Ryther Report to Stakeholders: 2013-2014

Executive Review

This report represents the third consecutive year of an ongoing effort to inform constituents, officials and supporters about some important specifics of Ryther's operations. This was deemed as necessary when, a few years ago, it became clear that Ryther had evolved but for far too many people their view of what Ryther was had not changed. For most of Ryther's history it had served as a supportive and even therapeutic long-term placement exclusively for the Children's Administration. Average Lengths of Stay were much longer and the children were much less acutely disturbed. This report makes clear with data that times have changed and so has Ryther.

You will note that this report is devoid of the usual emotionally charged stories circulated by organizations with similar missions. To be sure, Ryther has heart rending and shocking stories in abundance. However, this report is not intended for a wide audience. If you are reading this document, it means you have been identified as a discriminating and insightful observer of the nonprofit community of organizations. This is not to say you don't have a tender heart: if you are on our list you have demonstrated that already. But we believe you need more than immediate sensory gratification to make thoughtful judgments about the world around you. We think you want and need to have as much relevant data as possible to make any kind of decision on just about any topic.

Alas, we at Ryther are not satisfied that the data in this report is enough. Every year we continue to try to expand the volume and array of critical performance measures that we gather. One thing you can be sure of is that we won't stop trying.

Lee Grogg, Ryther CEO

Introduction

Ryther is about to enter its 130th year of service to the people of the Puget Sound. It is a markedly different organization than that which Olive Ryther left to us upon her passing in 1934. Ryther is much larger than it has ever been with an annual budget of about $10 Million serving over 2600 clients per year. The array of services and programs is wider than ever before and the organization has expanded its reach from providing outpatient counseling and psychiatry in suburban Snohomish County to the streets of downtown Seattle where Ryther provides mental health care to homeless youth who are sometimes in their early twenties. Ryther's Purpose, however, remains unchanged.

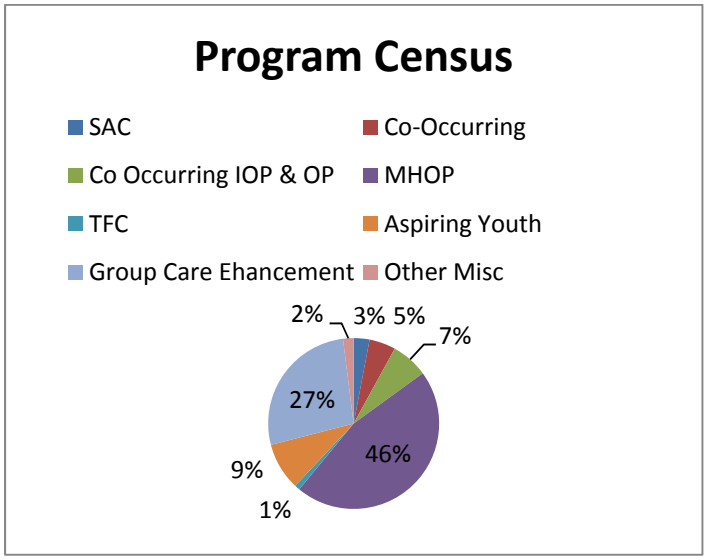
Ryther's Purpose and Philosophy

Ryther's Purpose: Ryther offers and develops safe places and opportunities for children, youth and families to heal and grow so that they can reach their highest potential.

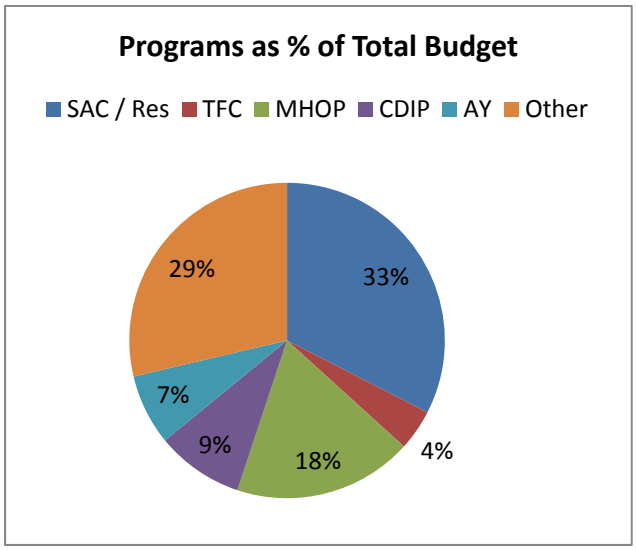
Moreover, Ryther's philosophy hasn't changed since the days of Mrs. Ryther.

Ryther's Philosophy: In all things that Ryther does or is associated with, at all times and in all places, the best interests and well-being of the children and families will be the top priority of the organization and everyone associated with it.

Ryther believes that it remains relevant to the community by offering high quality service with accountability. This Stakeholder's Report represents only one of the ways Ryther expresses its accountability to all concerned. Ryther has also believed that part of accountability is growing and changing with the needs of the community, its children and the times. Accordingly where Ryther was once exclusively a provider of long term child residential care, Ryther is now multiservice behavioral healthcare provider where live in care represents only a small portion of its operations.



What was called Residential is now Sub-Acute Hospital Alternative Care and represents only 3% of Ryther's population.



Sub-Acute Hospital Alternative Care, while serving a small number of children, consumes a third of Ryther's annual operating revenues. This program handles very difficult and complex cases that few other organizations even attempt to serve.

Where Ryther was once almost totally dependent on public sector funding, Ryther has diversified its services into more self-sustaining endeavors. In 2010, Ryther earned only about 10% of its operating revenues on a budget of under $8 million from private fees and payments. Today, that segment of revenue accounts for about 26% of all revenues. Still, challenges continue to exist in the world of behaviorally and emotionally disordered children.

Ryther's Sub-Acute Hospital Alternative Care

Since 2008, there has been a significant decline in facility-based Behavior Rehabilitation Services (BRS) care and a general decline in BRS utilization overall. This has occurred despite the fact that there has been no change in the incidence and prevalence of severe mental health disorders among children and adolescents, either nationally or in Washington State. At least 70 BRS facility beds have closed just in Western Washington alone in that time period. Recently, Children's Administration (CA) has reported a significant uptick in calls to, and opened cases with, Child Protective Services (CPS); typically the need for services for severely behaviorally and emotionally disturbed children rises proportionately. Additionally, Washington State continues to have the lowest psychiatric hospital bed capacity in the 50 States.

That the need is growing is evidenced by the number of new children's psychiatric hospital beds planned for expansion by a number of organizations that would, in the next four years, essentially double the State's capacity. Despite this planned expansion, Washington State would still remain among the lowest, if not the lowest per capita in the United States. Severely emotionally and behaviorally disturbed children are not going away.

One of the consequences of these events has been an ever increasing concentration of more seriously disturbed and disordered children in the facilities that have somehow survived. In most respects, the few BRS facilities remaining are handling a far more difficult population than was originally anticipated when the BRS system was created. Most BRS facilities have had to increase not only the number of staff but the educational qualifications of that staff to safely handle this new and more difficult population. That being said, facility-based BRS care is reimbursed at the same daily rate as was being paid in 2004.

Ryther, formerly known as Ryther Child Center, is representative of the problems and challenges being faced by BRS facilities. Moreover, Ryther and its coping strategies represent the increasing value these facilities provide to the State of Washington. Ryther served 76 of the State's most complex and difficult clients from both the Child Welfare System and referrals from the private sector. The children with severe behavioral disorders from the Child Welfare System are sent to Ryther and other providers under the auspices of the BRS Program within the State's Children's Administration.

BRS children in need of structured care that Ryther now labels as Sub-Acute Hospital Alternative Care, account for about 3% of the organization's census, but consume a third of its resources. The age range of children served in this service runs from 6 to 14, with 80% being ten and older. On average, BRS children coming to Ryther have failed in **nine** previous placements.

100% of all BRS children arriving at Ryther are rated as the most severe or 1-A. In 2004, only about 50% arrived with that level of severity **assigned** by CA. The children come from 10 Counties in Washington State with 71% from King County and 12% from Snohomish County; the remaining 17% are from other I-5 corridor counties. Most of the children admitted to Ryther have multiple psychiatric diagnoses, but 40% suffer from severe Post Traumatic Stress Disorder. 27% of the children are diagnosed with a range of mood disorders with suicidal ideation as a common manifestation.

36.7% of the children entering Ryther have had at least one recent psychiatric hospitalization.
The increasing acuity of the children, as well as the concentration of those children, has led to some serious problems in care management.

The rate of staff injuries and assaults per occupied bed day has nearly tripled since 2008. In FY 2013-2014 Ryther staff experienced 447 assaults. 48% of the children in the Sub-Acute program are prescribed up to three medications to manage their symptoms. Ryther's utilization rate of its Sub-Acute Hospital Diversion Care units has not dropped below 95% in four years.

Ryther's Adaptation

In order for Ryther to continue to safely care for the changing population of children referred to it by CA, Ryther took a number of significant and costly steps including:

- Increase of full time Child Psychiatrists on staff from one to three
- Addition of two full time Doctoral level Psychologists
- Increase in direct care staff to patient ratio to 2 to 1 during waking hours, and 3 to 1 overnight
- Private room for each client
- Case manager and Masters qualified therapist for every 12 children
- Increased in number of Evidence-Based Practices in its repertoire of treatment strategies, including the following:

    - Trauma Focused Cognitive Behavioral Therapy (CBT)
    - Parent-Child Interaction Therapy (PCIT)
    - Enhanced CBT
    - Dialectical Behavioral Therapy (DBT Skills)
    - Eye Movement Desensitization and Reprocessing (EMDR)

In addition to these therapies, Ryther has significantly intensified the number and array of what it calls Enrichment Activities and events ranging from Best Buddies, to Therapy Dogs, Equine Therapy, Experiential Learning-Challenge Course, Tribal sponsored events such as drumming, and many more; 84 in all. These are experiences that augment treatment and prepare children for less restrictive placements that are **not** provided or available in most acute psychiatric hospital units.

Results

Because of the improvements made in treatment and ancillary services that are available to the children, Ryther has been able to achieve some interesting and significant results in behavioral and symptom management as shown on the graph below. These are the behaviors that prevent children from going to less restrictive settings as well as finding permanency.

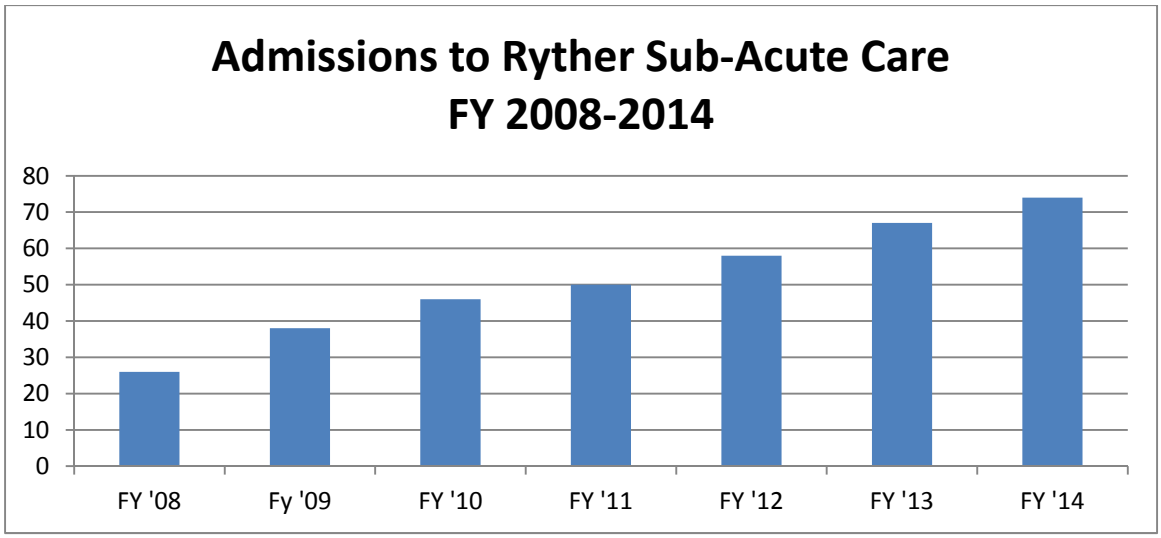
Behavioral and Symptom Improvement

Behaviors Preventing Less Restrictive Settings	*% children presenting at Intake*	*% Measurable Improvement at DC*
Aggression	**91%**	**82%**
Assaultiveness	**74%**	**91%**
Sexualized Behaviors	**53%**	**87%**
Running/AWOL	**47%**	**85%**
Suicidal Ideation	**47%**	**80%**
Threatening/Intimidating	**47%**	**75%**
Self- Injurious Behaviors	**44%**	**95%**
Enuresis	**33%**	**71%**
Homicidal Ideation	**21%**	**89%**
Encopresis	**16%**	**100%**

CFARS Results

Ryther, as do all BRS contractors, uses the Children's Functional Assessment Rating Scale (CFARS) to measure function across 16 domains of living and life skills. Among the 26 BRS children discharged from Ryther in 2013, 100% showed improvement in at least one/multiple domain(s), and in the 5 domains Ryther considers to be the most significant in terms of moving to less structured living arrangements, 92% showed significant improvement.

Typically, this meant moving downward in severity by a factor of 1.5 to 2.0 category levels. For instance, in a domain where the problem with function was considered to be severe, the acuity would be reduced to slight, or slight to moderate severity.



BRS clients have an Average Length of Stay (ALOS) of 10.5 months, but on average, three of those months occur after Ryther has informed Children's Administration that the children are ready to move to less structured settings.

Ryther's efforts to improve the quality of treatment have shown some other positive indicators. In 2008, Ryther's rate of utilization of restraints was 0.1497 per occupied bed day. That rate is now 0 .0942 per occupied bed day.

80% of Ryther's children are discharged to less restrictive settings with 40% transferred to "permanent" placements.

Co-Occurring, Mental Health Chemical Dependence Inpatient

In FY 2013-2014 Ryther discharged 126 adolescent boys between the ages of 13 and 18 years. Those clients came to Ryther from 21Counties in Washington State. King, Snohomish, Pierce and Whatcom Counties accounted for 59% of the total, while the remaining 41% came from the remaining 17 counties. The vast majority of the teenagers served were from west of the Cascades.

The major drug dependencies with which these teens were involved were as follows:

- Cannabis Dependence 40%
- Poly-substance Dependence 11%
- Alcohol Dependence 11%
- Amphetamine Dependence 7%
- Opioid Dependence 3%

The Mental Health diagnoses among this population were very, diverse:

- Stress Disorder and PTSD
- ADHD
- Anxiety Disorder
- Bipolar Disorder
- Depression
- Mood Disorder
- Panic Disorder
- Psychotic Disorders
- Various Personality Disorders

Behavioral Problems Presented and Addressed

Behavioral Problems Noted at Intake	***% Teens Discharged Presenting***	***% Teens Showing Improvement***
Self-Harm	**44.4%**	**87.5%**
Sexualized Behavior	**25.4%**	**81.3%**
Aggressive	**88.9%**	**82.1%**
Avoidant	**99.2%**	**69.6%**
Rule Non-Compliance	**89.7%**	**83.2%**
Social Skills	**89.7%**	**72.6%**
Psychosis	**12.7%**	**62.5%**
Property Destruction	**99.0%**	**80.8%**

64% of the teen boys graduated or successfully completed the treatment program, while 45% were discharged unsuccessfully. Private insurance clients have a successful completion rate of about 58% and publicly paid clients have a successful completion rate of 66%. The reason for the difference is that many times the publicly sponsored (Medicaid, State of Washington) are facing criminal justice consequences if they fail in their treatment. The overall Average Length of Stay (ALOS) is 29 days.

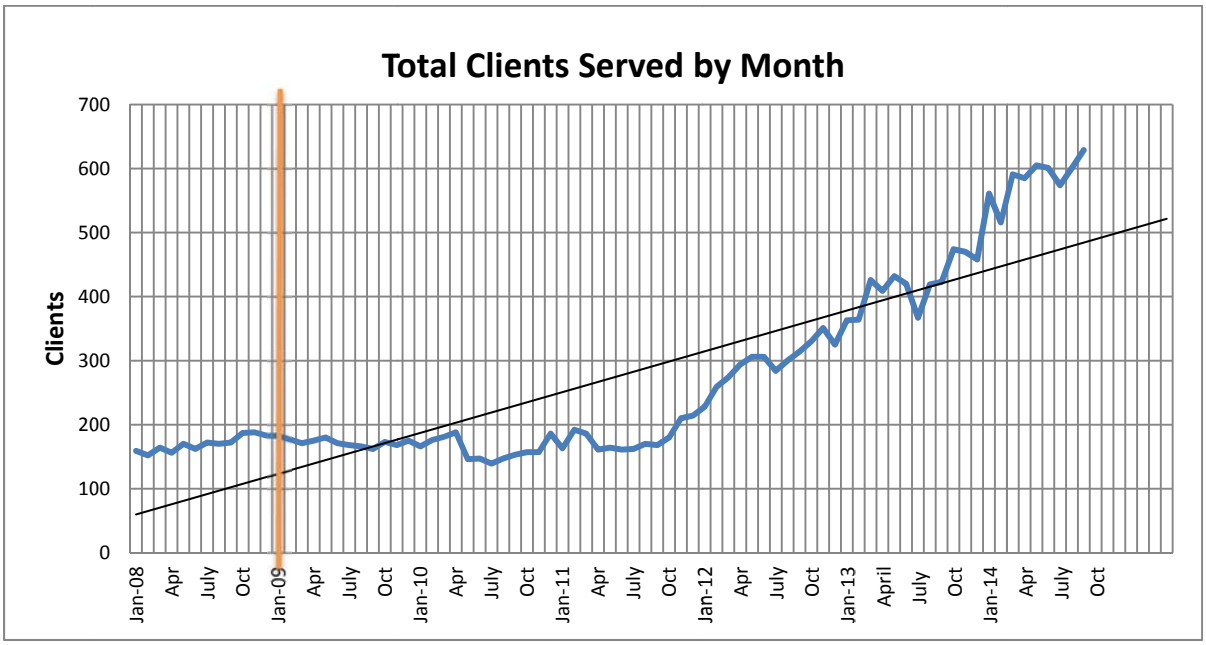
Ryther strives to contact every discharged client in six months post stay to assess the progress they have made in improving their mental health and sobriety. In the past fiscal year, Ryther attempted to contact 85 clients and was successful in 58 of those cases. Of those successfully contacted, 59% were either clean and sober and or were successfully engaged in a less intensive treatment program.

Ryther's Co-occurring Outpatient Program

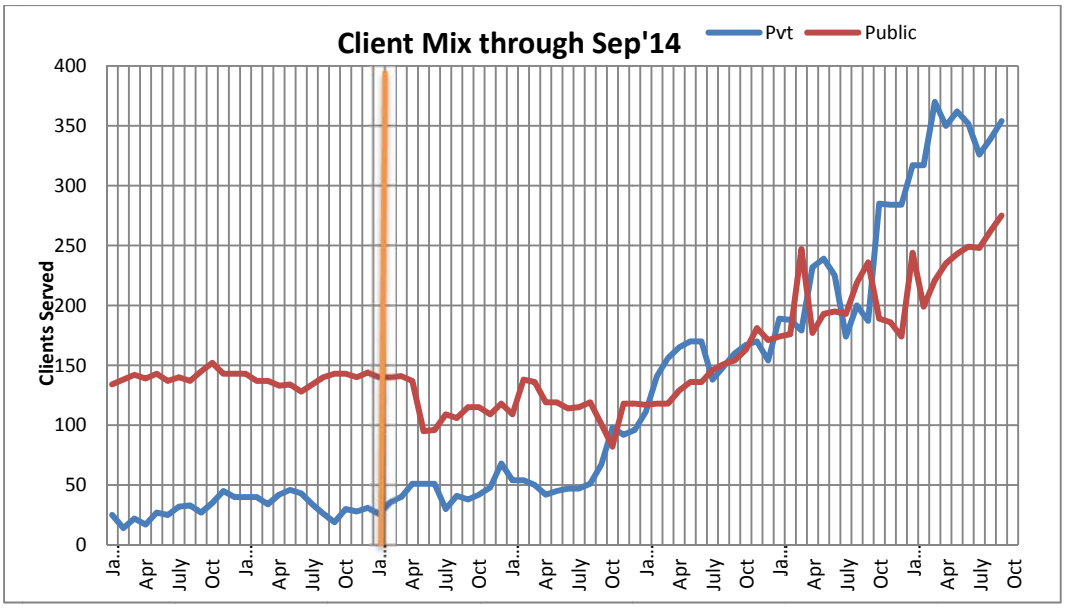
Ryther initiated an Intensive Outpatient Program (IOP) for teenagers, both boys and girls, in 2013. This program has three elements; IOP for Chemical Dependence issues, IOP for Co-Occurring and Mental Health Issues and an Assessment only program. By the end of the Fiscal Year, Ryther had served 53 adolescents in its treatment program and had provided assessment only services to 71. Of the 53 receiving treatment services, **23** were successfully discharged, with **70%** having achieved their goals for treatment. The client base for this service is in three Western Washington counties. (King, Snohomish and Pierce).

Ryther's Outpatient Mental Health Service

Since 2010 Ryther has emphasized growing its outpatient services. In 2010 Ryther served about 160 enrolled clients per month. Now, it serves 600 clients per month. In FY 2014 the total number of clients served was just under 1300. The charts below highlight the growth of the program.



The vast majority of Ryther's outpatient clientele resides in King County, though in 2012 Ryther opened an office in Mukilteo, expanding the number of Snohomish County residents being served. The client mix has undergone a metamorphosis as startling as the growth. Privately insured clients were once the exception for Ryther. Now, they account for more than half of outpatients served as graph illustrates.



The children served range in age from two years to 19+ years. 39% are between the ages of two and 12, while 53% are adolescents between the ages of 13 and 19 years. Anxiety and Mood Disorders account for 54% of the primary diagnoses given to our clients in this program. Post-Traumatic Stress Disorder (PTSD) and Attention Deficit Disorder are the next most common diagnoses.

Often, people in the mental health field consider these diagnoses as somehow less severe than the array of thought disorders and psychoses seen in older populations. Unquestionably, those disorders are very difficult to treat and the presentation that such patients make can be disturbing and or frightening. Children are rarely diagnosed with psychotic disorders, but it does happen and Ryther does, in fact, treat them. If, however, severity is measured in terms of family disruption, pain and suffering, the children in the Ryther program have to be considered very severe and the consequence of their illnesses are often catastrophic. (See the Adverse Childhood Experiences Study at acestudy.org)

The 1,287 clients served by Ryther in FY '13 and FY '14 on average had 11.4 visits both in individual and group settings. A variety of evidence-based and best practices were utilized by Ryther staff employed in the program, all of whom are in possession of a Masters level degree. The most common therapies used include various cognitive behavioral therapies (CBT, Trauma Focused CBT, DBT, and Enhanced CBT), supplemented with psychopharmacology when appropriate.

Ryther attempts to perform a symptom severity assessment at the beginning of treatment and at fixed time frames for all children entering the program. In Fiscal Year 2013-2014 Ryther was able to assess 90% (563) of the children eligible to be measured. Of those 507 children assessed at fixed points in time, 90% were able to maintain or improve their scores. Ryther also administers a mailed and electronic client satisfaction survey each summer. This past summer's survey achieved a 36% response rate and 90% of the respondents indicated that they would refer a family member or friend to Ryther if the need was present. While Ryther has invested modestly in marketing and advertising, the impressive

growth of the program (266% increase in patients served since 2010) only a portion of that growth can be attributed to those efforts. Referrals and repeat referrals account for most of the program's growth. Clearly Ryther has made serious and apparently successful efforts to satisfy its "customers."

Conclusion

This annual report is intended to be informative for people who may be interested in what and how Ryther is doing. It is not intended to be a self-promotional marketing tool; though reporting on outcomes that end up being positive might be cynically viewed otherwise. The fact is that Ryther continues to face a great many challenges.

Chief among those challenges is financing. Unquestionably, Ryther's Sub-Acute Hospital Alternative Care program is expensive. The intense acuity of the children we serve makes that unavoidable. The only alternatives in caring for these kinds of children are all much more expensive than Ryther. Not only does the State of Washington reimburse inadequately, private insurers are reluctant to pay Ryther and when they do pay they add considerable administrative overhead costs to become eligible for reimbursement and to process claims, if they're willing to consider payment at all.

There also remains today a good deal of stigma attached to seeking and receiving mental health services for children. Parents often postpone seeking help and then too often try half measures before trying very costly alternatives that may promise quick or easy results that do not pan out. This is understandable, since dealing with a very troubled child can be catastrophically expensive and emotionally devastating. This can mean that when the child does get to Ryther, problems are far more complicated and difficult to resolve.

Perhaps most concerning is that by and large our children's health and social services systems are so entrenched in their traditional fragmented silos that bringing together all the necessary skills and services to truly meet a child's behavioral health needs with accountability is so rare as to be nonexistent. Wrap around has become a popular term and concept in social services, but as it relates to seriously emotionally disturbed children, its effectiveness and efficiency is at best very doubtful and rarely truly accountable. On the mental health side the traditional mental health providers seldom play well with primary care providers who should, in reality, be the captains of the child's health team.

This is the context in which Ryther finds itself. Ryther fills a niche outside traditional boundaries that few understand unless they are responsible for a placement or hospital discharge plan for an especially complicated child with severe behaviors. Such persons, whether they are working in a child welfare office or a psychiatric hospital with these responsibilities, come to understand this niche. This means that it is not enough for Ryther simply to do good work with accountability and good results. Ryther must find a way to advocate and educate the public and officials on a scale that is at least very costly. In many respects, Ryther's future depends on this kind of advocacy.