienced racism before or during the COVID-19 pandemic. The highest levels were reported among Asian students (64%) and Black students and students of multiple races (both 55%). The survey cannot determine the extent to which events during the pandemic contributed to reported racism. However, experiences of racism among youth have been linked to poor mental health, academic performance, and lifelong health risk behaviors.

School connectedness provided critical protection for students during COVID-19

Findings also highlight that a sense of being cared for, supported, and belonging at school — called "school connectedness" — had an important effect on students during a time of severe disruption. Youth who felt connected to adults and peers at school were significantly less likely than those who did not to report persistent feelings of sadness or hopelessness (35% vs. 53%); that they seriously considered attempting suicide (14% vs. 26%); or attempted suicide (6% vs. 12%). However, fewer than half (47%) of youth reported feeling close to people at school during the pandemic.

"School connectedness is a key to addressing youth adversities at all times – especially during times of severe disruptions," said Kathleen A. Ethier, PhD, Director of CDC's Division of Adolescent and School Health. "Students need our support now more than ever, whether by making sure that their schools are inclusive and safe or by providing opportunities to engage in their communities and be mentored by supportive adults."

We all have a role to play to help youth recover from challenges during COVID-19

Youth with poor mental health may struggle with school and grades, decision making, and their health. Mental health problems in youth are also often associated with other health and behavioral risks such as increased risk of drug use, experiencing violence, and higher risk sexual behaviors.

Schools are crucial partners in supporting the health and wellbeing of students. In addition to education, they provide opportunities for academic, social, mental health, and physical health services that can help protect against negative outcomes. Schools are facing unprecedented disruptions during the pandemic, however, and cannot address these complex challenges alone.

"In the face of adversity, support from schools, families, and communities protects adolescents from potentially devastating consequences," said Jonathan Mermin, M.D., director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC's lead Center for monitoring and addressing school-based health. "These data tell us what works. So, what will it take for our schools and communities to help youth withstand the challenges of the COVID-19 pandemic and beyond?"

More Information

These data, released as an *MMWR Surveillance Supplement*, come from the Adolescent Behaviors and Experiences Survey (ABES), CDC's first nationally representative survey of public- and private-school high school students to assess the well-being of U.S. youth during the COVID-19 pandemic. Funded through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, CDC fielded the survey during January – June 2021.

CDC's Division of Adolescent and School Health on mental health among students: https://www.cdc.gov/healthyyouth/mental-health/index.htm.

For more information from CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, visit www.cdc.gov/nchhstp/newsroom

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Last Reviewed: March 31, 2022

Exhibit 6

U.S. Surgeon General Public Health Advisory, Protecting Youth Mental Health

PROTECTING YOUTH MENTAL HEALTH

The U.S. Surgeon General's Advisory

2021

TABLE OF CONTENTS

INTRODUCTION FROM THE SURGEON GENERAL

Every child's path to adulthood—reaching developmental and emotional milestones, learning healthy social skills, and dealing with problems—is different and difficult. Many face added challenges along the way, often beyond their control. There's no map, and the road is never straight.

But the challenges today's generation of young people face are unprecedented and uniquely hard to navigate. And the effect these challenges have had on their mental health is devastating.

Recent national surveys of young people have shown alarming increases in the prevalence of certain mental health challenges—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. We know that mental health is shaped by many factors, from our genes and brain chemistry to our relationships with family and friends, neighborhood conditions, and larger social forces and policies. We also know that, too often, young people are bombarded with messages through the media and popular culture that erode their sense of self-worth—telling them they are not good looking enough, popular enough, smart enough, or rich enough. That comes as progress on legitimate, and distressing, issues like climate change, income inequality, racial injustice, the opioid epidemic, and gun violence feels too slow.

And while technology platforms have improved our lives in important ways, increasing our ability to build new communities, deliver resources, and access information, we know that, for many people, they can also have adverse effects. 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 environments young people need and deserve.

All of that was true even before the COVID-19 pandemic dramatically altered young peoples' experiences at home, at school, and in the community. The pandemic era's unfathomable number of deaths, pervasive sense of fear, economic instability, and forced physical distancing from loved ones, friends, and communities have exacerbated the unprecedented stresses young people already faced.

It would be a tragedy if we beat back one public health crisis only to allow another to grow in its place. That's why I am issuing this Surgeon General's Advisory. Mental health challenges in children, adolescents, and young adults are real, and they are widespread. But most importantly, they are treatable, and often preventable. This Advisory shows us how.

To be sure, this isn't an issue we can fix overnight or with a single prescription. Ensuring healthy children and families will take an all-of-society effort, including policy, institutional, and individual changes in how we view and prioritize mental health. This Advisory provides actionable recommendations for young people and their families, schools and health care systems, technology and media companies, employers, community organizations, and governments alike.

Our obligation to act is not just medical—it's moral. I believe that, coming out of the COVID-19 pandemic, we have an unprecedented opportunity as a country to rebuild in a way that refocuses our identity and common values, puts people first, and strengthens our connections to each other.

If we seize this moment, step up for our children and their families in their moment of need, and lead with inclusion, kindness, and respect, we can lay the foundation for a healthier, more resilient, and more fulfilled nation.

Vivek H. Murthy, M.D., M.B.A.
Vice Admiral, U.S. Public Health Service
Surgeon General of the United States

ABOUT THE ADVISORY

A Surgeon General's Advisory is a public statement that calls the American people's attention to an urgent public health issue and provides recommendations for how it should be addressed. Advisories are reserved for significant public health challenges that need the nation's immediate awareness and action.

This Advisory offers recommendations for supporting the mental health of children, adolescents, and young adults. While many of these recommendations apply to **individuals**, the reality is that people have widely varying degrees of control over their circumstances. As a result, not all recommendations will be feasible for everyone.

That's why systemic change is essential. The Advisory includes essential recommendations for the **institutions** that surround young people and shape their day-to-day lives—schools, community organizations, health care systems, technology companies, media, funders and foundations, employers, and government. They all have an important role to play in supporting the mental health of children and youth.

For additional background and to read other Surgeon General's Advisories, visit SurgeonGeneral.gov.

BACKGROUND

Youth Mental Health Prior to the COVID-19 Pandemic

Mental health affects every aspect of our lives: how we feel about ourselves and the world; solve problems, cope with stress, and overcome challenges; build relationships and connect with others; and perform in school, at work, and throughout life. Mental health encompasses our emotional, psychological, and social wellbeing, and is an essential component of overall health.[1] As described in the 1999 Surgeon General's Report on Mental Health, it is the "springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem."[2]

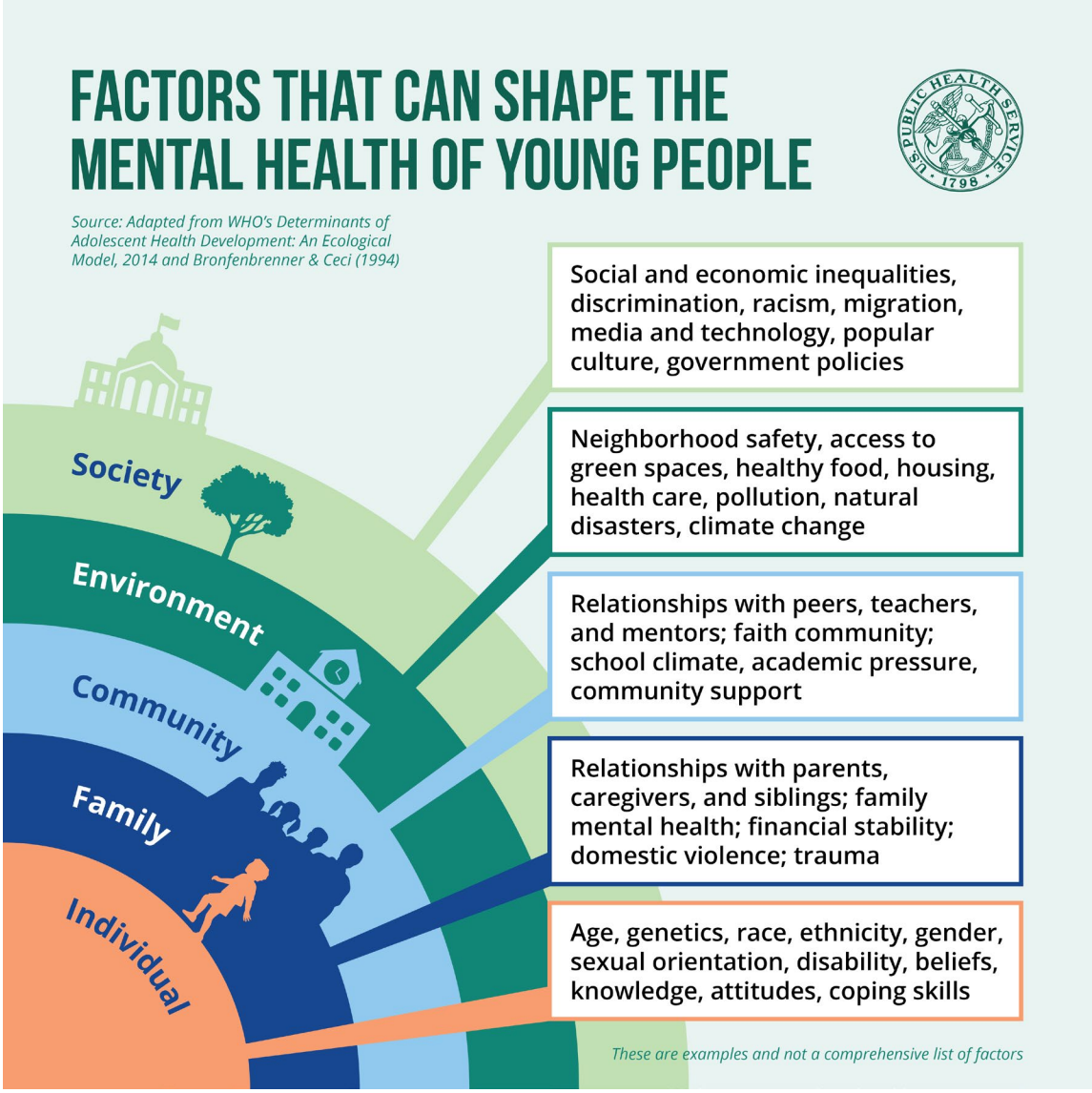
Mental health challenges can be difficult to define, diagnose, and address, partly because it isn't always clear when an issue is serious enough to warrant intervention.[2] All of us, at all ages, occasionally experience fear, worry, sadness, or distress. In most cases, these symptoms are short-lived and don't affect our ability to function. But, at other times, symptoms can cause serious difficulties with daily functioning and affect our relationships with others, as in the case of conditions such as anxiety disorders, major depressive disorder, schizophrenia, bipolar disorder, and eating disorders, among others.[3]

Mental health conditions can be shaped by **biological factors**, including genes and brain chemistry, and **environmental factors**, including life experiences. Some mental health disorders seem to cluster in families, but they are often shaped by multiple genes, and whether an individual develops symptoms can be further modified by their experiences and surrounding environment.[4, 5] Environmental factors can range from exposure to alcohol or drugs during pregnancy, to birth complications, to discrimination and racism, to adverse childhood experiences (ACEs) such as abuse, neglect, exposure to community violence, and living in under-resourced or racially segregated neighborhoods.[6, 7, 8, 9, 10, 11, 12] ACEs can undermine a child's sense of safety, stability, bonding, and wellbeing.[13] Moreover, ACEs may lead to the development of toxic stress. Toxic stress can cause long lasting changes, including disrupting brain development and increasing the risk for mental health conditions and other health problems such as obesity, heart disease, and diabetes, both during and beyond childhood as well as for future generations.[12, 14]

Biological and environmental factors can also be interrelated, making it difficult to isolate unique "causes" of mental health challenges. For example, if a child is genetically predisposed to depression, they might be more affected by experiences such as bullying than other children.[15, 16]

Figure 1 (next page) includes a longer list of factors that shape the mental health of young people.

FIGURE 1


FACTORS THAT CAN SHAPE THE MENTAL HEALTH OF YOUNG PEOPLE
Source: Adapted from WHO's Determinants of Adolescent Health Development: An Ecological Model, 2014 and Bronfenbrenner & Ceci (1994)
Society
Environment
Community
Family
Individual
Social and economic inequalities, discrimination, racism, migration, media and technology, popular culture, government policies
Neighborhood safety, access to green spaces, healthy food, housing, health care, pollution, natural disasters, climate change
Relationships with peers, teachers, and mentors; faith community; school climate, academic pressure, community support
Relationships with parents, caregivers, and siblings; family mental health; financial stability; domestic violence; trauma
Age, genetics, race, ethnicity, gender, sexual orientation, disability, beliefs, knowledge, attitudes, coping skills
These are examples and not a comprehensive list of factors

Even before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the US with a reported mental, emotional, developmental, or behavioral disorder.[17] In 2016, of the 7.7 million children with treatable mental health disorder, about half did not receive adequate treatment.[18]

Unfortunately, in recent years, national surveys of youth have shown major increases in certain mental health symptoms, including depressive symptoms and suicidal ideation. From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%.[19] Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%.[20] Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%.[21] Early estimates from the National Center for Health Statistics suggest there were tragically more than 6,600 deaths by suicide among the 10-24 age group in 2020.[22]

Scientists have proposed various hypotheses to explain these trends. While some believe that the trends in reporting of mental health challenges are partly due to young people becoming more willing to openly discuss mental health concerns,[23] other researchers point to the growing use of digital media,[24, 25, 26] increasing academic pressure,[27, 28, 29] limited access to mental health care,[18, 30] health risk behaviors such as alcohol and drug use,[31] and broader stressors such as the 2008 financial crisis, rising income inequality, racism, gun violence, and climate change.[32, 33, 34, 35]

It's also important to acknowledge that the prevalence of mental health challenges varies across subpopulations. For instance, girls are much more likely to be diagnosed with anxiety, depression, or an eating disorder, while boys are more likely to die by suicide or be diagnosed with a behavior disorder, such as attention deficit hyperactivity disorder (ADHD).[36, 37, 38] In recent years, suicide rates among Black children (below age 13) have been increasing rapidly, with Black children nearly twice as likely to die by suicide than White children.[39] Moreover, socioeconomically disadvantaged children and adolescents—for instance, those growing up in poverty—are two to three times more likely to develop mental health conditions than peers with higher socioeconomic status.[40]

The COVID-19 Pandemic's Impact on the Mental Health of Children and Youth

During the pandemic, children, adolescents, and young adults have faced unprecedented challenges. The COVID-19 pandemic has dramatically changed their world, including how they attend school, interact with friends, and receive health care. They missed first days of school, months or even years of in-person schooling, graduation ceremonies, sports competitions, playdates, and time with relatives. They and their family may have lost access to mental health care, social services, income, food, or housing.[41] They may have had COVID-19 themselves, suffered from long COVID symptoms, or lost a loved one to the disease—it's estimated that as of June 2021, more than 140,000 children in the US had lost a parent or grandparent caregiver to COVID-19.[42]

Since the pandemic began, rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders, have increased. Recent research covering 80,000 youth globally found that depressive and anxiety symptoms doubled during the pandemic, with 25% of youth experiencing depressive symptoms and 20% experiencing anxiety symptoms.[43] Negative emotions or behaviors such as impulsivity and irritability—associated with conditions such as ADHD—appear to have moderately increased.[44] Early clinical data are also concerning: In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019.[45] Moreover, pandemic-related measures reduced in-person interactions among children, friends, social supports, and professionals such as teachers, school counselors, pediatricians, and child welfare workers. This made it harder to recognize signs of child abuse, mental health concerns, and other challenges.[46]

During the pandemic, young people also experienced other challenges that may have affected their mental and emotional wellbeing: the national reckoning over the deaths of Black Americans at the hands of police officers, including the murder of George Floyd; COVID-related violence against Asian Americans; gun violence; an increasingly polarized political dialogue; growing concerns about climate change; and emotionally-charged misinformation.[47, 48, 49, 50, 51]

Although the pandemic's long-term impact on children and young people is not fully understood, there is some cause for optimism. According to more than 50 years of research, increases in distress symptoms are common during disasters, but most people cope well and do not go on to develop mental health disorders.[52] Several measures of distress that increased early in the pandemic appear to have returned to pre-pandemic levels by mid-2020.[53, 54] Some other measures of wellbeing, such as rates of life satisfaction and loneliness, remained largely unchanged throughout the first year of the pandemic.[53, 55] And while data on youth suicide rates are limited, early evidence does not show significant increases.[56, 57]

In addition, some young people thrived during the pandemic: They got more sleep, spent more quality time with family, experienced less academic stress and bullying, had more flexible schedules, and improved their coping skills.[44, 58, 59, 60] Many young people are resilient, able to bounce back from difficult experiences such as stress, adversity, and trauma.[61]

That said, the pandemic is ongoing, with nearly 1,000 Americans dying per day as of early December 2021.[62] And many millions of children and youth have faced and continue to face major challenges. Importantly, the pandemic's negative impacts, such as illness and death in families and disruptions in school and social life, disproportionately impacted those who were vulnerable to begin with and widened disparities.[63] For additional details, see Boxes 1 and 2. **Box 1** discusses **risk factors** contributing to children's mental health symptoms during the pandemic. **Box 2** discusses **demographic groups** at greater risk of developing mental health problems during the pandemic.

BOX 1

RISK FACTORS CONTRIBUTING TO YOUTH MENTAL HEALTH SYMPTOMS DURING THE PANDEMIC *Note: Not a comprehensive list of risk factors*

Having **mental health challenges** before the pandemic[61, 64]

Living in an **urban area** or an **area with more severe COVID-19 outbreaks**[65]

Having parents or caregivers who were **frontline workers**[66]

Having parents or caregivers at elevated risk of **burnout** (for example, due to parenting demands)[67, 68]

Being **worried about COVID-19**[64]

Experiencing **disruptions in routine**, such as not seeing friends or going to school in person[69, 70, 71]

Experiencing more **adverse childhood experiences (ACEs)** such as abuse, neglect, community violence, and discrimination[72, 73, 74]

Experiencing more **financial instability, food shortages, or housing instability**[75, 76]

Experiencing **trauma**, such as losing a family member or caregiver to COVID-19[77]

BOX 2

GROUPS AT HIGHER RISK OF MENTAL HEALTH CHALLENGES DURING THE PANDEMIC

Note: Not a comprehensive list of groups or risk factors

Youth with intellectual and developmental disabilities (IDDs), who found it especially difficult to manage disruptions to school and services such as special education, counseling, occupational, and speech therapies[78, 79, 80, 81, 82]

Racial and ethnic minority youth,[83] **including:**

- **American Indian and Alaska Native youth,** many of whom faced challenges staying connected with friends and attending school due to limited internet access[84]
- **Black youth**, who were more likely than other youth to lose a parent or caregiver to COVID-19[42]
- **Latino youth**, who reported high rates of loneliness and poor or decreased mental health during the pandemic[85, 86]
- **Asian American, Native Hawaiian, and Pacific Islander youth**, who reported increased stress due to COVID-19-related hate and harassment[87, 88]

LGBTQ+ youth, who lost access to school-based services and were sometimes confined to homes where they were not supported or accepted[89, 90]

Low-income youth, who faced economic, educational, and social disruptions (for example, losing access to free school lunches)[91]

Youth in rural areas, who faced additional challenges in participating in school or accessing mental health services (for example, due to limited internet connectivity)[92]

Youth in immigrant households, who faced language and technology barriers to accessing health care services and education[93]

Special youth populations, including youth involved with the juvenile justice, or child welfare systems, as well as runaway youth and youth experiencing homelessness[61, 94, 95, 96]

Additional considerations:

- **Youth with multiple risk factors.** Many young people are part of more than one at-risk group, which can put at them at even higher risk of mental health challenges. For example, children with IDDs who lost a parent to COVID-19, or Black children from low-income families, may require additional support to address multiple risk factors.[97]
- **Discrimination in the health care system.** Some groups of youth and their families, such as people of color, immigrants, LGBTQ+ people, and people with disabilities, may be more hesitant to engage with the health care system (including mental health services) due to current and past experiences with discrimination.[97, 98, 99]
- **Risks of COVID-19 to children with mental health conditions.** Children with mood disorders, such as depression and bipolar disorder, as well as schizophrenia spectrum disorders, are at elevated risk of severe COVID-19 illness.[100, 101, 102]

WE CAN TAKE ACTION

The good news is that, throughout the pandemic, many people have recognized the unprecedented need to support youth mental health and wellbeing and have taken action to do so. Many young people found ways to cope with disruption and stay connected.[103] Families helped children adjust to remote learning.[104] Educators and school staff supported their students while facing unprecedented challenges themselves.[105] Health care professionals rapidly shifted to telehealth.[106] Community organizations stepped in to protect at-risk youth.[107] Employers helped employees adapt to remote work environments.[108] And governments invested trillions of dollars to mitigate financial hardship for families, support COVID-19 testing and vaccination, provide health care and other social services, and support the safe reopening of schools, among other policies.[109, 110, 111]

But there is much more to be done, and each of us has a role to play. Supporting the mental health of children and youth will require a whole-of-society effort to address longstanding challenges, strengthen the resilience of young people, support their families and communities, and mitigate the pandemic's mental health impacts. Here is what we must do:

- **Recognize that mental health is an essential part of overall health.** Mental health conditions are real, common, and treatable, and people experiencing mental health challenges deserve support, compassion, and care, not stigma and shame. Mental health is no less important than physical health. And that must be reflected in our how we communicate about and prioritize mental health.

- **Empower youth and their families to recognize, manage, and learn from difficult emotions.** For youth, this includes building strong relationships with peers and supportive adults, practicing techniques to manage emotions, taking care of body and mind, being attentive to use of social media and technology, and seeking help when needed. For families and caregivers, this means addressing their own mental health and substance use conditions, being positive role models for children, promoting positive relationships between children and others as well as with social media and technology, and learning to identify and address challenges early. Youth and families should know that asking for help is a sign of strength.

- **Ensure that every child has access to high-quality, affordable, and culturally competent mental health care.** Care should be tailored to children's developmental stages and health needs, and available in primary care practices, schools, and other community-based settings. It's particularly important to intervene early, so that emerging symptoms don't turn into crises.

- **Support the mental health of children and youth in educational, community, and childcare settings.** This includes creating positive, safe, and affirming educational environments, expanding programming that promotes healthy development (such as social and emotional learning), and providing a continuum of supports to meet the social, emotional, behavioral, and mental health needs of children and youth. To achieve this, we must also expand and support the early childhood and education workforce.

- **Address the economic and social barriers that contribute to poor mental health for young people, families, and caregivers.** Priorities should include reducing child poverty and ensuring access to quality childcare, early childhood services, and education; healthy food; affordable health care; stable housing; and safe neighborhoods.[112, 113]

- **Increase timely data collection and research to identify and respond to youth mental health needs more rapidly.** The country needs an integrated, real-time data infrastructure for understanding youth mental health trends. More research is also needed on the relationship between technology and mental health, and technology companies should be more transparent with their data and algorithmic processes to enable this research. We also need to better understand the needs of at-risk youth, including youth facing multiple risk factors. Governments and other stakeholders should engage directly with young people to understand trends and design effective solutions.

WE CAN TAKE ACTION

WHAT YOUNG PEOPLE CAN DO

Since many of the challenges young people face are outside of their control, we need a whole-of-society effort to support children's mental health and wellbeing from birth to adulthood. That said, below are important steps children and young people themselves can take to protect, improve, and advocate for their mental health and that of their family, friends, and neighbors:

- **Remember that mental health challenges are real, common, and treatable.** Struggling with your mental health does not mean you are broken or that you did something wrong. Mental health is shaped by many factors, including biology and life experiences, and there are many ways mental health challenges can be addressed.

- **Ask for help.** Find trusted adults, friends, or family members to talk to about stressful situations. For example, if you or someone you know is being bullied, tell a trusted adult. If you are struggling to manage negative emotions, reach out to a school nurse or counselor, a teacher, a parent or caregiver, a coach, a faith leader, or someone else you look up to and trust. Look into therapy or counseling resources to get support when something causes distress and interferes with your life. Reaching out to others can be hard and takes courage, but it is worth the effort and reminds us we are not alone.

- **Invest in healthy relationships.** Social connection is a powerful buffer to stress and a source of wellbeing. But too often in our fast-paced lives, quality time with people gets crowded out. Make space in your life for the people you love. Spend time with others regularly, in-person and virtually.[114] Find people who support and care about you and have open and honest conversations with them about your feelings. Get involved in group activities, such as recreation and outdoor activities, after-school programs, and mentorship programs.[115]

- **Find ways to serve.** Volunteering in your community and helping others can be a great way to connect with people, build a sense of purpose, and develop your own sense of self-worth.[116] Helping others when you are the one struggling can seem counterintuitive. But service is a powerful antidote to isolation, and it reminds us that we have value to add to the world.

- **Learn and practice techniques to manage stress and other difficult emotions.** Try to recognize situations that may be emotionally challenging for you, and come up with strategies to manage those emotions. For example, if you find it stressful to look at COVID-related news, try to check the news less often, take a break for a day or a week at a time, keep notifications off throughout the day, and avoid looking at negative stories before bed.[51]

- **Take care of your body and mind.** Stick to a schedule, eat well, stay physically active, get quality sleep, stay hydrated, and spend time outside.[117, 118, 119] And avoid substances that can ultimately make you feel tired, down, or depressed, such as alcohol, marijuana, vaping, and tobacco.[120]

- **Be intentional about your use of social media, video games, and other technologies.** Here are some questions to help guide your technology use: How much time are you spending online? Is it taking away from healthy offline activities, like exercising, seeing friends, reading, and sleeping? What content are you consuming, and how does it make you feel? Are you online because you want to be, or because you feel like you have to be?

- **Be a source of support for others.** Talk to your family and friends about mental health, listen and be a source of support to them, and connect them to the right resources.[121] Advocate for and contribute your ideas at the local, state, or national levels. For example, look into joining Youth Advisory Councils or mental health peer support programs in your community.[122]

RESOURCES FOR YOUNG PEOPLE

If you're in crisis, get immediate help: Call the National Suicide Prevention Lifeline at 1-800-273-8255, **chat** with trained counselors 24/7, or get help in **other ways** through the Lifeline

How Right Now (Centers for Disease Control and Prevention): Resources for coping with negative emotions and stress, talking to loved ones, and finding inspiration

Youth Engaged 4 Change: Opportunities for youth to make a difference in their lives and in the world around them

Supporting Emotional Wellbeing in Children and Youth (National Academies of Medicine): Tools for children, teens, and parents to learn how to cope with challenges

Mental Health Resource Center (JED Foundation): Information about common emotional health issues and how to overcome challenges

Youth Wellbeing Initiatives (National Council for Mental Wellbeing): Collection of initiatives to improve mental wellbeing in youth and young adults

Kids, Teens, and Young Adults (National Alliance on Mental Illness): Resources for young people to get mental health support

One Mind PsyberGuide: A guide to navigating mental health apps and digital technologies

FindTreatment.gov (SAMHSA): Information on substance use and mental health treatment

Trevor Project: Suicide prevention and crisis intervention resources for LGBTQ+ young people

AAKOMA Mental Health Resources (The AAKOMA Project): Resources to support the mental health of youth of color and their caregivers

Mental Health for Immigrants (Informed Immigrant): Tips for managing the mental health of yourself and others

WE CAN TAKE ACTION

WHAT FAMILY MEMBERS AND CAREGIVERS CAN DO

Families and caregivers play a critical role in providing the safe, stable, and nurturing environments and relationships young people need to thrive. Below are recommendations for how families and caregivers can engage with children and youth on mental health topics, help them become more resilient, and address emerging mental health challenges:

- **Be the best role model you can be for young people by taking care of your own mental and physical health.** Young people often learn behaviors and habits from what they see around them. You can model good habits by talking to children about the importance of mental health, seeking help when you need it, and showing positive ways you deal with stress so children learn from you. Additional ways to take care of your own mental health include taking breaks, getting enough sleep, exercising, eating balanced meals, maintaining regular routines, obtaining health insurance coverage, staying connected with family and friends, and taking time to unplug from technology or social media.[123]

- **Help children and youth develop strong, safe, and stable relationships with you and other supportive adults.** Research shows that the most important thing a child needs to be resilient is a stable and committed relationship with a supportive adult.[124] Spend time with children on activities that are meaningful to them, show them love and acceptance, praise them for the things they do well, listen to them, and communicate openly about their feelings. Encourage children to ask for help and connect them with other adults who can serve as mentors.[125]

- **Encourage children and youth to build healthy social relationships with peers.** This can be done through self-directed play and structured activities such as school, after school programs, sports, and volunteering.[126] Since peers can play a major role (both positive and negative) in children's development, it's important to help children learn how to deal with peer pressure. Have open conversations with your child about their values and teach them to be confident and comfortable in expressing their needs and boundaries.

- **Do your best to provide children and youth with a supportive, stable, and predictable home and neighborhood environment.** A lot may be outside of your control, and there will be trial and error as you figure out what works best for your child. That said, try to help children stick to a regular and predictable daily schedule, such as regular dinnertime and bedtime.[117, 126, 127] Be thoughtful about whether and how to discuss stressful topics such as financial and marital problems. The American Psychological Association offers tips on how to talk with your child about difficult topics.[128] It's also important to minimize children's exposure to violence, which puts them at risk of mental health and substance use challenges.[129]

- **Try to minimize negative influences and behaviors in young people's lives.** Talk to children early about the risks of alcohol and other drugs, both short-term (such as car crashes and other accidents) and long-term (such as reduced cognitive abilities). The earlier a child or adolescent begins using substances, the greater their chances of developing substance use problems.[131] Mental health and substance use problems can also occur at the same time. For example, some young people struggling with stress or difficult feelings turn to alcohol or drug use.[132] And alcohol and other drugs can also affect mental health, for example by altering mood or energy levels.[133]

- **Ensure children and youth have regular check-ups with a pediatrician, family doctor, or other health care professional.** Health care professionals can help you monitor your children's health, give you advice on how to prevent problems, and diagnose and treat physical and mental illnesses. Obtaining health insurance coverage for your children can help. To learn more about enrolling in Medicaid, the Children's Health Insurance Program (CHIP), or a Marketplace plan, go to **HealthCare.gov** or **InsureKidsNow.gov**.

- **Look out for warning signs of distress, and seek help when needed.** Signs of distress in children can show up in a number of ways, such as irritability, anger, withdrawal, and other changes in their thoughts, appearance, performance at school, sleeping or eating patterns, or other behaviors.)[134] If you notice concerning changes in your child, let them know you're there and ready to support them however they need. Don't be afraid to ask for help by talking to a doctor, nurse, or other professional or looking into other available resources in your community. For example, schools often have counseling services and additional accommodations (e.g., for students enrolled in special education programs).

- **Minimize children's access to means of self-harm, including firearms and prescription medications.** Dispose of unused or expired prescriptions and keep medications out of reach for children and youth. If you choose to keep firearms in the home, ensure that they are stored safely: unloaded and locked up (e.g., in a lock box or safe). Having firearms in the home increases the likelihood of firearm-related death.[135, 136] In fact, firearms are by far the most lethal means of suicide: 90% of attempted suicides with a firearm result in death, compared to less than 10% of attempted suicides overall.[137]

- **Be attentive to how children and youth spend time online.** Digital technology can help young people connect with friends and family, learn about current events, express themselves, and access telehealth and other resources.[138] At the same time, children can have negative experiences online, such as being bullied, finding harmful information, and negatively comparing themselves to others.[139] **Box 3** has a list of questions you can ask yourself about your child's use of technology.

- **Be a voice for mental health in your community.** There are many ways to do this, from talking openly with friends and family about the importance of mental health, to going to school board meetings or a town hall, to volunteering with an advocacy group, to promoting greater funding and awareness of mental health programs in schools and local organizations, such as churches, libraries, parks and recreation, or sports teams.

BOX 3

TECHNOLOGY AND YOUTH MENTAL HEALTH: QUESTIONS FOR FAMILIES TO CONSIDER

Time

- How much time is my child spending online? Is it taking away from healthy offline activities, such as exercising, seeing friends, reading, and sleeping?
- Are there healthy limits I can set on my child's use of technology, such as limiting screen time to specific times of the day or week, or limiting certain kinds of uses?

Content

- Am I aware of what devices and content my child has access to?
- Is my child getting something meaningful and constructive out of content they are looking at, creating, or sharing? How do I know?
- Are there healthier ways my child could engage online? (Examples: Finding meal recipes, researching options for a family outing, video chatting with a relative, etc.)
- Is being online riskier for my child than for some other children? For example, does my child have a mental health condition that might make them react more strongly to certain kinds of stressful or emotional content?

Impact

- How does my child feel about the time they spend online?
- Is my child engaging because they want to, or because they feel like they have to?
- How can I create space for open conversations with my child about their experiences online?
- How do I feel about my own use of technology? Can I be a better role model for my child?

RESOURCES FOR FAMILIES

Children's Mental Health and **COVID-19 Parental Resources Kit** (CDC): Resources for supporting children's social, emotional, and mental health

HealthyChildren.org (American Academy of Pediatrics): Parenting tips and other resources

What's On Your Mind? (UNICEF): Guide for talking to children about mental health

Family Resource Center (Child Mind Institute): Family resources on child mental health, including **Media Guidelines for Kids of All Ages**

NetSmartz (National Center for Missing and Exploited Children): Online platform to teach children online safety in age-appropriate ways

Parents' Ultimate Guides (Common Sense Media): Information about the safety of current media and technology trends and apps for your children

HealthCare.gov or **InsureKidsNow.gov**: Information on enrolling in health insurance coverage

MentalHealth.gov: What to look for, how to talk about mental health, and how to get help

Aging and Disability Networks (ACL): Connect with advocacy and caregiver resources

WHAT EDUCATORS, SCHOOL STAFF, AND SCHOOL DISTRICTS CAN DO

The experiences children and young people have at school have a major impact on their mental health. At school, children can learn new knowledge and skills, develop close relationships with peers and supportive adults, and find a sense of purpose, fulfillment, and belonging. They can also find help to manage mental health challenges. On the other hand, children can also have highly negative experiences at school, such as being bullied, facing academic stress, or missing out on educational opportunities (for example, due to under-resourced schools). Mental health challenges can reveal themselves in a variety of ways at school, such as in a student having trouble concentrating in class, being withdrawn, acting out, or struggling to make friends. In light of these factors, below are recommendations for how schools, educators, and staff can support the mental health of all students:

- **Create positive, safe, and affirming school environments.** This could include developing and enforcing anti-bullying policies, training students and staff on how to prevent harm (e.g., implementing bystander interventions for staff and students), being proactive about talking to students and families about mental health, and using inclusive language and behaviors.[140, 141] Where feasible, school districts should also consider structural changes, such as a later start to the school day, that support students' wellbeing.[142, 143]

- **Expand social and emotional learning programs and other evidence-based approaches that promote healthy development.** Examples of social, emotional, and behavioral learning programs include Sources of Strength, The Good Behavior Game, Life Skills Training, Check-In/Check-Out, and PATHS.[144, 145, 146, 147] Examples of other approaches include positive behavioral interventions and supports and digital media literacy education.

- **Learn how to recognize signs of changes in mental and physical health among students, including trauma and behavior changes. Take appropriate action when needed.**[148] Educators are often the first to notice if a student is struggling or behaving differently than usual (for example, withdrawing from normal activities or acting out). And educators are well-positioned to connect students to school counselors, nurses, or administrators who can further support students, including by providing or connecting students with services.[149]

- **Provide a continuum of supports to meet student mental health needs, including evidence-based prevention practices and trauma-informed mental health care.** Tiered supports should include coordination mechanisms to get students the right care at the right time.[150] For example, the Project AWARE (Advancing Wellness and Resilience in Education) program provides funds for state, local, and tribal governments to build school-provider partnerships and coordinate resources to support prevention, screening, early intervention, and mental health treatment for youth in school-based settings.[151] School districts could also improve the sharing of knowledge and best practices.

For example, districts could dedicate staff at the district level to implementing evidence-based programs across multiple schools). Districts could also implement mental health literacy training for school personnel (e.g., Mental Health Awareness Training, QPR training).

- **Expand the school-based mental health workforce.**[152] This includes using federal, state, and local resources to hire and train additional staff, such as school counselors, nurses, social workers, and school psychologists, including dedicated staff to support students with disabilities. For example, a lack of school counselors makes it harder to support children experiencing mental health challenges. The American School Counselor Association (ASCA) recommends 1 counselor for every 250 students, compared to a national average of 1 counselor for every 424 students (with significant variation by state).[153] The American Rescue Plan's Elementary and Secondary School Emergency Relief funds can be used for this purpose and for other strategies outlined in this document.[154]

- **Support the mental health of all school personnel.** Opportunities include establishing realistic workloads and student-to-staff ratios, providing competitive wages and benefits (including health insurance with affordable mental health coverage), regularly assessing staff wellbeing, and integrating wellness into professional development.[155] In addition to directly benefitting school staff, these measures will also help school personnel maintain their own empathy, compassion, and ability to create positive environments for students.[156]

- **Promote enrolling and retaining eligible children in Medicaid, CHIP, or a Marketplace plan, so that children have health coverage that includes behavioral health services.** The Connecting Kids to Coverage National Campaign also has outreach resources for schools, providers, and community-based organizations to use to encourage parents and caregivers to enroll in Medicaid and CHIP to access important mental health benefits. Families can be directed to **HealthCare.gov** or **InsureKidsNow.gov**. Schools can use Medicaid funds to support enrollment activities and mental health services.[157]

- **Protect and prioritize students with higher needs and those at higher risk of mental health challenges**, such as students with disabilities, personal or family mental health challenges, or other risk factors (e.g., adverse childhood experiences, trauma, poverty).[158]

RESOURCES FOR EDUCATORS, SCHOOL STAFF, AND SCHOOL DISTRICTS

Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs (Dept. of Education): Guidance for schools, school districts, and education departments

National Center for School Mental Health: Resources to promote a positive school climate

StopBullying.gov: Learn about what bullying is, who is at risk, and how you can help

Turnaround for Children Toolbox: Tools to drive change towards a more equitable, whole- child approach to school

Design Principles for Schools: Framework for redesigning schools with a focus on supporting students' learning and social and emotional development

Safe Schools Fit Toolkit (National Center for Healthy Safe Children): Resources and guides to build safe and healthy schools

Mental Health Technology Transfer Center Network: School mental health resources

WHAT HEALTH CARE ORGANIZATIONS AND HEALTH PROFESSIONALS CAN DO

Our health care system today is not set up to optimally support the mental health and wellbeing of children and youth. In addition to changing government policy (see recommendations for Governments on page 33), we must reimagine how health care organizations and health professionals prevent, identify, and address mental health challenges. Below are some steps health care organizations and health professionals can take:

- **Recognize that the best treatment is prevention of mental health challenges. Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all youth, especially those with a history of adversity.** In addition to working in the clinic, for example to educate families on their role in healthy child development, health care professionals should work with other sectors (e.g., schools, child care, justice, social services, public health) on prevention strategies. For instance, health care professionals can refer patients to resources such as economic supports, school enrichment programs, and legal supports.[12]

- **Routinely screen children for mental health challenges and risk factors, including adverse childhood experiences (ACEs).[159] Screenings can be done in primary care, schools, emergency departments, and other settings.** For example, primary care providers can conduct screenings during well-visit appointments, annual physicals, or routine vaccinations using principles of trauma-informed care. Screenings should account for the diverse ways in which mental health challenges can manifest, such as changes in physical health, sleep patterns, and behaviors. It's critical that screening services link to appropriate follow-up care. The American Academy of Pediatrics offers tools and resources for screening processes. California's ACEs Aware initiative offers ACEs screening tools for children, adolescents, and young adults.

- **Identify and address the mental health needs of parents, caregivers, and other family members.** The mental health of children and youth is closely linked to the mental health and wellbeing of their families. Screening parents and caregivers for depression, intimate partner violence, substance use, and other challenges can be combined with broader assessments of food insecurity, housing instability, and other social determinants of health.[160]

- **Combine the efforts of clinical staff with those of trusted community partners and child-serving systems (e.g., child welfare, juvenile justice).** For example, hospital-based violence intervention programs (HVIPs) identify patients at risk of repeat violent injury and link them to hospital- and community-based resources to address risk factors for violence.[161, 162, 163, 164] Another example initiative is school-hospital partnerships, such as behavioral health urgent care clinics supported by schools.[165] New payment and delivery models, such as the Centers for Medicare & Medicaid Services Innovation Center's Integrated Care for Kids (InCK) Model, can be used to support the mental health-related needs of children across settings.[166]

- **Build multidisciplinary teams to implement services that are tailored to the needs of children and their families.** Enlist children and families as partners and engage them in all stages of decision-making, from screening to treatment.[167] Recognize that a variety of cultural and other factors shape whether children and families are able or willing to seek mental health services. Accordingly, services should be culturally appropriate, offered in multiple languages (including ASL), and delivered by a diverse mental health workforce. Additionally, **support the wellbeing of mental health workers and community leaders,** building their capacity to support youth and their families.

RESOURCES FOR HEALTH CARE ORGANIZATIONS AND HEALTH PROFESSIONALS

Mental Health Initiatives (American Academy of Pediatrics): Information and guidance on supporting the healthy mental development of children, adolescents, and families. For example, see **here** for information on developing age-appropriate screening processes.

HealthySteps Model (Zero to Three): A primary care model that brings together child development experts, specialists, and pediatric primary care providers to promote healthy child development

Evidence-Based Practices Resource Center (Substance Abuse and Mental Health Services Administration): Information to incorporate evidence-based practices into communities and clinical settings

Behavioral Health Integration Compendium (American Medical Association): Steps for integrating behavioral health care into a clinical practice

Telemental Health Resource Center (Western Regional Children's Advocacy Center): Information and tools to set up telehealth programs for mental health

ACEs Screening Tools (California's ACEs Aware Initiative): Offers tools to screen children, adolescents, and adults for ACEs

Trauma Screening Tools (Childhood Trauma Toolkit, Centre for Addiction and Mental Health): ACEs questionnaire and developmental trauma symptom screening checklist

WE CAN TAKE ACTION

WHAT MEDIA ORGANIZATIONS, ENTERTAINMENT COMPANIES, AND JOURNALISTS CAN DO

Note: See next section for recommendations specific to technology platforms such as social media companies.

Media organizations, entertainment companies, and journalists can have a powerful impact on young people. In some cases, this impact can be positive. For example, television programs can keep children and adolescents informed about current events and teach them valuable lessons.[168] On the other hand, false, misleading, or exaggerated media narratives can perpetuate misconceptions and stigma against people with mental health or substance use problems.[169, 170] In addition, media coverage of traumatic events, such as bombings and natural disasters, can contribute to psychological distress among consumers.[171, 172, 173, 174, 175] Particularly in times of global crisis, such as the COVID-19 pandemic, people can come away from news stories feeling anxious and powerless.[176] Below are steps media organizations can take to protect the mental health of viewers while staying true to their role in informing the public:

- **Recognize the impact media coverage of negative events can have on the public's mental health.** The solution isn't to hide or downplay negative news, but rather to avoid misleading consumers, and to be more attentive to how stories are framed. Example best practices include:
  - Being **fact-based** in reporting and avoiding language that shocks, provokes, or creates a sense of panic.
  - Being more **cautious** about showing distressing content, particularly graphic images or video, without context or warnings for viewers. Help viewers **decide** whether they want to engage with the content.[177]
  - Giving audiences **context**, including highlighting uncertainties and conflicting reports. When discussing preliminary research—such as papers that have not yet been peer-reviewed—outlets should be forthright about the preliminary nature of the findings, get independent experts to weigh in, and identify areas of uncertainty.
  - Offering the public ways to make a **positive difference** (for example, ways to donate funds or supplies to victims of a natural disaster).
  - Including **positive messages and stories of hope and healing** (particularly when covering pandemics, natural disasters, and incidents of mass violence).

- **Normalize stories about mental health and mental illness across all forms of media, taking care to avoid harmful stereotypes, promote scientifically accurate information, and include stories of help, hope, and healing.** Example best practices[178] include:
  - Avoiding harmful **stereotypes** about mental illness, such as the idea that people who have a mental illness are prone to violence or that mental illness causes violence. Research shows this is not the case.[179]
  - Avoiding **demeaning language** (e.g., "crazy," "psycho," "looney," "wacko", "nut," "junkie"). This includes using **person-centered language**, or language that focuses on the person rather than a disease label.[180] For example, instead of referring to someone as a "schizophrenic," refer to them as a "person living with schizophrenia."
  - Include stories of people seeking **help**, getting **treatment**, and successfully **recovering**. These can also include examples of people getting help from friends, family neighbors, or even strangers (not just mental health professionals).[181]
  - Direct consumers to **mental health resources** (as part of any mental health-related TV episode, movie, news story, podcast, or other media).
  - Craft more **authentic stories** by consulting with subject matter experts and people with personal experience of mental illness or mental health challenges.
- **Whenever depicting suicide or suicidal ideation, adhere to best practices such as the National Recommendations for Depicting Suicide.**[182] For example:
  - Convey that suicide is complex and often caused by multiple factors, not a single event.
  - Show that help is available. For example, in TV shows or movies, show characters reaching out to health professionals, talking to supportive peers, friends, or family, or calling or texting a crisis hotline.

RESOURCES FOR MEDIA ORGANIZATIONS, ENTERTAINMENT COMPANIES, AND JOURNALISTS

Mental Health Media Guide: A guide to mental health storytelling developed by a coalition of mental health experts and entertainment industry leaders

National Center on Disability and Journalism Resources: Effective, sensitive ways to talk about disability in the media

National Recommendations for Depicting Suicide (National Action Alliance): Guidance for content creators to tell more balanced and authentic stories involving suicide

WE CAN TAKE ACTION

WHAT SOCIAL MEDIA, VIDEO GAMING, AND OTHER TECHNOLOGY COMPANIES CAN DO

Over the past two decades, more and more of our lives have moved onto social media platforms and other digital public spaces. The COVID-19 pandemic has rapidly accelerated this trend. During the pandemic, the time teenagers spent in front of screens for activities not related to school more than doubled, from 3.8 to 7.7 hours per day.[183] In 2020, 81% of 14- to 22-year-olds said they used social media either "daily" or "almost constantly."[138]

In these digital public spaces, which privately owned and tend to be run for profit, there can be tension between what's best for the technology company and what's best for the individual user or for society. Business models are often built around maximizing user engagement as opposed to safeguarding users' health and ensuring that users engage with one another in safe and healthy ways.[184, 185] **This translates to technology companies focusing on maximizing time spent, not time well spent.**

In recent years, there has been growing concern about the impact of digital technologies, particularly social media, on the mental health and wellbeing of children and young people.[186, 187, 188] Part of the challenge with research on this topic is that digital technology involves a vast range of devices, platforms, products, and activities, so it's hard to generalize. Researchers also have limited access to data to inform potential research.

Many researchers argue that digital technologies can expose children to bullying, contribute to obesity and eating disorders, trade off with sleep, encourage children to negatively compare themselves to others, and lead to depression, anxiety, and self-harm.[139, 187, 189, 190, 191, 192] Several studies have linked time spent on social media to mental health challenges such as anxiety and depression.[26, 193, 194, 195, 196, 197] Meanwhile, others have cast doubt on the idea that technology or social media use is a major factor in youth wellbeing.[198, 199, 200, 201, 202, 203]

Importantly, the impact of technology almost certainly varies from person to person, and it also matters what technology is being used and how.[204] **So, even if technology doesn't harm young people on average, certain kinds of online activities likely do harm some young people.** For example, some research has linked "passive" social media use (such as scrolling through posts and auto-play video) to declines in wellbeing (versus more "active" use such as commenting on posts or recording videos).[205]

There can also be benefits to certain online activities, such as connecting meaningfully with friends and family, learning a new skill, or accessing health care, and these also vary from person to person.[206] For example, LGBTQ+ young people may be more vulnerable than other young people to cyberbullying but also more likely to consider social media important for feeling less alone, expressing themselves, finding inspiration, and getting support.[138, 207]

There is a clear need to better understand the impact of technologies such as social media on different kinds of users, and to address the harms to users most at risk. We need more research using strong data and research methods, such as longitudinal and experimental designs, behavioral (as opposed to self-reported) measures of time spent online and types of content engaged with, as well as data on subgroups of users (e.g., boys vs. girls).[208, 209]

Most importantly, technology companies must step up and take responsibility for creating a safe digital environment for children and youth. Today, most companies are not transparent about the impact of their products, which prevents parents and young people from making informed decisions and researchers from identifying problems and solutions. At a minimum, the public and researchers deserve much more transparency. More broadly, below are specific recommendations for how these companies can prioritize the wellbeing of users above monetizing those users for profit:

- **Prioritize user health and wellbeing at all stages of product development.**[210]
  - **Elevate user safety, health, and wellbeing in the culture and leadership of technology companies.** Senior technology executives should acknowledge that their products can harm some young people and take material and measurable steps to prevent and mitigate these harms, even at the expense of engagement, scale, and profit. Leaders should be accountable for creating a safe, accessible, and inclusive digital environment for their users and designing safe products.

  - **Assess and address risks to users at the front end of product development.** Build products and services using a precautionary approach that focuses on making them safe for youth before they are deployed. Company employees at all levels, especially those involved in product development, should be expected to prioritize user health and wellbeing in their day-to-day work. For example, consider how to align performance incentives for product developers to measures of user wellbeing. Develop consistent procedures for receiving input on proposed products from youth, parents, health and youth development professionals, and civil society, for example through advisory groups. Create ways for employees to voice concerns about products without fear of retaliation.

  - **Continually measure the impact of products on user health and wellbeing and share data with the public.** Supplement traditional product success metrics, such as monthly active users, with dedicated metrics for user health and wellbeing. In addition to relying on user-reported data (e.g., surveys), consider using behavioral data (e.g., analysis of user inputs such as typed keywords). Make results publicly available. Take corrective action to address harms.

  - **Recognize that the impact of platforms and products can vary from user to user, and proactively ensure that products designed for adults are also safe for children and adolescents.** Consider many kinds of users, including users of different ages and developmental stages, when developing new products and features. Talk to those users and collect data to identify subgroups who may be harmed by certain products or ways of engaging. Use this data to inform product design and research.

- **Be transparent and allow for independent researchers and the public to study the impact of company products on user health and wellbeing.**
  - **Allow users to provide informative data about their online experience to independent researchers.** This should be a fully consented process that allows users to individually request personal data about their use to transfer to researchers (e.g., timestamps of when and how long use takes place; type of content seen and engaged with; whether, when, and how interactions with others took place). Companies should also allow third-party researchers to request data on behalf of users if evidence of full user consent is provided and facilitate the automated transfer of data to third-party researchers (e.g., through application programming interfaces or APIs).

  - **Directly provide researchers with data to enable understanding of (a) subgroups of users most at risk of harm and (b) algorithmic design and operation.** Data on algorithmic design and operation should be of sufficient granularity to allow researchers to understand when, why, and how users are shown different types of content.

  - **Partner with researchers and experts to analyze the mental health impacts of new products and features in advance of rollout. Regularly publish findings.** Where possible, design evaluations in ways that enable causal inference (for example, using randomized interventions).

  - **Allow a broad range of researchers to access data and previous research instead of providing access to a privileged few.** Make research results publicly available and do not bind researchers to non-disclosure agreements. Avoid conflicts of interest that cast doubt on researchers' independence.

- **Build user-friendly tools that help children and adolescents engage online in healthy ways.**
  - **Take a holistic approach to designing online spaces hospitable to young people.** For example, support the creation of **industry-wide safety standards for online health and wellbeing,** in partnership with civil society groups. Just as we have safety standards for offline activities, such as driving, we should also consider standards for online activities.[211, 212] Private organizations, such as video game companies, have already begun sharing best practices and developing a common framework for protecting users.[213]

  - **Limit children's exposure to harmful online content.** This can involve a mix of limiting access for younger users, reducing content amplification, prohibiting data collection of and targeted advertising to children, ensuring privacy settings are maximized by default, removing content quickly if it violates company policies, tightening age verification requirements and audits, enabling independent algorithm audits, and imposing consequences for users found to be circumventing age restrictions or other policies.[227] Companies should conduct research to evaluate whether these measures work. For example, children today can easily get around age limits by claiming to be older than they really are. To address this, some companies have required users to upload an ID and a selfie to verify identity and age (without storing the underlying ID or selfie data).[214]

- **Give users opportunities to control their online activity, including by opting out of content they may find harmful.** For example, some companies have built in "frictions," such as notifications that remind people to take breaks and limit screen time.[215] Other examples of frictions could include banning "auto-play" functions on videos or limiting scrolling capabilities for youth users. Also consider allowing users to opt out of content they believe may harm their mental health, such as ads involving violence, alcohol, or gambling, or content related to eating disorders.[216]

- **Develop products that actively safeguard and promote mental health and wellbeing.** New technologies create opportunities to reach large numbers of youth with educational interventions, such as directing youth to mental health tips and resources.[217] There are also emerging digital technologies—often referred to as "digital therapeutics"—that prevent, manage, and treat health conditions. More and more of these technologies are gaining clinical validation and regulatory approval.[218, 219]

- **Promote equitable access to technology that supports the wellbeing of children and youth.** For example, donate digital technology and remote services (e.g., internet access) to under-resourced populations.

RESOURCES FOR SOCIAL MEDIA, VIDEO GAMING, AND OTHER TECHNOLOGY COMPANIES

Safety by Design (Australia's eSafety Commissioner): Ways technology companies can minimize online threats and harms before they occur

Toolkit For Technologists (Center for Humane Technology): Principles to help create value-driven and humane technology environments

The Children's Code (UK's Information Commissioner): Standards for online services to protect children's safety, rights, and privacy online

The Unseen Teen (Data & Society): A report with challenges and recommendations on improving digital wellbeing for adolescent users

The U.S. Access Board: U.S. federal agency providing technical assistance for content creators and developers

WE CAN TAKE ACTION

WHAT COMMUNITY ORGANIZATIONS CAN DO

Thousands of community organizations are doing heroic work every day to support the mental health of children and young people. While different groups address different parts of the problem, serve different youth populations, and implement different solutions, all community organizations can keep the following recommendations in mind as they continue their work:

- **Educate the public about the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness.** Community groups can play a key role in fostering open dialogue about mental health at the local level and correcting misconceptions and biases. For example, community groups can partner with trusted messengers such as faith leaders and health care professionals to speak to community members about youth mental health needs. It's particularly important to address misconceptions in populations that have an outsized influence over young people, such as families, educators, health care professionals, juvenile justice officials, online influencers, and the media.

- **Implement evidence-based programs that promote healthy development, support children, youth, and their families, and increase their resilience.** Examples include youth enrichment programs (e.g., mentoring, after-school programs), skill-based parenting and family relationship approaches, and other efforts that address social determinants of youth health such as poverty, exposure to trauma, and lack of access to education and health care. A few respected programs include The Incredible Years,[220] Strengthening Families,[220] The Martinsburg Initiative,[221] and the Drug-Free Communities (DFC) Support Program.[222]

- **Ensure that programs rigorously evaluate mental health-related outcomes.** For example, track outcomes around anxiety, depression, and suicide (including ideation, plans, and attempts), as well as around upstream risk and protective factors (e.g., social connectedness, coping skills, economic supports).[223]

- **Address the unique mental health needs of at-risk youth, such as racial and ethnic minorities, LGBTQ+ youth, and youth with disabilities.** Youth-serving organizations should think intentionally about how and to whom program services are offered. For example, actively recruit and engage populations who have historically been prevented from equal access to opportunities and may benefit the most from services. Engage with youth to understand what unique barriers prevent them from accessing mental health services. Recruit program staff directly from communities being served. Build program staff capacity to recognize personal biases, as well as structural challenges in these communities. For example, provide training on cultural and linguistic competence and related topics.

- **Elevate the voices of children, young people, and their families.** Youth are experts on their own lives, so it is important to engage youth in community-based mental health efforts. Explore youth advisory councils and other ways to involve young people in all phases of programming, from ideation to implementation. Gather feedback to understand what is and isn't working. Include youth and families directly in delivering services, for example by creating peer support programs.

RESOURCES FOR COMMUNITY ORGANIZATIONS

Having conversations in your community (MentalHealth.gov): Provides a toolkit to help communities and groups plan and facilitate dialogues about mental health.

Preventing Adverse Childhood Experiences (ACEs) (CDC): Guidance to equip communities with the best available evidence for the prevention of ACEs

A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors (CDC): Strategies to help communities sharpen their focus on prevention activities to stop youth violence and its consequences

Preventing Suicide: A Technical Package of Policy, Programs, and Practices (CDC): Strategies to help communities sharpen their focus on activities to prevent suicide

The Community Guide on Mental Health (Community Preventive Services Task Force, or CPSTF): Evidence-based findings to select community interventions to improve mental health

Mentoring for Youth with Mental Health Challenges (National Mentoring Resource Center): Research on mentoring for youth (ages 18 and younger) experiencing mental health challenges

WE CAN TAKE ACTION

WHAT FUNDERS AND FOUNDATIONS CAN DO

Philanthropic and other funding organizations play a critical role in supporting the mental health of children and young people across the full continuum of need. For example, they can make bets on promising but untested technologies or programs for which government funding may not be available. They can also serve as reliable partners to community-based organizations across the country, and promote and build cross-sector partnerships. Below are some recommendations for how funding organizations can support youth mental health:

- **Create sustained investments in equitable prevention, promotion, and early intervention.** Prioritize interventions that address social and economic factors known to affect children's healthy development and mental health, such as poverty, discrimination, and inequality, among others.[224]

- **Incentivize coordination across grantees and foster cross-sector partnerships to maximize reach and bring together a diversity of expertise.** The scale and complexity of mental health issues among young people require collaborative approaches. Consider leveraging resources across sectors to advance practices, policies, and research that support the mental health of children, youth, and families. And support grantees in developing and sharing meaningful mental health outcome measures.

- **Scale up evidence-based interventions, technologies, and services.** Use a structured process to assess an intervention's readiness to scale and support high-quality implementation at a community level.[225] Share information and convene stakeholders to provide education and consultation to spread innovation.

- **Invest in innovative approaches and research on mental health.** For example, fund participatory research that involves young people in understanding their online experiences. Develop and test new solutions, including digitally enabled solutions that can reach young people at scale and in underserved communities. Consider different kinds of funding models, such as incubators and accelerators, that can drive funding toward promising projects at very early stages.[226, 227]

- **Elevate and amplify the voices of youth and families in all stages of funding and evaluation.** Listening to young people is critical to understanding what kinds of solutions will work and what communities need to scale successful interventions. Bring young people, parents, and caregivers to the table to identify their needs and create ongoing meaningful opportunities to inform grantmaking strategies and decision-making. Engage youth from different identities and backgrounds—particularly those that come from vulnerable communities.

RESOURCES FOR FUNDERS AND FOUNDATIONS

Grantmakers in Health: Resources for health funders to learn, connect, and grow

Incorporating Youth Voice and the Lived Experience in Research (NAM): Seminar examining the importance of including youth voices in research

Health in Mind: A Philanthropic Guide for Mental Health and Addiction (UPenn Center for High Impact Philanthropy): Guidance for funders on mental health and addiction

COVID-19 Pandemic: Supporting Mental Health (UPenn Center for High Impact Philanthropy): Guidance for funders on how to help individuals and communities struggling with the stress of COVID-19

The Promise of Adolescence (NAM): Report supported by the Funders for Adolescent Science Translation (FAST) Collaborative with recommendations for funders and other adolescent-serving systems on supporting young people's development

Disability & Philanthropy Forum: Resources to advance disability inclusion in philanthropy

WE CAN TAKE ACTION

WHAT EMPLOYERS CAN DO

Employers can play an outsized role in supporting the mental health of children and young people. They can **directly** help younger employees, such as high school students working part-time jobs or young adults starting out in the labor force after high school or college. For example, employers can provide affordable health insurance that covers mental health needs.

Employers can also support children and youth **indirectly**. For example, they can offer insurance coverage for employees' dependent children, offer parent-friendly benefits such as family leave and childcare, and promote work-life balance and a positive culture at work to reduce family stress.

Below are some recommendations for how employers can support the mental health of young people:

- **Provide access to comprehensive, affordable, and age-appropriate mental health care for all employees and their families, including dependent children.** Research shows that parental mental health challenges not only impact their productivity in the workplace, but can also affect the mental health of their children.[228, 229] Employers should offer health insurance plans that include no or low out-of-pocket costs for mental health services, and a robust network of high-quality mental health care providers.

- **Implement policies that address underlying drivers of employee mental health challenges, including both home and workplace stressors.** Employers should:
  - Offer paid family leave and sick leave where feasible. Consider additional employee benefits such as respite care for caregivers and mental health and wellness tools.
  - Help caregivers secure affordable childcare, or offer more flexible work arrangements. This can reduce stress and improve productivity.[230, 231]
  - Ensure employees are aware of and can easily make use of these benefits. For example, include information on mental health benefits in emails, webinars, and during onboarding and training for all new hires.

- **Create a workplace culture that affirms the importance of the mental health and wellbeing of all employees and their families.**
  - Create space for employees to speak up about how they are feeling and encourage company leaders to serve as role models for discussing mental health and modeling healthy behaviors. For example, ensure that senior leaders take advantage of benefits such as paid leave and vacation days.

- Solicit ideas from employees about how to support their mental health and wellbeing as well as that of their children and families.

- Adopt clear messaging that promotes mental health awareness and addresses common misconceptions about mental health (for example, that mental health issues are not a sign of weakness).

- Provide managers and supervisors with training to help recognize negative mental health symptoms in themselves and colleagues and encourage employees to seek help.[232] Mental health employee resource groups, for example, can help increase mental health awareness, build community, and offer peer support.

- **Regularly assess employees' sense of wellbeing within the workplace.** Tools such as employee surveys can help employers understand the wellbeing of employees across demographic groups (e.g., gender, race, sexual orientation), levels of seniority, business units, and geographies, and to identify opportunities for improvement. Employers should make sure to assess the wellbeing of young adults just starting out in the workforce, as well as of parents with young children.

RESOURCES FOR EMPLOYERS

Center for Workplace Mental Health (American Psychiatric Association Foundation): Resources to help employers create a more supportive workplace environment

Work and Wellbeing Initiative (Harvard-MIT Collaboration): **Employer toolkit** to help improve workplace conditions and list of **employee assessment tools**

What Works Wellbeing (UK): UK's independent body for wellbeing evidence, policy, and practice. For example, see example employee wellbeing **snapshot survey**.

Employer's Guide to Digital Tools and Solutions for Mental Health (One Mind PsyberGuide): Information for employers on digital mental health solutions for employees

Generation Work (Annie E. Casey Foundation): Research briefs, blogs, and tools to help employers of youth better understand and integrate positive youth development approaches

Mental Health Toolkit (Employer Assistance and Resource Network on Disability Inclusion): Background, tools and resources to help employers learn more about mental health and cultivate a welcoming and supportive work environment

Office of Disability Employment Policy (Department of Labor): Resources for disability-related workplace policies and practices

WHAT FEDERAL, STATE, LOCAL, AND TRIBAL GOVERNMENTS CAN DO

Note: For actions taken by the Biden Administration from January to October 2021 to support youth mental health, see ***Fact Sheet: Improving Access and Care for Youth Mental Health and Substance Use conditions.***

Ultimately, youth mental health challenges cannot be addressed solely by the efforts of youth, their families, local communities, and private organizations. Federal, state, local, and tribal governments all have a role to play. While the below recommendations are not comprehensive, their implementation would mark an enormous step forward in supporting youth and their families:

- **Address the economic and social barriers that contribute to poor mental health for young people, families, and caregivers.** Priorities should include reducing child poverty and ensuring access to quality childcare, early childhood services, and education; healthy food; affordable health care; stable housing; and safe neighborhoods with amenities such as parks and playgrounds. Recent federal investments in child poverty reduction, safe school reopening, and other pandemic-related measures represent historic progress on this front, but additional investments are needed at all levels of government.[233] Emphasis should be placed on preventing adverse childhood experiences (ACEs), which are strong risk factors for mental health challenges.[12]

- **Take action to ensure safe experiences online for children and young people.** Example opportunities include but are not limited to increasing investment in research on the role of social media and technology in youth mental health; educating consumers about potential mental health risks online; requiring companies to be more transparent with researchers and the public (e.g., disclosing meaningful data for research purposes, enabling systemic auditing of social media algorithms), and developing safety standards for online services (e.g., standards for data collection, age verification, user engagement techniques such as 'nudges', and advertising aimed at kids and teens). For instance, the United Kingdom's Age appropriate design code has led companies including Instagram, TikTok, and YouTube to announce product changes to protect their users' safety, rights, and privacy.[234, 235] In addition, the Australian government's Safety by Design initiatives have resulted in a set of principles for user safety, tools for companies to assess their safety practices, resources for investors and financial entities to manage online safety risks, and a pilot program with universities to embed Safety by Design materials into curricula.[236]

- **Ensure all children and youth have comprehensive and affordable coverage for mental health care.** Example opportunities include strengthening public and private insurance coverage for children and young adults (e.g., by promoting enrollment), ensuring adequate payment for pediatric mental health services, investing in innovative payment models for integrated and team-based care, increasing the participation of mental health professionals in insurance networks, and ensuring compliance with mental health parity laws.[237] Local, state, and tribal governments can access outreach and enrollment resources to help enroll and retain eligible children in Medicaid and CHIP at InsureKidsNow.gov.

- **Support integration of screening and treatment into primary care.** For example, continue expanding **Pediatric Mental Health Care Access programs**, which give primary care providers teleconsultations, training, technical assistance, and care coordination to support diagnosis, treatment, and referral for children with mental health and substance use needs.[238, 239, 240] Expanding screening for ACEs is also critical. For instance, California recently enacted a law that will significantly expand coverage for ACEs screening.[241]

- **Provide resources and technical assistance to strengthen school-based mental health programs.** Example opportunities include improving education about mental health, increasing screening of students for mental health concerns, investing in additional staff (e.g., school counselors) to support student mental health needs, improving care coordination, and financing school-based mental health services. As mentioned in the earlier section with recommendations for educators, the American Rescue Plan's Elementary and Secondary School Emergency Relief funds can be used for these purposes, along with Project AWARE (Advancing Wellness and Resilience in Education) program funds, which provide support for state, local, and tribal governments in building school-provider partnerships and coordinating resources to support prevention, screening, early intervention, and mental health treatment for youth in school-based settings.[242] In California, a recent law will ensure that all middle and high school students learn about mental health in health education classes.[243] And, in New Jersey, a recent program will provide funding for school districts to screen students for depression.[244]

- **Invest in prevention programs, such as evidence-based social and emotional learning.** Example opportunities include implementing developmentally appropriate social and emotional learning standards and programs, supporting professional development for educators, and providing funding for teachers and school leaders to work with families to support student health needs. For example, the CDC's Legacy for Children program, which promotes positive parenting among low-income mothers, has been found to improve children's behavioral, social, and emotional health.[245]

- **Expand the use of telehealth for mental health challenges.** Example opportunities include addressing regulatory barriers (such as limits on provision of telehealth across state lines), ensuring appropriate payment, and expanding broadband access. For instance, Colorado recently established the "I Matter" program, offering young people three free behavioral health sessions, primarily via telehealth.[246]

- **Expand and support the mental health workforce.** Example opportunities include investing in training and hiring individuals from a broader set of disciplines (e.g., peer supports, community health workers, family counselors, care coordinators), accelerating training and loan repayment initiatives, supporting the mental health and wellbeing of health workers, and recruiting a diverse workforce that reflects local communities. In the school setting, governments should invest in building a pipeline of school counselors, nurses, social workers, and school psychologists.[253]

- **Expand and strengthen suicide prevention and mental health crisis services.** Example opportunities include providing flexible funding to fund crisis care needs, increasing access to intensive outpatient and other "step-down" programs, supporting access to trauma-informed services for traumatized children, implementing the 988 mental health crisis and suicide prevention hotline, and promoting public awareness of crisis hotlines and other resources. Governments should also collaborate with the private sector and local communities to reduce access to firearms and other lethal means of suicide and promote best practices such as safe storage.

- **Improve coordination across all levels of government to address youth mental health needs.** One example is to ensure households eligible for social services and supports are receiving them. For instance, states can align renewal processes across Medicaid and the Supplemental Nutrition Assistance Program (SNAP), use data from SNAP files to complete Medicaid renewal, and allow qualified entities like schools to make presumptive eligibility determinations.[247]

- **Support continued reduction in biases, discrimination, and stigma related to mental health.** Example opportunities include enforcing laws that support the needs of at-risk youth (e.g., students with disabilities), identifying and improving policies and programs that inappropriately target or harm youth with mental health needs, and conducting targeted education campaigns to address stigma, promote new cultural norms, and increase safety and trust in local communities.

- **Support the mental health needs of youth involved in the juvenile justice system.** Example opportunities include investing in alternatives to incarceration (e.g., school, probation, and police-based diversion models for youth with mental health needs[248]), expanding mental health training for staff, supporting high-quality and trauma-informed mental health care inside these systems, and improving coordination across different youth-serving agencies.[249]

- **Support the mental health needs of youth involved in the child welfare system.** Example opportunities include expanding family-centered mental health services to prevent unnecessary entry and increase reunification;[250] ensuring youth and caregivers are informed about medications; investing in peer support services; providing mental health services before, during, and after new placements and when emancipating from foster care;[251] ensuring youth have access to mental health services in community settings whenever possible; and avoiding unnecessary placements in non-family settings. Coordination should be improved across different youth-serving agencies.

- *See "Where Additional Research is Needed" section for recommendations specific to research and data on youth mental health*

WHERE ADDITIONAL RESEARCH IS NEEDED

Despite the evidence that millions of young people are suffering and in crisis, there is still a lot we don't know. Below are recommendations for the kinds of research questions and studies that should be prioritized to better understand and address youth mental health needs:

- **Improve mental health data collection and integration to understand youth mental health needs, trends, services, and evidence-based interventions.**
  - Today, data on youth mental health are collected and analyzed by multiple agencies and often take months or years to be released. The federal government should strengthen research and data integration across governments, health systems, and community organizations to ensure regular, longitudinal surveillance of national mental health trends across the age continuum. Data collection and data linkages should be improved to enable real-time surveillance (e.g., at the census tract level).

  - Data should be able to be disaggregated to enable analysis of trends (by age, gender, race, ethnicity, disability status and type, sexual orientation, socioeconomic background, family characteristics, insurance status, etc.)[252]

- **Foster public-private research partnerships.** For example, academic partners, community-based organizations, technology companies, health care companies, and others can partner to conduct novel studies using nontraditional data sources (e.g., data from wearables and online platforms) to better understand needs, track outcomes, and evaluate risk and protective factors for youth mental health.

- **Increase investments in basic, clinical, and health services research to identify treatment targets for mental health conditions and develop innovative, scalable therapies.** For example, conduct research to optimize stepped-care approaches to treatment for youth populations (e.g., different kinds of cognitive-behavioral therapy such as self-guided, computerized, and group-based vs. solely individual therapy).[253]

- **Prioritize data and research with at-risk youth populations, such as racial, ethnic, and sexual and gender minority youth, individuals from lower socioeconomic backgrounds, youth with disabilities, youth involved in the juvenile justice system, and other groups.**[254] Researchers and research sponsors should ensure that these populations are represented in basic, translational, effectiveness, and services research studies. This will help improve understanding of disparities in risk and trajectories for mental illnesses, responsiveness to interventions, and access to, and engagement with, quality mental health services.

- **Advance dissemination and implementation science to scale up and improve compliance with evidence-based mental health practices in systems that serve children, youth, and their families.** For example, appropriate funding agencies can prioritize demonstration projects of effective evidence-based interventions in and across schools or other systems (e.g., primary care offices, clinics, treatment facilities, family services, child welfare settings, juvenile justice settings). Translate findings into actionable policy proposals and disseminate them effectively to improve adoption of best practices.

- **Conduct research to expand understanding of social media and digital technology's impact on youth mental health and identify opportunities for intervention.** For example, explore the impact of frequent exposure to social comparisons, hateful speech, and graphic content on children and youth, and which groups are most- and least-affected. Also, identify opportunities for families to engage with youth around social media as a means of connection, and offer guidance in handling difficult interactions and content. Explore how pre-existing mental health status and environmental conditions in young people's lives inform how they engage with and experience content online, and empower young people with effective strategies (e.g., mood management) to actively manage their online experiences.

CONCLUSION

As we learn the lessons of the COVID-19 pandemic, and start recovering and rebuilding, we have an opportunity to offer a more comprehensive, more fulfilling, and more inclusive vision of what constitutes public health. And for a generation of children facing unprecedented pressures and stresses, day in and day out, change can't come soon enough.

It won't come overnight. Many of the recommendations offered in this Advisory require structural buy-in and change.

But everyone has a role to play in combating this mental health pandemic. Without individual engagement, no amount of energy or resources can overcome the biggest barrier to mental health care: the stigma associated with seeking help. For too long, mental and emotional health has been considered, at best, the absence of disease, and at worst, a shame to be hidden and ignored.

If we each start reorienting our priorities to create accessible space in our homes, schools, workplaces, and communities for seeking and giving assistance, we can all start building a culture that normalizes and promotes mental health care.

This is the moment to demand change—with our voices and with our actions.

Only when we do will we be able to protect, strengthen, and support the health and safety of all children, adolescents, and young adults—and ensure everyone has a platform to thrive.

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    National Institute on Drug Abuse (NIDA)
    Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)
Office of the Assistant Secretary for Health (OASH)
    Office of Minority Health (OMH)
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
    Office of Human Services Policy (HSP)
    Office of Behavioral Health, Disability, and Aging Policy (BHDAP)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Additional Partners
Department of Education
    Office of Special Education and Rehabilitative Services (OSERS)
Department of Justice (DOJ)
    Office of Justice Programs (OJP)
White House Domestic Policy Council (DPC)
White House Office of Science and Technology Policy (OSTP)

Note: Examples and external resources in this advisory are provided for informational purposes only, and their inclusion does not constitute an endorsement by any government office or agency.

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Figure 1 Sources

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Exhibit 7

Directory of Shoals Employed and Contracted Providers

List of Shoals Employed or Contracted Providers

1. Praveen Narahari, M.D. (Psychiatrist)
    - Employed (Residency Program Director and Psychiatric Medical Director)
2. Ali Pervaiz, M.D. (Psychiatrist)
    - Employed (Residency Faculty)
3. Gary Gay, M.D.
    - Contract to provide coverage (Former Psychiatric Medical Director)
4. ER/ED physicians from both NAMC and NASH
    - (NASH - Employed) – (NAMC – Contracted service)
5. Aaron Karr, D.O. (Physician)
    - Independent Family Medicine Physician
6. Timothy Whalen, M.D. (Psychiatrist)
    - Independent Psychiatrist
7. Liz James, CEO of Riverbend (Local 410 Board Facility)
    - Independent

Exhibit 8

Map of Hospitals in the North Psychiatric Care Region with Psychiatric Beds

NORTH PSYCHIATRIC CARE REGION HOSPITALS
WITH PSYCHIATRIC BEDS

NORTH ALABAMA SHOALS HOSPITAL
201 W. Avalon Avenue
Muscle Shoals, AL 35661

1 **THE SANCTUARY AT THE WOODLANDS**
1910 Cherokee Avenue SW
Cullman, AL 35055

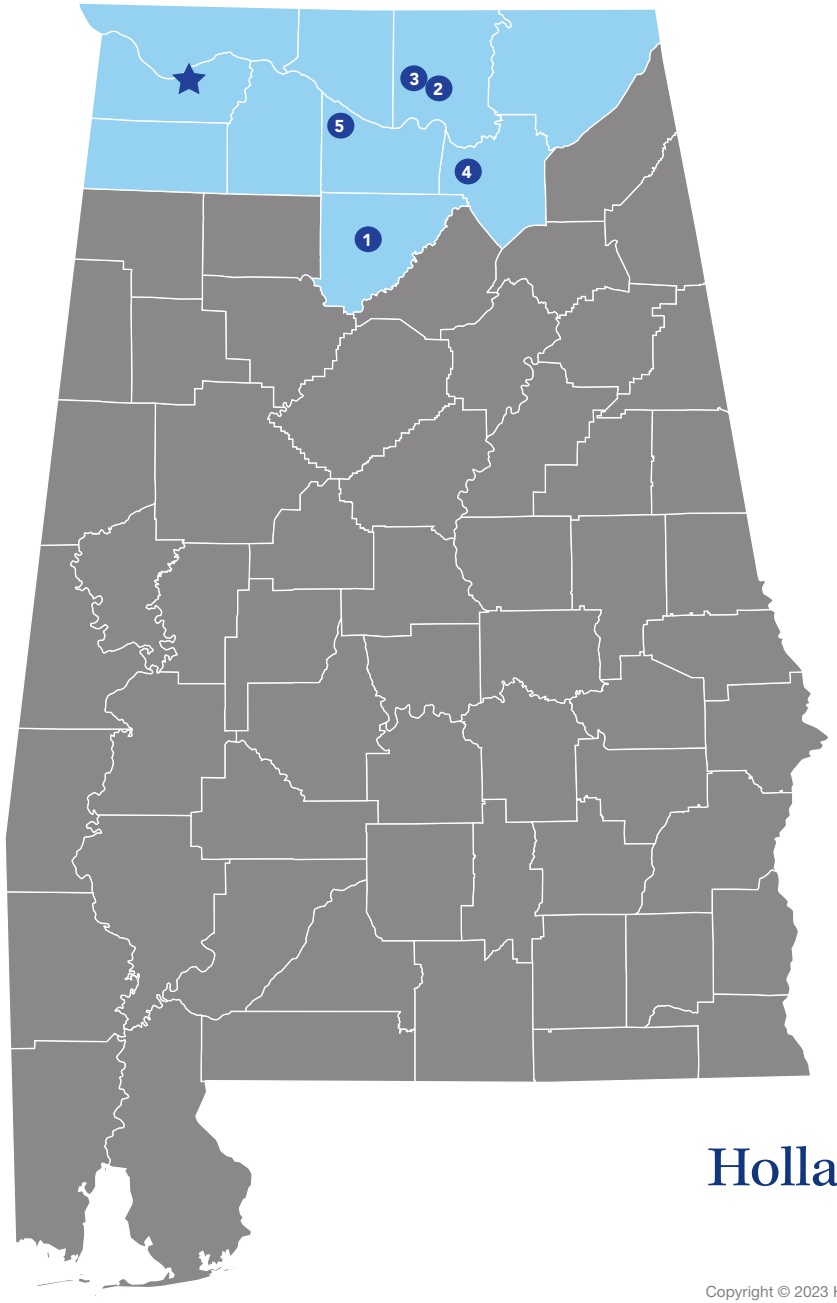
2 **THE HUNTSVILLE HOSPITAL**
101 Sivley Road
Huntsville, AL 35801

3 **UNITY PSYCHIATRIC CARE – HUNTSVILLE**
5315 Millennium Drive
Huntsville, AL 35806

4 **MARSHALL MEDICAL CENTER NORTH CAMPUS**
8000 Alabama Highway 69
Guntersville, AL 35976

5 **DECATUR MORGAN WEST**
2205 Beltline Road SW
Decatur, AL 35601

TYPE OF PSYCHIATRIC BED
- Adult
- Child/Adolescent
- Geriatric



Holland & Knight
www.hklaw.com

Exhibit 9

ADPH Hospital Facilities Directory

Health Care Facilities Directory

Hospitals

Cullman County

Cullman Regional Medical Center
1912 Alabama Highway 157
Cullman, AL 35058 (256) 737-2598
175 bed General Hospital
Authorized bed capacity: 150
Licensee Type: Nonprofit Corporation
Administrator: James Clements
Fac ID: H2201 License: Regular
Medicare: 01-0035
Deemed Status

Sanctuary At The Woodlands, The
1910 Cherokee Avenue, SW
Cullman, AL 35055 (256) 255-0820
40 bed Specialized Psychiatric Hospital
Authorized bed capacity: 40
Licensee Type: Limited Liability Company
Administrator: Kyle Smith
Fac ID: H2203 License: Regular
Medicare: 01-4016

Health Care Facilities Directory

Hospitals

Colbert County

Helen Keller Memorial Hospital
1300 S. Montgomery Avenue
PO Box 610
Sheffield, AL 35660 (256) 386-4551
185 bed General Hospital
Authorized bed capacity: 166
Licensee Type: Hospital Authority
Administrator: Kyle Buchanan
Fac ID: H1701 License: Regular
Medicare: 01-0019
Deemed Status

North Alabama Shoals Hospital
201 W. Avalon Avenue
PO Box 3359
Muscle Shoals, AL 35661 (256) 386-1815
198 bed General Hospital
Authorized bed capacity: 157
Licensee Type: Limited Liability Company
Administrator: Russell Pigg
Fac ID: H1702 License: Regular
Medicare: 01-0157
Deemed Status

Health Care Facilities Directory

Hospitals

Franklin County

Red Bay Hospital
211 Hospital Road
PO Box 490
Red Bay, AL 35582 (256) 386-4551
25 bed Critical Access Hospital
Authorized bed capacity: 25
Licensee Type: Hospital Authority
Administrator: Sherry Jolley
Fac ID: H3002 License: Regular
Medicare: 01-1302

Russellville Hospital
15155 Highway 43
PO Box 1089
Russellville, AL 35653 (256) 332-8676
100 bed General Hospital
Authorized bed capacity: 49
Licensee Type: Nonprofit Corporation
Administrator: Stephen Proctor
Fac ID: H3001 License: Regular
Medicare: 01-0158
Deemed Status

Health Care Facilities Directory

Hospitals

Jackson County

Creekside Hospital
200 Rowland Dr.
Bridgeport, AL 35740 (423) 508-8859
21 bed Specialized Psychiatric Hospital
Authorized bed capacity: 21
Licensee Type: Limited Liability Company
Administrator: Phil Rowland
Fac ID: H3603 License: Regular
Medicare: N/A

Highlands Medical Center
380 Woods Cove Road
PO Box 1050
Scottsboro, AL 35768-2428 (256) 218-3792
170 bed General Hospital
Authorized bed capacity: 170
Licensee Type: Hospital Authority
Administrator: Ashley Pool
Fac ID: H3601 License: Regular
Medicare: 01-0061
Deemed Status

Health Care Facilities Directory

Hospitals

Lauderdale County

North Alabama Medical Center
1701 Veterans Drive
Florence, AL 35630-4928 (256) 629-1900
263 bed General Hospital
Authorized bed capacity: 263
Licensee Type: Limited Liability Company
Administrator: Russell Pigg
Fac ID: H3902 License: Regular
Medicare: 01-0006
Deemed Status

Health Care Facilities Directory

Hospitals

Lawrence County

Lawrence Medical Center
202 Hospital Street
PO Box 39
Moulton, AL 35650 (256) 974-2223
98 bed General Hospital
Authorized bed capacity: 98
Licensee Type: Limited Liability Company
Administrator: Dean Griffin
Fac ID: H4002 License: Regular
Medicare: 01-0059
Deemed Status

Health Care Facilities Directory

Hospitals

Limestone County

Athens Limestone Hospital
700 West Market Street
Athens, AL 35611 (256) 262-6468
71 bed General Hospital
Authorized bed capacity: 71
Licensee Type: Limited Liability Company
Administrator: Traci Collins
Fac ID: H4201 License: Regular
Medicare: 01-0079
Deemed Status

North Alabama Specialty Hospital
700 West Market St., 2nd Floor
Athens, AL 35611 (256) 714-0032
31 bed Specialized Long Term Care Hospital
Authorized bed capacity: 31
Licensee Type: Limited Liability Company
Administrator: Douglas H Beverly
Fac ID: H4203 License: Regular
Medicare: 01-2014
Deemed Status

Health Care Facilities Directory

Hospitals

Madison County

Crestwood Medical Center
One Hospital Drive Southwest
Huntsville, AL 35801 (256) 429-5000
180 bed General Hospital
Authorized bed capacity: 180
Licensee Type: Limited Partnership
Administrator: Matthew A Banks
Fac ID: H4501 License: Regular
Medicare: 01-0131
Deemed Status

Encompass Health Rehabilitation Hospital of North Alabama
1490 Highway 72 East
Huntsville, AL 35811-1508 (205) 968-6304
85 bed Specialized Rehabilitation Hospital
Authorized bed capacity: 85
Licensee Type: Limited Liability Company
Administrator: Brent Robert Mills
Fac ID: H4502 License: Regular
Medicare: 01-3029
Deemed Status

Huntsville Hospital, The
101 Sivley Road
Huntsville, AL 35801 (256) 265-2853
881 bed General Hospital
Authorized bed capacity: 881
Licensee Type: Hospital Authority
Administrator: Jeff Samz
Fac ID: H4503 License: Regular
Medicare: 01-0039
Deemed Status

Madison Hospital
8375 Highway 72 West
Madison, AL 35758 (256) 817-5010
90 bed General Hospital
Authorized bed capacity: 90
Licensee Type: Hospital Authority
Administrator: Jeff Samz
Fac ID: H4506 License: Regular
Medicare: N/A
Deemed Status

Madison County

Unity Psychiatric Care- Huntsville
5315 Millennium Drive
Huntsville, AL 35806 (256) 964-6704
20 bed Specialized Psychiatric Hospital
Authorized bed capacity: 20
Licensee Type: Corporation
Administrator: Nicole Nance
Fac ID: H4505 License: Regular
Medicare: 01-4018

Health Care Facilities Directory

Hospitals

Marshall County

Marshall Medical Centers North Campus
8000 Alabama Highway 69
Guntersville, AL 35976 (256) 894-6733
90 bed General Hospital
Authorized bed capacity: 90
Licensee Type: City
Administrator: Chris Rush
Fac ID: H4804 License: Regular
Medicare: N/A
Deemed Status

Marshall Medical Centers South Campus
2505 U.S. Highway 431 South
P.O. Drawer 758
Boaz, AL 35957 (256) 894-6733
150 bed General Hospital
Authorized bed capacity: 150
Licensee Type: City
Administrator: Chris Rush
Fac ID: H4802 License: Regular
Medicare: 01-0005
Deemed Status

Health Care Facilities Directory

Hospitals

Morgan County

Decatur Morgan Hospital - Decatur Campus
1201 Seventh Street, Southeast
Decatur, AL 35601 (256) 973-3535
273 bed General Hospital
Authorized bed capacity: 230
Licensee Type: Limited Liability Company
Administrator: Kelli Powers
Fac ID: H5202 License: Regular
Medicare: 01-0085
Deemed Status

Decatur Morgan Hospital - Parkway Campus
1874 Beltline Road, S.W.
Decatur, AL 35601 (256) 973-3535
120 bed General Hospital
Authorized bed capacity: 108
Licensee Type: Corporation
Administrator: Kelli Powers
Fac ID: H5201 License: Regular
Medicare: 01-0054
Deemed Status

Decatur Morgan West
2205 Beltline Road SW
PO Box 2240
Decatur, AL 35601 (256) 973-3535
64 bed Specialized Psychiatric Hospital
Authorized bed capacity: 64
Licensee Type: Limited Liability Company
Administrator: Kelli Powers
Fac ID: H5206 License: Regular
Medicare: 01-S085
Deemed Status

Exhibit 10

North Psychiatric Care Region Populations 2000-2020 and Projections for 2025-2040

North Pyschiatric Care Region Population 2000-2020 and Projections 2025-2040

County	Census 2000	Census 2010	Census 2020	2025	2030	2035	2040	Change 2020-2040 Number	Change 2020-2040 Percent
Alabama	*4,447,100*	*4,779,736*	*5,024,279*	*5,165,416*	*5,306,554*	*5,447,691*	*5,588,829*	*564,550*	*11.2*
Colbert	54,984	54,428	57,227	57,803	58,380	58,956	59,532	*2,305*	*4.0*
Cullman	77,483	80,406	87,866	90,403	92,940	95,477	98,014	*10,148*	*11.5*
Franklin	31,223	31,704	32,113	32,349	32,584	32,820	33,056	*943*	*2.9*
Jackson	53,926	53,227	52,579	52,297	52,015	51,733	51,452	*-1,127*	*-2.1*
Lauderdale	87,966	92,709	93,564	94,966	96,368	97,770	99,172	*5,608*	*6.0*
Lawrence	34,803	34,339	33,073	32,686	32,298	31,911	31,523	*-1,550*	*-4.7*
Limestone	65,676	82,782	103,570	112,669	121,768	130,867	139,966	*36,396*	*35.1*
Madison	276,700	334,811	388,153	414,976	441,800	468,623	495,446	*107,293*	*27.6*
Marshall	82,231	93,019	97,612	101,346	105,081	108,815	112,549	*14,937*	*15.3*
Morgan	111,064	119,490	123,421	126,454	129,488	132,521	135,554	*12,133*	*9.8*

Source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, August 2022

Exhibit 11

Alabama Employee Behavioral Health Care UnitedHealthcare Article

5 ways to help employees find the behavioral health care they need

As some employees struggle for access amidst dramatic changes in the behavioral health care system, here's what employers can do to help guide employees to quality, affordable care.

Behavioral health issues are on the rise.[1] In fact, more than 1 in 4 employees have quit a job because of their mental health, while 1 in 5 say their company doesn't do enough for their mental health, according to a recent survey.[2]

"The whole world at a minimum has experienced more stress, which has contributed to the increase in diagnosis for anxiety and depression, substance use and alcoholism, and prescriptions for behavioral health treatment. Suicide rates have gone up in all populations," says Dr. Rhonda Randall, executive vice president and chief medical officer for UnitedHealthcare Employer & Individual.

Given these trends, the stakes couldn't be higher for employers. When employees and their family members experience emotional distress, which may manifest as sleep problems, aches and pains, and low motivation, it may affect their quality of life and may lead to tardiness and missed days at work, lower work quality, safety-related mishaps and the need for medical care.

UnitedHealthcare's **behavioral health strategy** is designed to help employees find care across a comprehensive continuum of care. And it includes the promotion of general well-being and treatment of conditions, such as substance use.

> **"It's become more common to know someone affected by a mental health condition. Younger generations are especially open to conversations about mental health, which helps to reduce the stigma."**
>
> **Dr. Rhonda Randall**
> Chief Medical Officer
> UnitedHealthcare Employer & Individual

Employers can help employees find behavioral health care by:

- Promoting virtual care to help improve access to providers
- Building a benefits strategy that includes a full continuum of care
- Offering a guided experience to support employees and their families
- Trying to reduce stigma, especially for at-risk populations
- Reinforcing the connection between physical and behavioral health

continued

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Promote virtual care as a proven strategy for improving access to providers

Evidence suggests that the COVID-19 pandemic has accelerated the demand for behavioral health care for years to come, and consumers will continue to have a growing need for faster, easier access to mental health support.[3] With the U.S. only fulfilling 27% of its total need for mental health professionals, there will be a shortage of at least 245,000 behavioral health providers by 2025.[4]

"Data shows more licensed professionals in all 50 states, but some areas of the country lack certain types of providers," Randall says. "One of our solutions that helps to address these disparities is virtual care. It enables mental health professionals the ability to obtain licensure across state lines."

Innovative and effective digital tools, including virtual care solutions, are designed to help meet the needs of individuals and improve access to care. The pandemic created momentum around virtual care, including virtual therapy, that is not slowing down. In fact, 77% of employers plan to offer mental health support, including through virtual care and digital tools.[6]

More than half of U.S. adults are likely to use virtual tools for behavioral health needs. Providers are seeing 50–175 times more patients virtually than they have before.[7]

"Most of my patients prefer virtual. It's eliminated commuting and wait times in the office. At first, I had reservations about switching to virtual care, especially with new patients, but it hasn't made a difference working with them," says Dr. Martin H. Rosenzweig, chief medical officer of Optum Behavioral Health, which supports UnitedHealthcare's behavioral health benefits.

Offering virtual care options may also reduce the stigma surrounding seeking mental health support. Stigma tends to prevent older adults from seeking care versus younger adults who are generally more accepting of mental health care. Stigma is also more prevalent in some minority groups.[6]

UnitedHealthcare's behavioral health network[8]

315K+ providers + **136K+** virtual providers

Build a benefits strategy that provides access to a full continuum of solutions

UnitedHealthcare provides comprehensive support across a continuum of care designed to cover a range of employee needs from digital self-help tools to facility-based treatment. This model helps employees take preventive measures to maintain their mental health and overall well-being similar to physical health. As with other aspects of well-being, the focus of employers' efforts should move from reactive to preventive.[9]

Because employees don't always know they have behavioral health benefits and services, UnitedHealthcare helps create awareness by promoting it during open enrollment, onboarding and throughout the year. This helps to encourage the idea of getting care sooner, often before an employee knows they need help.

Solutions such as online education, self-help apps or coaching help equip employees with the tools they need to manage stress, burnout and anxiety. If an employee enters in the system through a crisis, they may access therapy or psychiatric treatment that may require medication or facility-based treatment.

"Our goal is to normalize mental well-being and think of it as common as maintaining physical health similar to seeking a wellness visit each year," says Trevor Porath, vice president of behavioral health solutions for UnitedHealthcare Employer & Individual. "We want to make every single touch point with a member an opportunity to advance mental well-being."

To build a more robust continuum of care, UnitedHealthcare has evaluated many vendors, bringing in solutions that fill in care gaps, including **AbleTo®** and **Self Care** to support identification, proactive outreach and virtual care delivery, and **Equip** and **Genoa Healthcare** for data and medication management and specialty behavioral health.

UnitedHealthcare behavioral health care continuum

Offer a guided member experience designed to support employees and their families

Low behavioral health literacy remains a challenge for consumers. They don't often recognize brand names for tools and resources or have a clear understanding of what terms like coaching mean when related to their mental health care.[10]

A member-guided experience, whether it starts through an Employee Assistance Program (EAP), primary care physician (PCP), care advocate or digitally, helps lead to an evidence-based recommendation on the continuum of care.

"Advocates are trained to listen for signs of distress when speaking to members," Randall says. "They also help guide members through the complexities of behavioral health including understanding provider types such as social workers, counselors and psychiatrists."

Predictive tools also help identify members who may need behavioral health support. Pulling from data such as diagnostic codes and utilization patterns, members are segmented based on their conditions—both the level of severity and stability—as well as their ability to engage. This information is used to support advocates or make program suggestions when an employee signs in to **myuhc.com®.**

For those without a behavioral health diagnosis or utilization of services, a prediction can be made on their level of risk based on **social determinants of health** data and prevalence of chronic disease—2 of the most critical factors that put employees at risk of developing or having an untreated behavioral condition.

"Due to the pandemic, more members entered into the behavioral health care space. It's important we help guide them to the right care at the right time on a comprehensive care continuum."

Stacie Grassmuck

Director of Behavioral Health Product and Innovation
UnitedHealthcare Employer & Individual

Try to reduce stigma among employees, especially in at-risk populations

During the pandemic, mental health has impacted all populations but has been the most profound among women, teens and racial minority groups.[6] Employers can help address this with targeted campaigns to highlight available resources and services such as virtual care that helps reduce stigma.

"It's so important to be compassionate with mental health due to stigma. Many employees are still afraid and ask if seeking these services will be reported back to their employer," says Heather Nelson, an advocate trained to provide medical and behavioral health support. "I reassure them an employer only receives general data on program use, which lets them know what their employees need."

In addition, minority groups may not seek mental health support as often as their white counterparts. Among adults with moderate or severe anxiety and/or depression, 64% of white adults received mental health services compared to 47% of Black adults and 60% of Hispanic adults.[11]

Diverse populations are more likely to utilize support from a provider of the same race since it makes them feel more comfortable and less judged. Currently, more than 80% of members in the American Psychological Association are white and less than 5% of members are African American.[12]

To support network diversification by raising cultural competency and promoting network diversity, UnitedHealthcare's plan has included:

- Strategic recruitment of specialty providers such as medication-assisted treatment providers
- Cultural competency training
- Provider ethnicity, gender and language as provider search criteria
- Scholarships for child psychiatrists and providers from diverse backgrounds

Reducing stigma at the workplace

Employers may help reduce stigma by avoiding language that could potentially hurt or inadvertently discourage someone from seeking mental health treatment. This includes:

Don't use	Use
Words that may reinforce stereotypes and minimize the importance of understanding mental health conditions, such as crazy, head case, lunatic	**Specific and sympathetic language**
A mental health condition to define the person	**"Someone who lives with a mental health condition" or "someone who is affected by a mental health condition"**
The disease to describe the person	**A person-first approach such as "a person living with schizophrenia" or "someone diagnosed with schizophrenia"**

Reinforce the connection between physical and behavioral health for better care coordination

UnitedHealthcare claims data show members with comorbid conditions have claims costs that are, on average, twice the claims for members with medical conditions alone.[13]

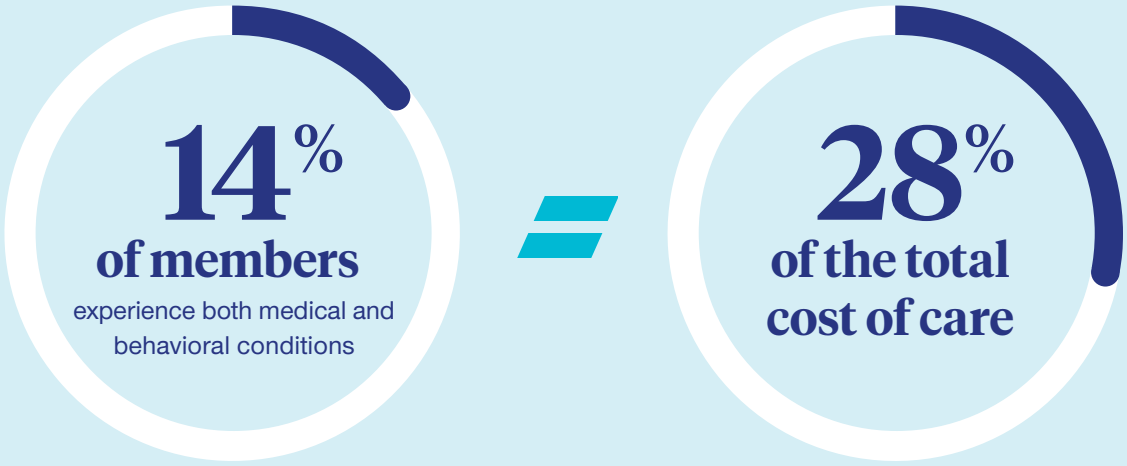
People with a mental health condition also experience higher morbidity and mortality rates compared to those without—mostly from untreated and preventable chronic physical conditions, such as cardiovascular disease, hypertension and diabetes.[14]

"Usually, when a behavioral health condition goes untreated, we're likely to see higher levels of medical care such as inpatient stays and emergency room utilization," says Stacie Grassmuck, director of behavioral health product and innovation for UnitedHealthcare Employer & Individual.

Integrated medical and behavioral benefits can address the full spectrum of health and well-being to provide whole-person care. When employers integrate behavioral, medical and pharmacy benefits, there is a single point of contact for an employee with a mental health condition who also has a chronic health condition.

"The integration of these benefits creates a more seamless experience with a single carrier. You also have better coordination between the benefits. For example, deciding whether to use an EAP benefit for mental health support or tapping into integrated benefits right away," Randall says.

In an average group plan population:[13]



"Mental health conditions are not benign illnesses — they really impact your workforce. The sooner you can intervene, you may be able to stop the progression of these diseases."

Dr. Martin H. Rosenzweig

Chief Medical Officer
Optum Behavioral Health

Planning for future behavioral health needs

History has shown that the mental health impact of disasters outlasts the physical impact, suggesting today's elevated mental health need will continue despite the pandemic being deemed over.[3] Employees with more severe behavioral health needs drive a disproportionate amount of an employer's overall health spend. Of the top 10% insured that drive the highest costs, 27% had behavioral health care needs and accounted for 57% of health care costs.[15]

The challenges in the behavioral health landscape call on all stakeholders—including private and public insurers, care providers, employers and government policymakers—to innovate to better serve the behavioral health needs of everyone. Insurers can leverage data to forge new relationships with members, allowing for preventive interventions to address behavioral health needs.[16]

Through data-driven solutions, UnitedHealthcare works with employers to help identify gaps in care. For example, behavioral health claims utilization based on location, age, gender and other measures helps an employer understand if their employees may need mental health support to prevent a higher, more costly level of care.

"When behavioral health claims are lower than expected norms, it's an indication that certain populations may not be getting the behavioral health support that they need," says Craig Kurtzweil, chief analytics officer for UnitedHealthcare Employer & Individual. "We want to see employee utilization and strategies such as using an in-network or local provider, inpatient versus outpatient services and virtual care to help keep the costs lower for the employer."

Employers are offering more differentiated behavioral health support that may help improve performance and retention.[15] They're also taking into account how they may contribute to overall well-being—recently citing mental and emotional health as the top well-being issue affecting their business followed by burnout, culture, virtual and hybrid work support and financial risk and stress.[17]

"Behavioral health treatment is effective. The response rate to therapy and medication is similar to a medical condition like diabetes," Rosenzweig says. "We want to intervene early to help employees manage their everyday stress while offering solutions that support a range of mental health needs."

Learn more

Contact your broker, consultant or UnitedHealthcare representative or visit **uhc.com/broker-consultant** and **uhc.com/employer**

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[17] 2022 Global Wellbeing Survey, Aon.

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Exhibit 12

American Psychological Association
2023 Trends Report

2023 TRENDS REPORT

Kids' mental health is in crisis. Here's what psychologists are doing to help

Research is focused on child and teen mental health, exploring why they are struggling and what can be done to help them

By Zara Abrams Date created: January 1, 2023 12 min read
Vol. 54 No. 1
Print version: page 63

Mental Health Children Teens

02:53

[This article is part of the 2023 Trends Report (/monitor/2023/01/trends-report)]

The COVID-19 pandemic era ushered in a new set of challenges for youth in the United States, leading to a mental health crisis as declared by the United States surgeon general just over a year ago. But U.S. children and teens have been suffering for far longer.

In the 10 years leading up to the pandemic, feelings of persistent sadness and hopelessness—as well as suicidal thoughts and behaviors—increased by about 40% among young people, according to the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm) .

"We're seeing really high rates of suicide and depression, and this has been going on for a while," said psychologist Kimberly Hoagwood, PhD, a professor of child and adolescent psychiatry at New York University's Grossman School of Medicine. "It certainly got worse during the pandemic."

In addition to the social isolation and academic disruption nearly all children and teens faced, many also lost caregivers to COVID-19, had a parent lose their job, or were victims of physical or emotional abuse at home.

All these difficulties, on top of growing concerns about social media, mass violence, natural disasters, climate change, and political polarization—not to mention the normal ups and downs of childhood and adolescence—can feel insurmountable for those who work with kids.

"The idea of a 'mental health crisis' is really broad. For providers and parents, the term can be anxiety-provoking," said Melissa Brymer, PhD, who directs terrorism and disaster programs at the UCLA–Duke University National Center for Child Traumatic Stress. "Part of our role is to highlight specific areas that are critical in this discussion."

Across the field, psychologists are doing just that. In addition to studying the biological, social, and structural contributors to the current situation, they are developing and disseminating solutions to families, in schools, and at the state level. They're exploring ways to improve clinical training and capacity and working to restructure policies to support the most vulnerable children and teens.

Psychologists were also behind new mental health recommendations from the U.S. Preventive Services Task Force, a group of volunteer health

professionals who evaluate evidence on various preventive health services. The task force now recommends regular anxiety screenings for youth ages 8 to 18 and regular depression screenings for adolescents ages 12 to 18.

"I see these trends in children's mental health problems as being critical, but there are solutions," Hoagwood said. "If we refocus our efforts toward those solutions, we could see some of these tides turn."

Sources of stress

Across the United States, more than 200,000 children lost a parent or primary caregiver (/monitor/2022/10/kids-covid-grief) to COVID-19 ("COVID-19 Orphanhood," Imperial College London, 2022). In the face of those losses, families had to curtail mourning rituals and goodbye traditions because of social distancing requirements and other public health measures, Brymer said. Many children are still grieving, sometimes while facing added challenges such as moving to a different home or transferring to a new school with unfamiliar peers.

The CDC also reports that during the pandemic, 29% of U.S. high school students had a parent or caregiver who lost their job, 55% were emotionally abused by a parent or caregiver, and 11% were physically abused (*Adolescent Behaviors and Experiences Survey—United States, January–June 2021*, CDC (https://www.cdc.gov/mmwr/ind2022_su.html)).

"Schools are crucial for keeping kids safe and connecting them with services, but the pandemic completely disrupted those kinds of supports," Brymer said.

Those extreme disruptions didn't affect all young people equally. Echoing pre-COVID-19 trends, the CDC also found that girls, LGBTQ+ youth, and those who have experienced racism were more likely to have poor mental health during the pandemic, said social psychologist Kathleen Ethier, PhD, director of the CDC's Division of Adolescent and School Health.

Contributing factors likely include stigma, discrimination, and online bullying, Ethier said. Female students also report much higher levels of sexual violence

than their male peers, which can further harm mental health.

As much hardship as COVID-19 wrought, it's far from the only factor contributing to the current crisis. Biology also appears to play a role. The age of puberty has been dropping for decades, especially in girls, likely leading to difficulty processing complex feelings (/monitor/2016/03/puberty) and knowing what to do about them (Eckert-Lind, C., et al., *JAMA Pediatrics*, Vol. 174, No. 4, 2020 (https://doi.org/10.1001/jamapediatrics.2019.5881)). In early puberty, regions of the brain linked to emotions and social behavior are developing more quickly than regions responsible for the cognitive control of behavior, such as the prefrontal cortex, Ethier said.

Those developmental changes drive young people to seek attention and approval from their peers (/news/apa/2022/social-media-children-teens) . For some, using social media fulfills that need in a healthy way, providing opportunities for connection and validation to youth who may be isolated from peers, geographically or otherwise.

For others, negative messages—including online bullying and unrealistic standards around physical appearance—appear to have a detrimental effect, but more research is needed to understand who is most at risk.

"There is clearly some aspect of young people's online life that's contributing [to the mental health crisis], we just don't know exactly what that is," said Ethier.

Finally, structural factors that affect millions of U.S. children, including poverty, food insecurity, homelessness, and lack of access to health care and educational opportunities, can lead to stress-response patterns that are known to underlie mental health challenges.

"Even in very young children, prolonged stress can trigger a cycle of emotion-regulation problems, which can in turn lead to anxiety, depression, and behavioral difficulties," Hoagwood said. "These things are well established, but we're not doing enough as a field to address them."

Building capacity in schools

The biggest challenge facing mental health care providers right now, experts say, is a shortage of providers trained to meet the mounting needs of children and adolescents.

"There's a growing recognition that mental health is just as important as physical health in young people's development, but that's happening just as mental health services are under extreme strain," said clinical psychologist Robin Gurwitch, PhD, a professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center.

Schools, for example, are a key way to reach and help children—but a 2022 Pew Research Center survey (https://www.pewresearch.org/fact-tank/2022/08/10/just-over-half-of-u-s-public-schools-offer-mental-health-

assessments-for-students-fewer-offer-treatment/) found that only about half of U.S. public schools offer mental health assessments and even fewer offer treatment services. Psychologists are now ramping up efforts to better equip schools to support student well-being onsite.

Much of that work involves changing policies at the school or district level to provide more support for all students. For example, school connectedness—the degree to which young people feel that adults and peers at school care about them and are invested in their success—is a key contributor to mental health. Youth who felt connected during middle and high school have fewer problems with substance use, mental health, suicidality, and risky sexual behavior as adults (Steiner, R. J., et al., *Pediatrics*, Vol. 144, No. 1, 2019 (https://doi.org/10.1542/peds.2018-3766)).

Through its What Works in Schools program (https://www.cdc.gov/healthyyouth/protective/school-connectedness/connectedness_schools.htm) , the CDC funds school districts to make changes that research shows foster school connectedness. Those include improving classroom management, implementing service-learning programs for students in their communities, bringing mentors from the community into schools, and making schools safer and more supportive for LGBTQ+ students.

Psychologists are also building training programs to help teachers and other school staff create supportive classrooms and aid students who are in distress. Classroom WISE (https://www.classroomwise.org/) (Well-Being Information and Strategies for Educators), developed by the Mental Health Technology Transfer Center Network and the University of Maryland's National Center for School Mental Health (NCSMH), is a free, flexible online course and resource library that draws on psychological research on social-emotional learning, behavioral regulation, mental health literacy, trauma, and more (Evidence-Based Components of Classroom WISE (PDF, 205KB), NCSMH, 2021 (https://static1.squarespace.com/static/601ca12e6df22c6353aaa6a5/t/618ec50f5d0a460eab55d2b8/1636746511826/ClassroomWISE+Evidence+Based+Components_Final.pdf)).

"We're using evidence-based practices from child and adolescent mental health but making these strategies readily available for teachers to apply in the classroom," said clinical psychologist Nancy Lever, PhD, codirector of NCSMH, who helped develop Classroom WISE.

The course incorporates the voices of students and educators and teaches actionable strategies such as how to create rules and routines that make classrooms feel safe and how to model emotional self-regulation. The strategies can be used by anyone who interacts with students, from teachers and administrators to school nurses, coaches, and bus drivers.

"What we need is to build capacity through all of the systems that are part of children's lives—in families, in schools, in the education of everybody who

interacts with children," said psychologist Ann Masten, PhD, a professor of child development at the University of Minnesota.

Other training efforts focus on the students themselves. Given that preteens and teenagers tend to seek support from their peers before turning to adults, the National Child Traumatic Stress Network (NCTSN) created conversation cards to equip kids with basic skills for talking about suicide. The advice, available in English and Spanish, includes how to ask about suicidal thoughts, how to listen without judgment, and when to seek guidance from an adult (Talking About Suicide With Friends and Peers, NCTSN, 2021 (https://www.nctsn.org/resources/talking-about-suicide-with-friends-and-peers)).

While training people across the school population to spot and address mental health concerns can help reduce the strain on mental health professionals, there will always be a subset of students who need more specialized support.

Telehealth, nearly ubiquitous these days, is one of the best ways to do that. In South Carolina, psychologist Regan Stewart, PhD, and her colleagues colaunched the Telehealth Outreach Program (https://telehealthfortrauma.com/) at the Medical University of South Carolina in 2015. Today, nearly every school in the state has telehealth equipment (Wi-Fi and tablets or laptops that kids can use at school or take home) and access to providers (psychology and social work graduate students and clinicians trained in trauma-focused cognitive behavioral therapy). Students who need services, which are free thanks to grant funding or covered by Medicaid, meet one-on-one with their clinician during the school day or after hours (*American Psychologist*, Vol. 75, No. 8, 2020 (https://doi.org/10.1037/amp0000691)).

"We learned a lot about the use of technology during the pandemic," Ethier said. "At this point, it's very much a matter of having sufficient resources so more school districts can access those sources of care."

Expanding the workforce

Limited resources are leaving families low on options, with some young people making multiple trips to the emergency room for mental health-related concerns or spending more than six months on a waiting list (https://www.wbur.org/news/2021/06/22/massachusetts-long-waits-mental-health-children-er-visits) for mental health support. That points to a need for more trained emergency responders and psychiatric beds, psychologists say, but also for better upstream screening and prevention to reduce the need for intensive care.

"Just as we need more capacity for psychiatric emergencies in kids, we also need an infusion of knowledge and ordinary strategies to support mental health on the positive side," Masten said.

In New York, Hoagwood helped launch the state-funded Evidence Based Treatment Dissemination Center (http://www.ideas4kidsmentalhealth.org/) in

2006, which offers free training on evidence-based practices for trauma, behavioral and attention problems, anxiety, depression, and more to all mental health professionals who work with children in state-licensed programs, which include foster care, juvenile justice, and school settings, among others. The center provides training on a core set of tools known as PracticeWise (https://www.practicewise.com/) (Chorpita, B. F., & Daleiden E. L., *Journal of Consulting and Clinical Psychology*, Vol. 77, No. 3, 2009 (https://doi.org/10.1037/a0014565)). It also offers tailored training based on requests from community agency leaders and clinicians who provide services to children and their families.

Hoagwood, in collaboration with a consortium of family advocates, state officials, and researchers, also helped build and test a state-approved training model and credentialing program for family and youth peer advocates. The peer advocate programs help expand the mental health workforce while giving families access to peers who have similar lived experience (*Psychiatric Services*, Vol. 71, No. 5, 2020).

Youth peer advocates are young adults who have personal experience with systems such as foster care, juvenile justice, or state psychiatric care. They work within care teams to provide basic education and emotional support to other youth, such as giving advice on what questions to ask a new mental health practitioner and explaining the differences between psychologists, psychiatrists, and social workers. Youth peer advocates in New York can now receive college credit for their training in peer specialist work.

"Making community health work into a viable career can also increase diversity among mental health workers and help us address structural racism," Hoagwood said.

Pediatricians are another group that can provide a first line of defense, drawing on their relationships with parents to destigmatize mental health care.

"Pediatricians are in many ways uniquely positioned to help address the mental health crisis in youth," said Janine A. Rethy, MD, MPH, division chief of community pediatrics at MedStar Georgetown University Hospital and an associate professor of pediatrics at Georgetown University School of

Related topics

Mental health
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Teens

(javascript:printThis();)

effectively respond, Rethy said—yet another area where psychologists may be able to help. Psychologists can provide direct consultations and training to pediatricians (/monitor/2022/06/career-consultations-pediatricians) through the Pediatric Mental Health Care Access program.

"The more we can weave mental health knowledge, capacity, and checkpoints into places where parents feel comfortable—like the doctor's office and at school—the better," Masten said. "All professionals who work with young people really need the knowledge that's being generated by psychologists."

11 emerging trends for 2023

Scientists reach a wider audience (/monitc commun psycholc

Psychologists take aim at misinformation (

Psychological research becomes more inclusive (/m incl res

EDI roles expand (/monitor/2(expanding-e

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Further reading

Science shows how to protect kids' mental health, but it's being ignored (https://www.apa.org/news/press/op-eds/mental-health-crisis-prevention)
Prinstein, M., & Ethier, K. A., *Scientific American*, 2022

How pediatricians can help mitigate the mental health crisis (https://www.contemporarypediatrics.com/view/how-pediatricians-can-help-

mitigate-the-mental-health-crisis)
Rethy, J. A., & Chawla, E. M., *Contemporary Pediatrics*, 2022

Review: Structural racism, children's mental health service systems, and recommendations for policy and practice change (https://doi.org/10.1016/j.jaac.2021.12.006)
Alvarez, K., et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 2022

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Exhibit 13

Shoals Hospital and NAMC Adult and Geriatric Patient ER Data

01.01.23 - 11.30.23 SHOALS ER Adult Psych Patients LOG													
DATA	January	February	March	April	May	June	July	August	September	October	November	Totals	
Total Patients	154	135	157	131	162	144	154	177	171	130	135	1650	Total
Male Patients	82	72	75	66	70	66	84	88	84	72	65	824	Total
Female Patients	72	63	82	65	92	78	70	89	87	58	70	826	Total
Adult	132	11	136	114	129	118	132	142	143	113	108	1278	Total
Geri	21	20	21	16	28	24	24	38	28	117	19	356	Total
AMA	17	23	17	10	18	14	16	23	23	10	16	187	Total
LWOT	3	5	5	2	6	4	3	6	5	0	1	40	Total
LOS > 3 HRS	118	110	136	105	121	121	128	145	135	102	114	1335	Total
LOS > 5 HRS	72	77	103	69	63	78	101	98	80	59	73	873	Total
LOS > 12 HRS	25	31	50	19	25	29	52	17	39	30	27	344	Total
Average LOS	7.08	9.58	11.02	7.52	7.20	8.4	11	6.19	9.08	8.26	8.42	8.49	(Average)
ADMIT TOTAL	73	60	71	76	75	85	88	94	68	79	76	845	Total

76.81818182	**(AVG. Admit Per Month)**
81%	**LOS > 3 HRS**
53%	**LOS > 5 HRS**
21%	**LOS > 12 HRS**

01.01.23 - 11.30.23 NAMC ER Adult Psych Patients LOG													
DATA	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Totals	
Total Patients	107	78	84	86	67	76	56	93	97	69	83	896	Total
Male Patients	56	35	47	41	28	38	28	48	55	29	34	439	Total
Female Patients	51	43	37	45	39	38	28	45	42	40	49	457	Total
Pediatrics	16	12	11	13	7	9	3	15	8	5	3	102	Total
Adult	86	60	65	64	56	56	47	68	73	56	70	701	Total
Geri	5	6	8	10	4	11	6	10	7	6	9	82	Total
AMA	5	3	4	0	2	3	2	3	7	1	2	32	Total
LWOT	9	2	4	1	0	0	0	3	7	2	1	29	Total
Greater than 5 HRS LOS	33	31	29	34	33	40	19	49	39	25	30	362	Total
Average LOS	5.08	8.35	8.15	6.43	8.10	7.06	6.23	6.37	7.17	7.33	7.55	7.07	(Average)
TXFR OUT	17	24	9	10	14	11	5	13	19	12	17	151	Total

Exhibit 14

Letters of Support

Infants' and Children's Clinic, P.C.

421 West College Street • Florence, AL 35630 (256) 764-9522
David R. Colvard, M.D., F.A.A.P. • Erika W. Crenshaw, M.D., F.A.A.P.
Richetta Huffman-Parker, M.D., F.A.A.P. • Grant R. Allen, M.D., F.A.A.P.
Cara C. Pope, M.D., F.A.A.P. • Jordan M. Rutherford, M.D., F.A.A.P
Jeff Cornelius, C.R.N.P. • Taylor R. King, C.R.N.P. • Maegan E. Jacobs, C.R.N.P.

December 7, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: North Alabama Shoals Hospital – Proposal to Adjust the Alabama State Health Plan for Colbert County to Increase the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing this letter to support North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and sixteen (16) child/adolescent psychiatric beds for use in Colbert County, Alabama (the "Project").

Adolescent psychiatric services for patients under the age of 18 as well as adult psychiatric services desperately need to be expanded in Colbert County. I witness this need on a regular basis in my practice. Our area is facing unprecedented mental health challenges with a significant increase in the need for care in recent years. According to the Centers for Disease Control and Prevention ("CDC"), the suicide rate for youth and young adults has increased 52.2% between 2000-2021. Currently, suicide is the second leading cause of death for this at-risk age group.

North Alabama Shoals Hospital is recognized as a leader in the Colbert County healthcare community and beyond. Over the years, North Alabama Shoals Hospital has provided much needed and high quality mental health services to patients in our community. As the conversation regarding the state of mental health in our nation evolves, the need for psychiatric services and availability of treatment to address those needs has become apparent and will continue to grow. I believe that we must increase and strengthen the services available within the State of Alabama, and in particular within Colbert County, so that the families and youth of our area and across the state have access to excellent mental health services like those provided by North Alabama Shoals Hospital and their staff of highly qualified providers.

Infants' and Children's Clinic, P.C.

421 West College Street • Florence, AL 35630 (256) 764-9522
David R. Colvard, M.D., F.A.A.P. • Erika W. Crenshaw, M.D., F.A.A.P.
Richetta Huffman-Parker, M.D., F.A.A.P. • Grant R. Allen, M.D., F.A.A.P.
Cara C. Pope, M.D., F.A.A.P. • Jordan M. Rutherford, M.D., F.A.A.P
Jeff Cornelius, C.R.N.P. • Taylor R. King, C.R.N.P. • Maegan E. Jacobs, C.R.N.P.

be an asset to the Muscle Shoals area. I fully support the proposed adjustment to provide for ten (10) additional adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds to allow increased access for adults and children requiring necessary mental health assistance. I would appreciate your consideration and approval of the application to adjust the State Health Plan and your continued support of the quality healthcare services provided for residents of the State of Alabama.

Sincerely,

Erika W. Crenshaw MD

Cara Pope MD

John Rutherford, MD

John E. Hamilton, MD

Jeff Cornelius, CRNP

December 14, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Mistie Reid
Mental Health Services Coord.
Muscle Shoals City School

#234133502_v1

December 14, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

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As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Allison Smalley, LICSW

Allison Smalley, LICSW
Renewed Mental Health
623 S. Seminary St. Ste. 104
Florence, AL 35630
256-904-1716

DANIEL ROSSER
JUDGE OF PROBATE
COLBERT COUNTY

COLBERT COUNTY COURTHOUSE
P.O. BOX 47
TUSCUMBIA, ALABAMA 35674
Phone: (256) 386-8542
Fax: (256) 386-8547
Record Room: (256) 386-8546

EMILY BENSON
OPERATIONS &
ELECTION DIRECTOR

DEBORAH ROBINSON
MOTOR VEHICLE SUPERVISOR

JENNIFER HARBIN
CHIEF PROBATE CLERK

PATRICIA GARGIS
RECORD ROOM
SUPERVISOR

December 18, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which is desperately needed in the County and in the Muscle Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Daniel Rosser
Colbert County Probate Judge

M. CHAD SMITH
DISTRICT AND JUVENILE COURT JUDGE OF COLBERT COUNTY

COLBERT COUNTY COURT HOUSE
201 North Main Street • Tuscumbia, AL 35674 • 256-386-8524

December 19, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Ms. Marsal,

I hope this letter finds you well. I am writing to bring to your attention a critical need within our community that directly impacts the well-being of the adolescents under our care. As a Juvenile Court Judge in Colbert County, I have witnessed a growing demand for mental health services for adolescents, particularly in the realm of psychiatric care.

Currently, Shoals Hospital in Muscle Shoals is a significant healthcare provider in our region, and I am pleased to acknowledge the efforts they make in providing essential medical services. However, it has come to my attention that there is a shortage of adolescent psychiatric beds available at Shoals Hospital. This shortage has created a gap in our ability to adequately address the mental health needs of the young individuals who come through our juvenile justice system.

I am reaching out to request your support in advocating for the addition of adolescent psychiatric beds at Shoals Hospital. By enhancing the psychiatric services available for adolescents, we can provide timely and appropriate mental health interventions for those in our community who are most vulnerable.

The lack of sufficient psychiatric resources often leads to delays in treatment, impacting the overall well-being and rehabilitation prospects of the youth within our system. By expanding these services, we can work together to ensure that our adolescents receive the specialized care they require.

I am more than willing to collaborate with the Department of Mental Health and any other relevant stakeholders to facilitate the implementation of these additional beds. Your assistance in this matter would not only benefit the young individuals involved in our juvenile justice system but also contribute to the overall mental health landscape of our community.

Thank you for your time and consideration. I look forward to the opportunity to discuss this matter further and explore potential solutions that will positively impact the lives of the adolescents we serve.

Sincerely,

M. Chad Smith
Colbert County District/Juvenile Court Judge

December 13 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Lauderdale County
Circuit Judge
Benjamin Graves

#234133502_v1

December 12, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

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As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Carole Medley
District Judge
Mental Health
Court Judge

#234133502_v1

December 12, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

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As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Will Mathow
Probate Judge
Lauderdale County

#234133502_v1

ELLIOTTJOHNSON
INSURANCE

December 14, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment to Increase Access to Psychiatric Services - North Alabama Shoals Hospital's Proposed Adjustment for Colbert County Application to Increase the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am Chairman of the Board of Trustees for North Alabama Shoals Hospital and North Alabama Medical Center, and I am writing this letter to support North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds for use in Muscle Shoals, Alabama, located in Colbert County (the "Adjustment").

The proposed Adjustment will provide much-needed increased access to high-quality adult and youth psychiatric treatment in Colbert County and surrounding counties. I see this as a benefit for our entire community. It will be a comfort and a relief to know that there will be a facility in close proximity where adult and adolescent patients may be brought to receive the vital care and treatment that they so desperately need.

I understand that North Alabama Shoals Hospital's request, if granted, will provide the necessary beds for increased access to such adult and youth psychiatric care services in the Colbert County, Alabama area. I fully support this application to adjust the State Health Plan and commend providers such as North Alabama Shoals Hospital for taking steps that are urgently needed to address the mental health treatment crisis in our community.

I respectfully urge the Statewide Health Coordinating Council to approve North Alabama Shoals Hospital's Adjustment application to increase access to adult and child/adolescent psychiatric services in the Colbert County area.

Sincerely,

Jeff Johnson
President

CITY OF FLORENCE, ALABAMA

Office of the Mayor

December 15, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As Mayor of Florence and a leader in the Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Andrew Betterton, Mayor

City of Florence

POST OFFICE BOX 98 | FLORENCE, AL 35631-0098
TELEPHONE 256-760-6400 | WWW.FLORENCEAL.ORG | FAX 256-760-6388

RIVERBEND
CENTER FOR MENTAL HEALTH

Elizabeth James, LICSW
Chief Executive Officer

December 14, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

RE: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Elizabeth James, LICSW
Chief Executive Officer

EJ/rp

MITCHELL D. HAYS

Circuit Judge
31st Judicial Circuit

Colbert County Courthouse
201 N. Main St., Tuscumbia, AL 35674
Phone: 256-386-8528
Fax: 256-389-9047

Alexis Curtin
Judicial Assistant

Joseph Washburn
Court Reporter

December 20, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

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Sincerely,

Mitchell D. Hays
Colbert County Circuit Judge

The Colbert County
Children's Policy Council
CHAMPIONS FOR CHILDREN

December 20, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

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I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals and Colbert County communities, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Suzanne Moore

Children's Policy Council Coordinator

The Colbert County Children's Policy Council, Inc.
201 North Water Street
Tuscumbia, Alabama 35674

COLBERT COUNTY JUVENILE PROBATION
201 North Water Street ~ Tuscumbia, Alabama 35674
Telephone: 256-386-8574

December 20, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

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As a member of and leader in the Colbert County community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,

Lee A. Cox

Lee A. Cox Lee.Cox@alacourt.gov
Roderick Fuqua Roderick.Fuqua@alacourt.gov
Mason Bradley Mason.Bradley@alacourt.gov
Heather Keeton Heather.Keeton@alacourt.gov

Dr. Carlos Nelson
Superintendent

SHEFFIELD CITY SCHOOLS

A Commitment to Quality Education

Robin Collum
Chief School Finance Officer

December 20, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union, Suite 870
Montgomery, Alabama 36104

Subject: Support for North Alabama Shoals Hospital's Application to Adjust the State Health Plan

Dear Ms.Marsal:

I fully support North Alabama Shoals Hospital's application to adjust the State Health Plan. The hospital is seeking to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, which is located in Colbert County.

As the Superintendent of Sheffield City Schools, I am witnessing firsthand the urgency of the mental health crisis that is affecting our students. The rise in student mental illness at an earlier age is posing significant challenges in our K-12 classrooms. It disrupts the learning environment and hinders the effective teaching of basic skills such as reading, mathematics, and writing. The current situation necessitates a proactive approach to address the mental health needs of our students.

The shortage of psychiatric care resources, especially for children and adolescents, is a pressing issue in Colbert County. The closure of mental and psychiatric hospitals in previous years has contributed to a situation where patients are going untreated and uneducated in how to provide for the welfare of younger children. Our community is in dire need of an expansion of mental health treatment options to cater to the growing demand for psychiatric services.

The mental health crisis not only affects the educational environment but also has broader implications for the overall well-being of our community. For example, I believe that approving North Alabama Shoals Hospital's request to add psychiatric beds will benefit the school and the

Dr. Carlos Nelson
Superintendent

SHEFFIELD CITY SCHOOLS

A Commitment to Quality Education

Robin Collum
Chief School Finance Officer

community. The additional services allow the hospital to serve more families and contribute to the future of Alabama by providing increased access to crucial psychiatric services.

In the current academic year, Sheffield City Schools, with approximately 1,000 students, have had to remove 5-8 students to be placed in a behavioral unit due to the lack of local psychiatric care options. The nearest community offering child/adolescent psychiatric care is located in Decatur, approximately 50 miles away, with limited space and an inability to accommodate the current need for such services.

Since the return to school from the pandemic, we have witnessed a surge in the need for social-emotional learning. Despite investing in programs and hiring additional counselors, our school counselors are not adequately trained to handle the mental health issues our students are facing. We are actively seeking resources to support our students and community in addressing these challenges.

Please consider the gravity of the situation and kindly request your approval of North Alabama Shoals Hospital's application to adjust the State Health Plan. Your continued support for quality healthcare services in our community is invaluable, and I appreciate your attention to this critical matter.

Thank you for your time and consideration.

Sincerely,

Carlos Nelson, Ed.D
Superintendent

December 13, 2023

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment Application for Colbert County - North Alabama Shoals Hospital's Proposed Increase in the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

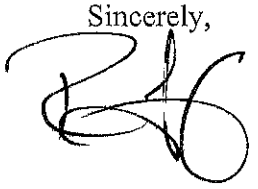
I am writing to express my strong support for North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds in Muscle Shoals, Alabama, located in Colbert County (the "Project"). This Project will provide increased access to adult and youth psychiatric treatment, which I desperately needed in the County and in the Muscle Shoals area in particular.

I have seen first-hand the urgency of the mental health crisis in our community due to lack of psychiatric care resources available for children and adolescents. An expansion of the mental health treatment options available for adults and adolescents in Colbert County and in Muscle Shoals in particular will benefit so many of the families and youth in our community who desperately need increased access to psychiatric services.

North Alabama Shoals Hospital is the Behavioral Health Center for Northwest Alabama. The closest community in the area providing access to child/adolescent psychiatric care currently is located in Decatur, which is unable to accommodate the current level of need for such services.

As a member of and leader in the Muscle Shoals community, I fully support North Alabama Shoals Hospital's request to add ten (10) adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds for use in Colbert County. I respectfully request your approval of the application to adjust the State Health Plan and appreciate your continued support for quality healthcare services in my community.

Sincerely,



Lauderdale County Sheriff's Department
P.O. Box 1710
Florence, Alabama 35631
256-760-5757
Joe Hamilton – Sheriff

January 4, 2024

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment to Increase Access to Psychiatric Services - North Alabama Shoals Hospital's Proposed Adjustment for Colbert County Application to Increase the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am the Sheriff of Lauderdale County and I am writing this letter to support North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds for use in Muscle Shoals, Alabama, located in Colbert County (the "Adjustment").

The proposed Adjustment will provide much-needed increased access to high-quality adult and youth psychiatric treatment in our county and surrounding counties. I see this as a benefit not only for our entire community, but also to our area of first responders. It will be a comfort and a relief to know that there will be a facility in close proximity where adult and adolescent patients may be brought by first responders to receive the vital care and treatment that they so desperately need.

I understand that North Alabama Shoals Hospital's request, if granted, will provide the necessary beds for increased access to such adult and youth psychiatric care services in the Colbert/Lauderdale County, Alabama area. I fully support this application to adjust the State Health Plan and commend providers such as North Alabama Shoals Hospital for taking steps that are urgently needed to address the mental health treatment crisis in our community.

I respectfully urge the Statewide Health Coordinating Council to approve North Alabama Shoals Hospital's Adjustment application to increase access to adult and child/adolescent psychiatric services in the Colbert/Lauderdale County area.

Sincerely

Joe Hamilton

Sheriff - Lauderdale Count

201 N. MAIN STREET
TUSCUMBIA, AL 35674

PHONE: 256.383.0741
FAX: 256.386.8599

ERIC BALENTINE
SHERIFF

January 05, 2024

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: State Health Plan Adjustment to Increase Access to Psychiatric Services - North Alabama Shoals Hospital's Proposed Adjustment for Colbert County Application to Increase the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am a first responder in Colbert County, and I am writing this letter to support North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and create sixteen (16) child/adolescent psychiatric beds for use in Muscle Shoals, Alabama, located in Colbert County (the "Adjustment").

The proposed Adjustment will provide much-needed increased access to high-quality adult and youth psychiatric treatment in Colbert County and surrounding counties. I see this as a benefit not only for our entire community, but also to our area of first responders. It will be a comfort and a relief to know that there will be a facility in close proximity where adult and adolescent patients may be brought by first responders to receive the vital care and treatment that they so desperately need.

I understand that North Alabama Shoals Hospital's request, if granted, will provide the necessary beds for increased access to such adult and youth psychiatric care services in the Colbert County, Alabama area. I fully support this application to adjust the State Health Plan and commend providers such as North Alabama Shoals Hospital for taking steps that are urgently needed to address the mental health treatment crisis in our community.

I respectfully urge the Statewide Health Coordinating Council to approve North Alabama Shoals Hospital's Adjustment application to increase access to adult and child/adolescent psychiatric services in the Colbert County area.

Sincerely,

Sheriff Eric Balentine
Colbert County

EB/ms

January 17th, 2024

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, Alabama 36104

Re: North Alabama Shoals Hospital – Proposal to Adjust the Alabama State Health Plan for Colbert County to Increase the Number of Adult Psychiatric Beds and Child/Adolescent Psychiatric Beds

Dear Ms. Marsal:

I am writing this letter to support North Alabama Shoals Hospital's application to adjust the State Health Plan to add ten (10) adult psychiatric beds and sixteen (16) child/adolescent psychiatric beds for use in Colbert County, Alabama (the "Project").

Adolescent psychiatric services for patients under the age of 18 as well as adult psychiatric services desperately need to be expanded in Colbert County. I witness this need on a regular basis in my practice. Our area is facing unprecedented mental health challenges with a significant increase in the need for care in recent years. According to the Centers for Disease Control and Prevention ("CDC"), the suicide rate for youth and young adults has increased 52.2% between 2000-2021. Currently, suicide is the second leading cause of death for this at-risk age group.

North Alabama Shoals Hospital is recognized as a leader in the Colbert County healthcare community and beyond. Over the years, North Alabama Shoals Hospital has provided much needed and high quality mental health services to patients in our community. As the conversation regarding the state of mental health in our nation evolves, the need for psychiatric services and availability of treatment to address those needs has become apparent and will continue to grow. I believe that we must increase and strengthen the services available within the State of Alabama, and in particular within Colbert County, so that the families and youth of our area and across the state have access to excellent mental health services like those provided by North Alabama Shoals Hospital and their staff of highly qualified providers.

Expansion of North Alabama Shoals Hospital's range of psychiatric treatment services will be an asset to the Muscle Shoals area. I fully support the proposed adjustment to provide for ten (10) additional adult psychiatric beds and to create sixteen (16) child/adolescent psychiatric beds to allow increased access for adults and children requiring necessary mental health assistance. I would appreciate your consideration and approval of the application to adjust the State Health Plan and your continued support of the quality healthcare services provided for residents of the State of Alabama.

Sincerely,

Dr. Jonathan D. Parker, DO, MS, FAAFP

Exhibit 15

New York Times Article, *"It's Life or Death": The Mental Health Crisis Among U.S. Teens*

'It's Life or Death': The Mental Health Crisis Among U.S. Teens

Depression, self-harm and suicide are rising among American adolescents. For one 13-year-old, the despair was almost too much to take.

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 April 23, 2022 Updated May 3, 2022

One evening last April, an anxious and free-spirited 13-year-old girl in suburban Minneapolis sprang furious from a chair in the living room and ran from the house — out a sliding door, across the patio, through the backyard and into the woods.

Moments earlier, the girl's mother, Linda, had stolen a look at her daughter's smartphone. The teenager, incensed by the intrusion, had grabbed the phone and fled. (The adolescent is being identified by an initial, M, and the parents by first name only, to protect the family's privacy.)

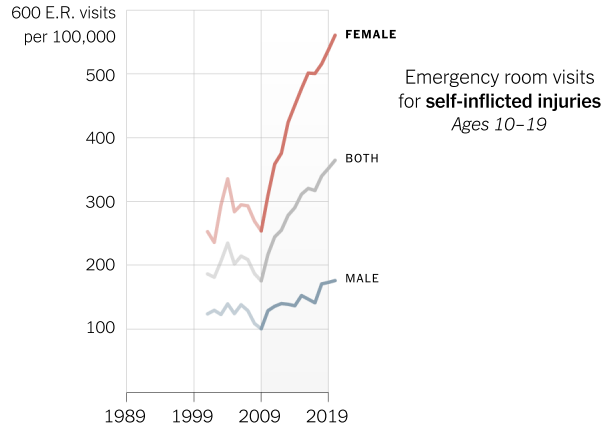
Linda was alarmed by photos she had seen on the phone. Some showed blood on M's ankles from intentional self-harm. Others were close-ups of M's romantic obsession, the anime character Genocide Jack — a brunette girl with a long red tongue who, in a video series, kills high school classmates with scissors.

In the preceding two years, Linda had watched M spiral downward: severe depression, self-harm, a suicide attempt. Now, she followed M into the woods, frantic. "Please tell me where u r," she texted. "I'm not mad."

American adolescence is undergoing a drastic change. Three decades ago, the gravest public health threats to teenagers in the United States came from binge drinking, drunken driving, teenage pregnancy and smoking. These have since fallen sharply, replaced by a new public health concern: soaring rates of mental health disorders.

In 2019, 13 percent of adolescents reported having a major depressive episode, a 60 percent increase from 2007. Emergency room visits by children and adolescents in that period also rose sharply for anxiety, mood disorders and self-harm. And for people ages 10 to 24, suicide rates, stable from 2000 to 2007, leaped nearly 60 percent by 2018, according to the Centers for Disease Control and Prevention.

Emergency room visits for self-harm by children and adolescents rose sharply over the last decade, particularly among young women.



By The New York Times | Source: Centers for Disease Control and Prevention

The decline in mental health among teenagers was intensified by the Covid pandemic but predated it, spanning racial and ethnic groups, urban and rural areas and the socioeconomic divide. In December, in a rare public advisory, the U.S. surgeon general warned of a “devastating” mental health crisis among adolescents. Numerous hospital and doctor groups have called it a national emergency, citing rising levels of mental illness, a severe shortage of therapists and treatment options, and insufficient research to explain the trend.

“Young people are more educated; less likely to get pregnant, use drugs; less likely to die of accident or injury,” said Candice Odgers, a psychologist at the University of California, Irvine. “By many markers, kids are doing fantastic and thriving. But there are these really important trends in anxiety, depression and suicide that stop us in our tracks.”

“We need to figure it out,” she said. “Because it’s life or death for these kids.”

Read about how Matt Richtel reported this series.

The crisis is often attributed to the rise of social media, but solid data on the issue is limited, the findings are nuanced and often contradictory and some adolescents appear to be more vulnerable than others to the effects of screen time. Federal research shows that teenagers as a group are also getting less sleep and exercise and spending less in-person time with friends — all crucial for healthy development — at a period in life when it is typical to test boundaries and explore one’s identity. The combined result for some adolescents is a kind of cognitive implosion: anxiety, depression, compulsive behaviors, self-harm and even suicide.

This surge has raised vexing questions. Are these issues inherent to adolescence that merely went unrecognized before — or are they being overdiagnosed now? Historical comparisons are difficult, as some data around certain issues, like teen anxiety and depression, began to be collected relatively recently. But the rising rates of emergency-room visits for suicide and self-harm leave little doubt that the physical nature of the threat has changed significantly.

As M descended, Linda and her husband realized they were part of an unenviable club: bewildered parents of an adolescent in profound distress. Linda talked with parents of other struggling teenagers; not long before the night M fled into the forest, Linda was jolted by the news that a local girl had died by suicide.

“You have no control over what they’re thinking,” Linda said. “I just want to tell people what can happen.”

‘A typical outpatient’

M at home in Minnesota last fall.

M is one of dozens of teenagers who spoke to The New York Times for a yearlong project exploring the changing nature of adolescence in the United States. The Times was given permission by M and the family to speak with M’s school counselor; M’s medical records were shared with The Times and, with the family’s permission, reviewed by outside experts not involved in M’s care.

“This is a typical outpatient,” said Emily Pluhar, a child and adolescent psychologist at Harvard University, describing M as “an internalizer.”

M, now 14, is tall, with red hair and blue eyes, and has a younger sister and older half brother. By turns shy and outspoken, M has thought extensively about pronouns and currently prefers “they.” At the beginning of seventh grade, M also asked to be called by the name of a popular Japanese anime character, whose first name starts with M. “I think we’re similar in that she’s, like, quiet and smart and plays electric bass, and I really like bass and guitars,” M said.

When M was 4, a psychologist the family consulted to assess M’s school readiness concluded that their “intellectual ability is in the very superior range,” according to the report. M enrolled in kindergarten as one of the younger class members.

At 10, M got a smartphone. Linda and her husband, Tony, both of whom had busy work schedules, worried that the device might lead to heavy screen time, but they felt it was necessary to stay in touch. At 11, M hit another adolescent milestone: puberty.

Over the last century, the age of puberty onset has dropped markedly for girls, to 12 years old today from 14 years old in 1990; the age of onset for boys has followed a similar path. Experts say this shift probably now plays a role in the adolescent mental health crisis, although it is just one of many factors that researchers are still working to understand.

When puberty hits, the brain becomes hypersensitive to social and hierarchical information, even as media flood it with opportunities to explore one's identity and gauge self-worth. Laurence Steinberg, a psychologist at Temple University, said that ability to maturely grapple with the resulting questions — Who am I? Who are my friends? Where do I fit in? — typically lags behind.

The falling age of puberty, he said, has created a "widening gap" between incoming stimulation and what the young brain can process:

"They're being exposed to this deluge at a much earlier age."

M first got a phone at age 10, a concession their parents felt was necessary to stay in touch.

M's first hint of trouble came in sixth grade, with challenges focusing in class. The school called a meeting with M's parents. One teacher suggested testing M for attention deficit hyperactivity disorder, but Linda and Tony were skeptical. The number of A.D.H.D. diagnoses in the United States rose 39 percent from 2003 to 2016, according to the C.D.C., and M's parents, both scientists in biomedical fields, were concerned that consulting an A.D.H.D. specialist would tilt the scales toward that diagnosis.

Instead, Linda tried to help M stay organized with an app that parents and students used to track assignments, test scores and grades. M felt put under a microscope.

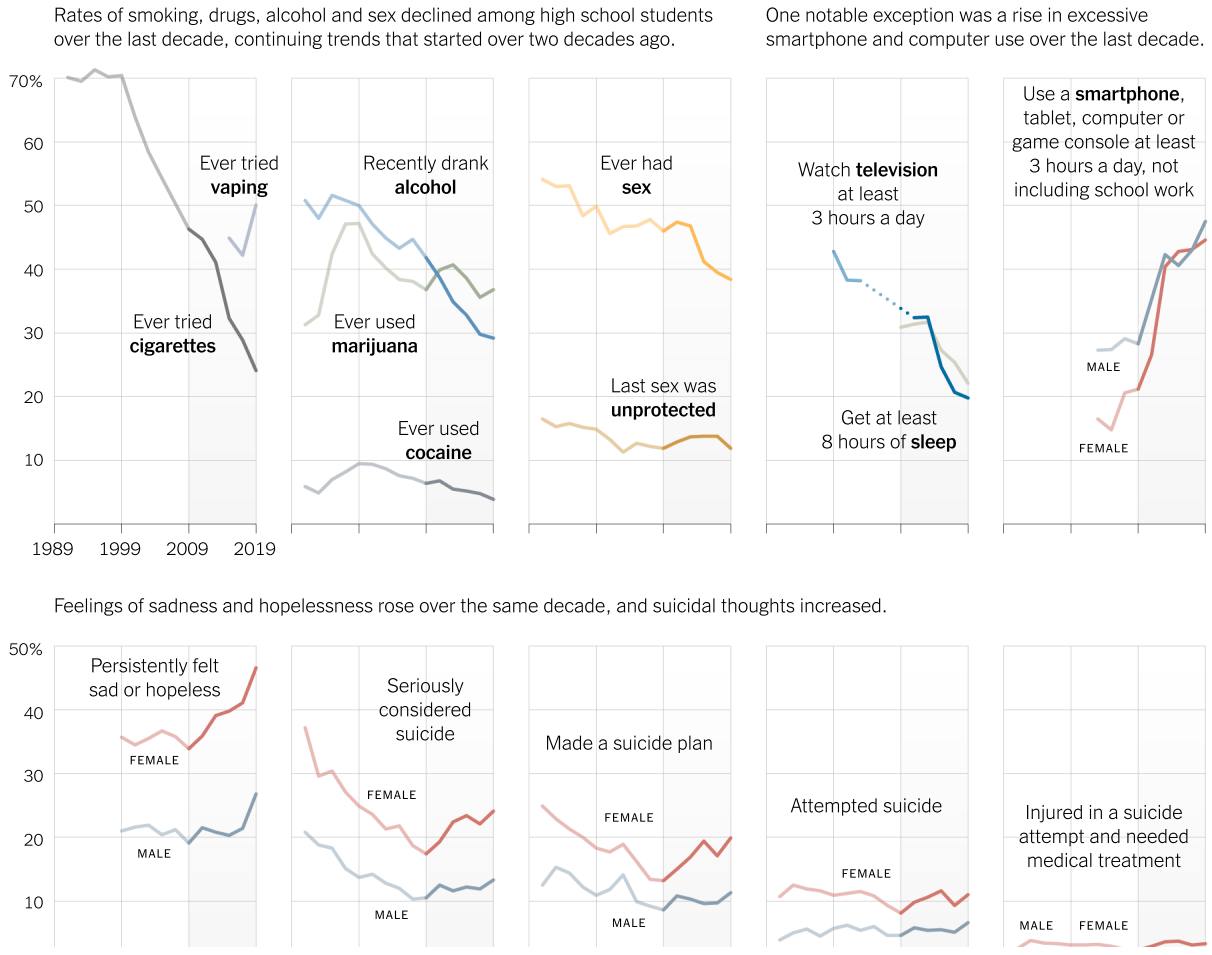
"She would say, 'Can you bring me your iPad so we can check Schoology?'" M recalled about Linda. "I would literally have an anxiety attack because I was so scared."

By the fall of 2019 — seventh grade — M was struggling socially, too. A close friend got popular, while M often came home from school and got into bed. "I felt like a plus one," M said. "I just wanted to be unconscious." Other times, M said, "I just sat in my room and cried."

The behavior seemed alien to Tony, who had lived a different childhood. As an adolescent in Vermont in the 1980s, he fished and played outdoors. By 15, he had his first serious girlfriend; in 1990, the summer before their senior year, he got her pregnant. Their son was born that December, and Tony and the mother shared custody.

Times have changed. Federal research shows that 38 percent of high-school-age teenagers report having had sex at least once, compared with roughly 50 percent in 1990. The teen birthrate has plummeted.

So has cigarette and alcohol use. In 2019, 4 percent of high school seniors reported having a cigarette in the last 30 days, down from 26.5 percent in 1997. Alcohol use by high schoolers hit 30-year lows at the same time. Use of OxyContin and other illicit drugs among high schoolers is down sharply over the last 20 years. Vaping of both nicotine and marijuana has risen in recent years, although both dropped sharply during the pandemic.

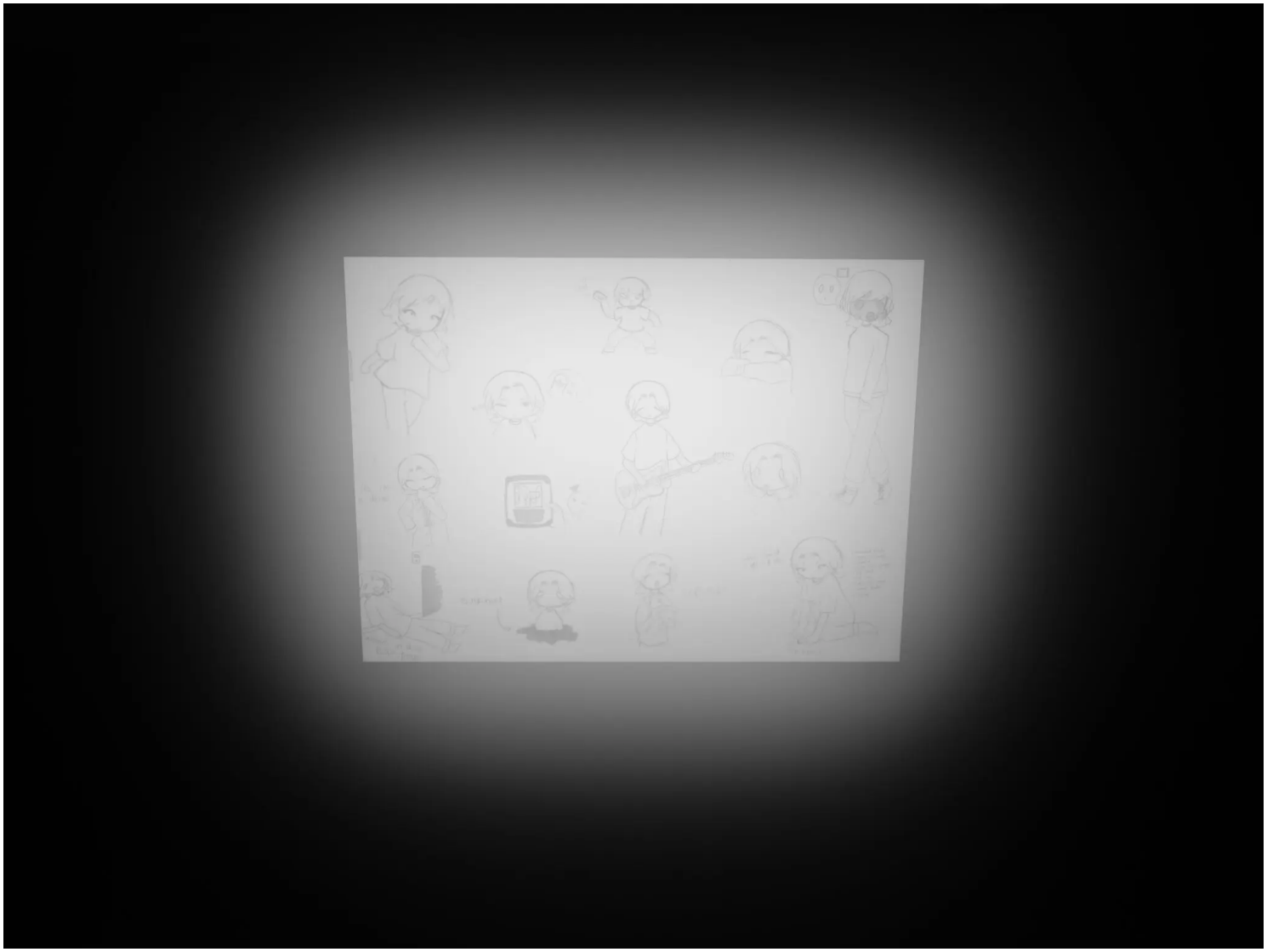


By The New York Times | Source: Centers for Disease Control and Prevention High School Youth Risk Behavior Survey

Experts cite multiple factors: public awareness campaigns, antismoking laws, parental oversight and a changing social lifestyle that is no longer strictly in-person.

Dr. Nora Volkow, director for the National Institute on Drug Abuse, described drug and alcohol use as “very much of a group dynamic.” She added: “To the extent that kids are not in the same place, one would expect a decrease in the behavior.”

A virtual crush



Drawings by M.

In the spring of 2020, M retreated further. Bewildered by online classes, M lied about participating, felt guilty and watched YouTube instead, devouring an anime series called “Danganronpa.” It is set in a high school where students learn from the evil headmaster, a bear, that the only way to graduate is to kill a peer.

M became enamored of one of the characters, Genocide Jack (sometimes known as Genocide Jill), who is described on one fan site as a witty “murderous fiend” who “kills handsome men” using scissors.

One night after dinner, M was upstairs and used scissors to cut both ankles. “I was mad at myself for not doing homework,” M said. “I was kind of thinking, ‘Oh, the pain feels good,’ like it was better than being stressed.” M couldn’t recall where the idea came from: “I wanted to hurt myself with anything.”

M's parents noticed superficial scratches on M's thighs that resembled cuts but did not raise the subject. Linda worried about the screen time but "it was pandemic," she said.

When school ended for summer break, M's mood improved. Over the summer, M discovered the mobile version of the "Danganronpa" video game and how to override the parental screen limits. M played all day.

"I was in front of my screen staring at Jack," M said. "Then I was playing 'Trigger Happy Havoc,' and I was, like, more in love."

"I was kind of just lonely," M said. M fantasized about the future with Jack: "I'd want her to almost kill me but not, and then we could spend the rest of our lives together."

An obsession with a virtual character is not uncommon, experts said. "This is a kid who is a bit lonely, a bit caught up in these narratives," said Nick Allen, a psychologist at the University of Oregon. "There's nothing new in coming up with stuff that freaks out their parents."

Nonetheless, he added, "extremely powerful" online experiences like these can encourage users to think, "That is going to be my identity, my sense of the future, my sense of where I belong socially," at a time when one's identity is a work in progress.

Dr. Pluhar of Harvard noted that "the challenge and the progress" of modern adolescence "is there are so many types of identity" — more choices and possibilities, which in turn could be overwhelming. Among the factors shaping mental health, Dr. Pluhar said, is the mind's churning and obsessing: "Rumination is a big piece of it."

M had a name for the main source of their mental health challenges: "Loneliness."

Elaniv

Tania Gainza, a social worker in Minnesota, and her daughter Elyana at home.

Health experts note that, for all its weight, the adolescent crisis at least is unfolding in a more accepting environment. Mental health issues have shed much of the stigma they carried three decades ago, and parents and adolescents alike are more at ease when discussing the subject among themselves and seeking help.

Indeed, Linda had begun having conversations with other parents who wondered whether the challenges their adolescents were facing represented typical moody teen behavior or something pathological. A colleague told Linda about her daughter's eating disorder. A mother named Sarah confided that her middle-school-age daughter was in therapy for anxiety and depression. "I told her, 'I understand where you're at way better than you think,'" Sarah recalled.

In a nearby suburb, the parents of Elaniv Burnett were struggling to understand their daughter's desperation. As a young child, Elaniv had been joyful, an eager student and graceful gymnast, her father, Dr. Tatnai Burnett, a gynecological surgeon at the Mayo Clinic, recalled: "The kind of kid where you go, 'Huh, we should have more kids.'"

But in 2014, when Elaniv was 9, her parents' marriage began to fracture, and Elaniv injured her ankle; she developed chronic pain, which sidelined her from gymnastics, and she went through a dark period. Then, in 2016, Dr. Burnett, who is Black, was held at gunpoint at home by the police, in full view of the family, after officers responded to a call of a possible intruder.

Recent research has found that wealth, education and opportunity do not shield Black families from mental health issues to the same degree they do for white families. From 1991 to 2017, suicide attempts by Black adolescents rose 73 percent, compared with an 18 percent rise among white adolescents. (The overall suicide rate remains higher among white adolescents.) The suicide rate leaped particularly for Black girls, up 6.6 percent per year on average from 2003 to 2017, new research shows.

In the fall of 2019, Elaniv was diagnosed with major depressive disorder. In a poem in her journal, she wrote: “Thoughts like racecars zoom constant in my head/ Self-hate and worthlessness/ Perpetual, they speed ahead.”

Elaniv began therapy, took medications and enrolled in an outdoor inpatient program in Utah. “We worked on ourselves, worked on our parenting, we changed so many things to try to help meet Elaniv where she was,” Dr. Burnett said. “We controlled electronics, monitored friendships.”

Elaniv’s mother, Tania Gainza, a clinical social worker, saw a generational trend. She had counseled an adolescent for years who was terrified of not meeting expectations. She heard about a local boy who killed himself seemingly without warning.

“There’s something different about this era or generation that makes them much more susceptible or vulnerable,” Ms. Gainza said. “There’s not that community, I guess.”

A rise in loneliness is a key factor, experts said. Recent studies have shown that teenagers in the United States and worldwide increasingly report feeling lonely, even in a period when their internet use has exploded.

“They’re hanging out with friends, but no friends are there,” said Bonnie Nagel, a psychologist at the Oregon Health & Science University. “It’s not the same social connectedness we need and not the kind that prevents one from feeling lonely.”

Often, she said, online social connections amount to seeing “pictures of people hanging out, flaunting it, as if to say, ‘Hey, I’m very socially connected,’ and ‘Hey, look at you by yourself.’”

The pandemic factor

When Linda cleared M's home of knives in the autumn of 2020, M began hitting their head with a barbell.

One day in the autumn of 2020, with the pandemic in full swing and eighth grade having gone fully remote, Linda found M sobbing in bed. M confessed to wanting to die.

Linda found an online therapist. After several sessions, "the therapist broke confidentiality," Linda said. "She said, 'You need to know about the knife.'"

In M's night stand, Tony found a pocketknife and a box knife with a cat's paw image on the handle that M had surreptitiously bought on Amazon and was using to self-harm. One night, M went further, tightening a red hair tie around their neck. "I was trying to see how far I could take it," M said.

The following February, M entered full-day group therapy. A psychiatrist at the clinic notified the family that M had admitted to being unable to stop cutting, medical records show. Linda "de-knived the house," she said, and hid all the pills. Then M engaged in a different kind of self-harm: hitting their head with an eight-pound workout barbell.

Linda recalled feeling stunned: "Oh, now I have to get rid of the blunt objects, too."

M was discharged with a diagnosis of depression and a prescription for antidepressants. From 2015 to 2019, prescriptions for antidepressants rose 38 percent for teenagers compared with 15 percent for adults, according to Express Scripts, a major mail-order pharmacy.

Subsequently, M also received a diagnosis of attention deficit disorder, not A.D.H.D., and given a prescription for methylphenidate, the generic name for medications including Ritalin and Concerta. “I’m still not sure I believe it,” Linda said.

M’s middle school has a trained mental health counselor. In March 2021, M visited him for the first time. During that visit, on a scale of 0 to 10, M ranked hopelessness and anxiety at 9, expressing terror at returning to school, a fear of falling behind and a wish to die.

But M’s mood improved; at a meeting a month later, M ranked hopelessness and sadness at 5 and anxiousness at 2. M felt therapy was crucial but wasn’t sure the medications helped; the school counselor credited M’s improvement to family support and getting back to school. He cautioned the parents, though, that the pendulum could swing back.

Into the forest

Tania held an urn containing the remains of her daughter, Elaniv.

Around that time, Linda heard through the grapevine that a girl named Elaniv Burnett had died following an overdose. “I’m sorry, I can’t take it anymore,” Elaniv wrote in a note. Her mother rushed her, still conscious, to the hospital, where Elaniv expressed regret at the overdose and described her terror. She died four days later, at age 15.

The news was still on Linda’s mind a few weeks later when M fled into the forest.

M’s family had recently returned from visiting both sets of grandparents. One set criticized M’s pronouns, the other M’s heavy screen use. Linda said she felt judged. She stole a look at M’s phone and saw the troubling photos.

“Let’s go for a walk,” she said to M and went upstairs briefly. When she returned, M had vanished, so she followed them into the woods, texting as she frantically looked for flashes of M’s white dress.

Finally M texted back: “I don’t want to talk to you.”

Linda returned home, and Tony went out. He found M along a commonly used trail. They walked, mostly in silence. “Then they were ready to come home,” he recalled.

The school year ended, and M improved, the anxiety ebbing. M took joy spending time with a friend, in person, walking home, strolling the forest.

But a few weeks later, a hurtful text from the friend plunged M into despair again, “like I was back to having no friends.”

M used an exfoliating blade to cut both ankles. “I don’t know how to stop it,” M said. “I can bet $20 that I’ll be in the hospital next year.”

When Linda saw the cuts, she confronted M, who handed over the blade. M let Linda examine the wounds.

“I think that’s good,” Linda said. “They let me look.”

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

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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?

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.

Matt Richtel is a best-selling author and Pulitzer Prize-winning reporter based in San Francisco. He joined The Times in 2000, and his work has focused on science, technology, business and narrative-driven storytelling around these issues. More about Matt Richtel

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