



Bluestone

Child & Adolescent Psychiatric Hospital

TRANSFORMING MENTAL HEALTH





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TRANSFORMING MENTAL HEALTH

2026 Bluestone Child & Adolescent Psychiatric Hospital Community Health Needs Assessment

To the Residents of Northeast Ohio:

Thank you for your interest in the 2026 Bluestone Child & Adolescent Psychiatric Hospital Community Health Needs Assessment (CHNA).

Bluestone Child & Adolescent Psychiatric Hospital is a 12-bed psychiatric hospital designed to create cutting-edge clinical care and positive patient experiences for youth in crisis. Bluestone was developed to fill a widening gap in services for children's acute mental health needs. Over the past 20 years, psychiatric hospitalization of youth has risen 42 percent while Ohio's number of pediatric psychiatric beds has fallen about 38 percent. In Cuyahoga County, there were only 25 psychiatric beds for approximately 325,090 youth; the Ohio Department of Mental Health and Addiction Services had not operated a child or adolescent inpatient program for more than two decades. Moreover, the hospitalization of individuals with autism is of increasing concern, as many hospitals are not equipped to admit or work with these patients.

Our commitment addressed this critical service gap by increasing the number of pediatric psychiatric beds in Cuyahoga County by 50 percent. Building upon the extensive experience of fellow Wingspan Care Group affiliates, the Bluestone facility and team of professionals ensures that the most vulnerable youth, such as those who are dually diagnosed or with autism spectrum disorder, receive the highest quality care and have the highest rate of success upon discharge. Built with a wide range of safety features, Bluestone is supported by an equally impressive team of professionals who understand that long-term success of the youth served is the number one priority. Our multidisciplinary staff includes Behavioral Nursing, Expressive Therapists and Clinical Social Workers, and Board Certified Child and Adolescent Psychiatrists.

The blend of quantitative and qualitative data presented in this report provides a description of the health status of the community served by Bluestone Psychiatric Hospital, the issues adolescents are struggling with, and the priorities that we will focus on over the next three years to improve the mental health of children and adolescents in our region.

We invite your comments and feedback on this report as well as on the mental health needs facing adolescents in Northeast Ohio.





ABOUT THIS REPORT

A Community Health Needs Assessment (CHNA) helps to gauge the health status of a community and guide development and implementation of strategies to create a healthier community. The CHNA process also promotes collaboration among local agencies and provides data to evaluate outcomes and impact of efforts to improve the population health. The CHNA process supports the commitment of a diverse group of community agencies and organizations working together to achieve a healthy community.

Facilitated by Strategy Solutions, Inc., with primary research support from Elizabeth Anthony, this CHNA follows best practices as outlined by the Association for Community Health Improvement, a division of the American Hospital Association. It is also designed to comply with Internal Revenue Service (IRS) guidelines (IRS Notice 2011-52) for charitable 501(c)(3) tax-exempt hospitals that was published in December 2014. The process has taken into account input from those who represent the broad interests of the communities served by Bluestone, including those with knowledge of public health, the medically underserved, as well as underrepresented populations and those with lived experience.

This CHNA includes two documents:

1. this report, which is a summary of key findings and priority areas,
2. a separate implementation plan document that outlines the Bluestone goals and implementation strategies to address the findings over the next three years.

This assessment is intentionally designed to frame adolescent mental health status in the context of the whole person, to better inform the community as we seek to leverage resources and investments that will improve the mental health of the community.

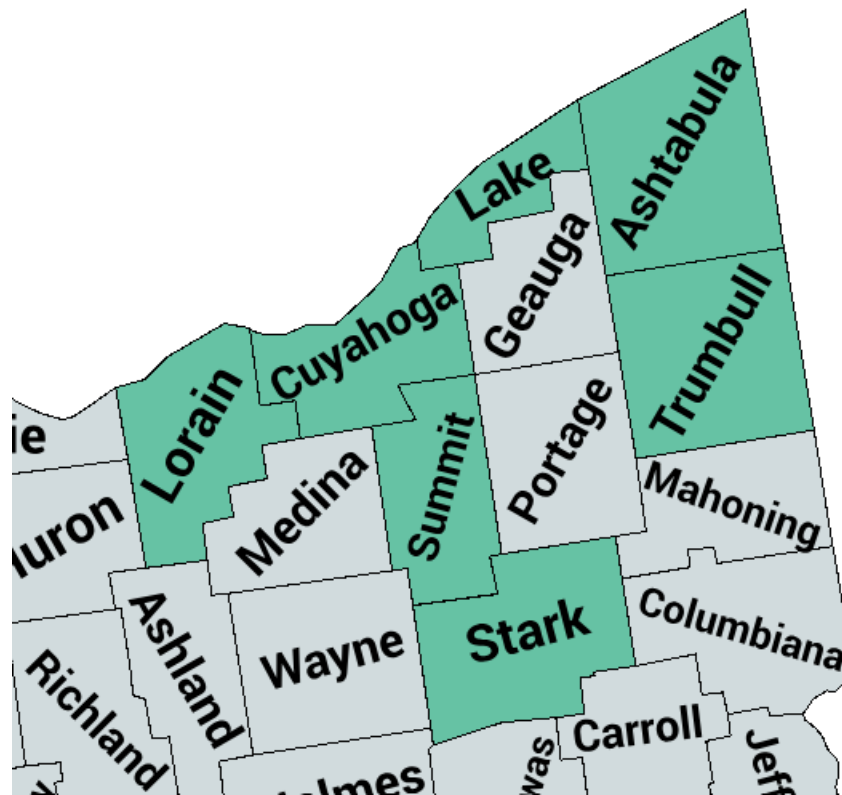
This blend of data offers a snapshot of the needs and issues facing adolescents today, the challenges many residents are struggling with, and what the priorities are that have been identified by Bluestone Psychiatric Hospital to address these needs.



PRIMARY SERVICE AREA

As recommended in Section 501(r)(3) of IRS guidelines, the hospital facility's community was determined by considering the geographic area and target populations served as well as the principal services offered. For this assessment, the community is defined as the hospital's primary service area, a 7-county area in Northeast Ohio. This represents the geography from which 70% of the patients have been served over the last three years (Figure 1). The 2026 CHNA includes the following counties: Ashtabula, Cuyahoga, Lake, Lorain, Stark, Summit, and Trumbull.

Figure 1: Bluestone Northeast Ohio Primary Service Area



EXECUTIVE SUMMARY

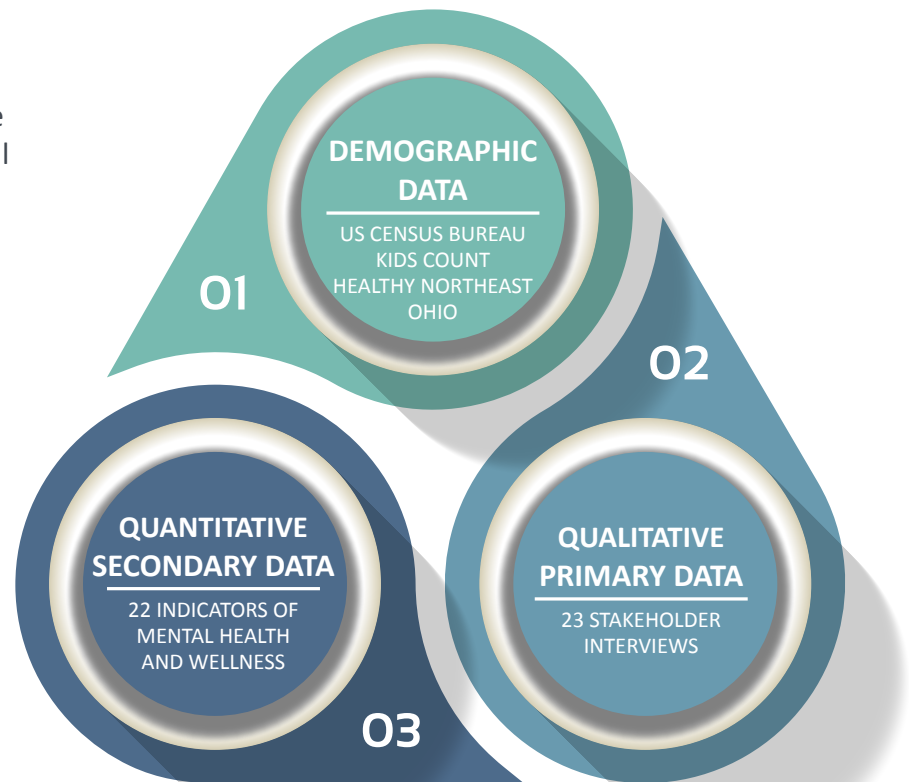
Established in 2022, this is the second Community Health Needs Assessment (CHNA) conducted by Bluestone Child & Adolescent Psychiatric Hospital in partnership with the community. In 2026, the Steering Committee for the study included 8 community leaders, representing a diverse cross-section of the region. The CHNA included a variety of quantitative and qualitative data collection and analysis methods including extensive secondary data from local, regional, state and national sources, along with input from 23 key community stakeholders through individual interviews. The report also includes evaluation of the implementation strategies from the prior assessment.

To support this assessment, data from numerous qualitative and quantitative sources were used to validate the findings, using a method called “triangulation” outlined in Figure 2. Three main types of data were used for this assessment:

- **Demographic Data** from the US Census Bureau, Kids Count and Healthy Northeast Ohio.
- **Qualitative Primary Data** from professional stakeholder interviews, providing the opportunity for leaders to share their views and suggestions about the needs and issues facing the community.
- **Quantitative Secondary Data** from the Ohio Department of Health and numerous other secondary sources identified as indicators related to health status, health equity, social equity, and sustainable communities in addition to disease incidence and prevalence as well as other secondary data from local partners pertaining to health-related services provided in the region.

This blend of data creates a snapshot of the issues and challenges facing children and adolescents in the Northeast Ohio region.

Figure 2: Data Triangulation



There are 627,205 children under the age of 18 in the 7-county service area that accounts for 70% of hospital admissions. This represents 24.0% of the state's youth population. The service territory, as well as the state has a slightly higher percentage of males aged 5-19. Children under the age of 19 in the service territory are predominantly White, with Cuyahoga County being the most diverse with the highest percentage of Black children (37.0%) and also a high percentage of Hispanic children (9.4%). Lorain County also has a large Hispanic population (15.9%). Ashtabula County has the highest percentage of children with a disability (7.3%).

General Findings

Improving Indicators

Across the service area, several positive trends demonstrate meaningful progress in child and youth well being. Multiple counties—especially Lake, Summit, Lorain, and Stark—consistently outperform both Ohio and national benchmarks across key health, socioeconomic, and behavioral indicators. For example, Lake and Summit counties report lower percentages of children with disabilities than the state and nation, as well as declining rates of child abuse and neglect intakes, with Ashtabula, Lake, Stark, and Summit showing steady declines from 2023 to 2025.

Health coverage remains a strong regional asset; counties such as Cuyahoga, Lake, Lorain, and Summit have higher proportions of insured children than both Ohio and the U.S. Similarly, multiple counties—including Lake, Lorain, and Stark—show lower rates of children living in poverty relative to state.

Youth disconnection from school and work is also trending in a favorable direction. Lake County, in particular, consistently outperforms the state for both disconnected youth and youth not working or in school. Maternal and infant health measures show additional strengths: Ashtabula and Lake have significantly lower rates of low birthweight and preterm births, while teen birth rates in Lake, Lorain, and Summit remain well below state and national averages.

Food security indicators also reflect positive movement, with Lake and Summit reporting lower percentages of food insecure children than both Ohio and the nation. Across several counties, adults report lower rates of excessive drinking than statewide averages.

Behavioral health data further highlight areas of improvement. Several counties—Cuyahoga, Lorain, Summit, and Trumbull—show lower percentages of Medicaid participating students diagnosed with specific behavioral health conditions compared to the state. In some counties, such as Lorain and Summit, indicators show declines in youth anxiety, depression, and overall mental health concerns, with notable reductions in students experiencing prolonged sadness or considering suicide.

Overall, these improving indicators signal important momentum in child health coverage, economic stability, youth connectedness, maternal/infant health, and behavioral health outcomes across several counties in the region.



Community Needs

Several counties—most notably Ashtabula, Cuyahoga, and Lorain—report higher rates of children with disabilities and lower levels of health insurance coverage than state and national averages. Economic vulnerability continues to affect many families: child poverty rates exceed state and national levels in Ashtabula, Cuyahoga, Summit, and Trumbull, with some counties showing substantially elevated rates of children living below the poverty line.

Youth disconnection remains a major concern in Ashtabula, Cuyahoga, Lorain, Stark, and Trumbull, where percentages of youth not in school or working outpace the state and, in some cases, the nation. Maternal and infant health indicators—including low birthweight, preterm births, and teen birth rates—remain elevated in Cuyahoga, Lorain, Summit, and Ashtabula counties. Food insecurity among children is also significantly higher than state and national benchmarks in Ashtabula, Cuyahoga, and Lorain.

Behavioral health needs represent some of the most urgent and widespread concerns. Many counties show increasing levels of youth anxiety, depression, marijuana use, and suicidal ideation, particularly among students in grades 7–12. Cuyahoga and Stark counties specifically demonstrate upward trends in mental health issues requiring further clinical assessment.

Additionally, every county has at least several areas where Medicaid participating students experience higher rates of behavioral health diagnoses than the state—ranging from anxiety and ADHD to depression, serious emotional disturbance, and substance use disorders. These elevated needs span Ashtabula, Cuyahoga, Lake, Lorain, Stark, Summit, and Trumbull counties.

Collectively, these community needs point to systemic gaps in behavioral health capacity, youth supports, economic stability, and maternal/child health services. They represent key opportunities for targeted, county specific strategies to strengthen upstream prevention, expand treatment capacity, and improve long term outcomes for children and families.

Community Input

Stakeholders across healthcare, behavioral health, education, juvenile justice, child welfare, and family advocacy systems described a youth behavioral health continuum that is overwhelmed, fragmented, and operating at capacity. Across interviews, there was strong alignment that youth are presenting with increasingly complex needs, including co-occurring mental health and substance use disorders, developmental disabilities, autism, trauma exposure, and aggressive behaviors. While respondents consistently recognized the dedication and collaboration of providers across the region, they emphasized that demand far exceeds available resources, particularly for high-acuity and multi-system involved youth.

The most urgent and repeatedly cited gap is the lack of appropriate crisis stabilization and step-down options. Youth who are unsafe at home but do not meet psychiatric admission criteria often cycle through emergency rooms, law enforcement, or juvenile detention,



only to be discharged without meaningful intervention or connection to follow-up care. Inpatient psychiatric beds, short-term respite placements, and Psychiatric Residential Treatment Facility (PRTF) capacity are insufficient, particularly for youth with aggressive behavior, autism, developmental disabilities, or co-occurring substance use disorders. Rural counties face additional geographic barriers, including long travel distances and limited local providers.

Stakeholders also underscored the significant impact of social determinants of health and systemic barriers on families' ability to engage in care. Poverty, transportation challenges, food insecurity, insurance limitations, and workforce shortages compound already complex clinical needs. Families are often overwhelmed, navigating multiple systems without adequate education, advocacy, or follow-up support. Participants emphasized that generational trauma and the ongoing effects of the opioid crisis are contributing to layered behavioral health challenges that require integrated, family-centered responses.

Collectively, stakeholders recommended expanding crisis stabilization and respite capacity; increasing inpatient and PRTF options locally; strengthening intensive home-based and community-based services; improving coordination and discharge planning across systems; expanding workforce capacity; enhancing family psychoeducation and peer advocacy; and investing in earlier prevention and school-based interventions. There was broad consensus that solutions must be coordinated, trauma-informed, geographically responsive, and designed to support youth within their homes and communities whenever possible.

Priorities

The Steering Committee met on January 29, 2026, to review primary and secondary data and discuss priorities. Upon review of both primary and secondary data, 15 potential priorities were identified for the hospital to possibly address through its Implementation Strategy. The Steering Committee reviewed this list and took into consideration the current implementation plan and progress made to date. The Steering Committee determined that all priority issues fell within the framework of the current implementation plan, with many of the identified needs remaining needs this assessment period. The committee recommended that Bluestone update the current implementation plan to reflect continued areas of need and incorporated any new priority areas. A total of 4 priority focus areas will be addressed, which will show up in the implementation plan published separately. The 4 goal areas include:

- » Workforce shortage: Continue to develop internal strategies to employee retention, recruitment, job satisfaction
- » Access to mental health services: Work to address barriers and explore service gaps
- » Community education/outreach on available services at Bluestone
- » Autism services: Access to inpatient care for this population as well as outreach to providers

Review & Approval

This CHNA report was adopted by the Bluestone Child & Adolescent Psychiatric Hospital Board of Directors on May 12, 2026.



METHODOLOGY

Our Approach

The Public Health Accreditation Board defines a community health assessment as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

According to Healthy People 2030, social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH as illustrated in Figure 3 include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Figure 3: Social Determinants of Health



Source: Healthy People 2030

Increasingly, there is a call to address these because healthcare can be most impactful in these interventions when partnering with other sectors in the community to address factors that impact health disparities. Hence, this report is designed to collect data related to both traditional public and community health indicators, as well as additional indicators related to the social determinants of health.

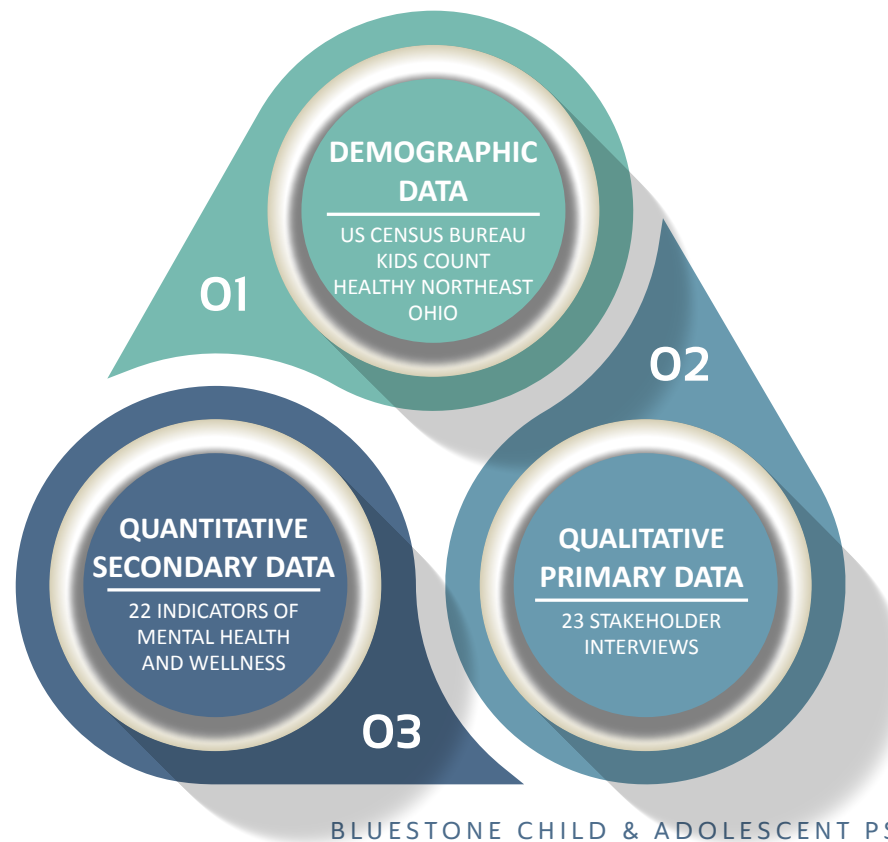
Data Methods

To support this assessment, data from numerous qualitative and quantitative sources were used to validate the findings, using a method called “triangulation” outlined in Figure 4. Three main types of data were used for this assessment::

- **Demographic Data** from the US Census Bureau, Kids Count and Healthy Northeast Ohio.
- **Qualitative Primary Data** from professional stakeholder interviews, providing the opportunity for leaders to share their views and suggestions about the needs and issues facing the community.
- **Quantitative Secondary Data** from the Ohio Department of Health and numerous other secondary sources identified as indicators related to health status, health equity, social equity, and sustainable communities in addition to disease incidence and prevalence as well as other secondary data from local partners pertaining to health-related services provided in the region.

This blend of data creates a snapshot of the issues challenges facing children and adolescents in the Northeast Ohio region.

Figure 4: Data Triangulation





The following is an overview of the specific methodologies for each type of data.

Secondary Data

Demographic Analysis

The demographic profile provides a description of the demographic, education and economic summary of the 7-county region in Northeast Ohio considered as the primary service area. Counties include:

- Ashtabula
- Cuyahoga
- Lake
- Lorain
- Stark
- Summit
- Trumbull

Demographic data was obtained from the U.S Census Bureau, Kids Count and Healthy NEO.

Secondary Health Indicators and Data Analysis

Secondary data for this CHNA came from many different sources. Secondary data included:

- The Centers for Disease Control and Prevention (CDC)
- Autism Speaks
- Ohio Healthy Youth Environments Survey
- Ohio Department of Education
- Healthy Northeast Ohio
- Kids Count

Data presented are the most recent published by the source at the time of the data collection. Utilization data from Bluestone Child & Adolescent Psychiatric Hospital is also included.



Community Input



Community input included primary qualitative data gathered through key informant stakeholder interviews.

Defining the hospital facility's community served

Key informant interviews were conducted to collect primary data on unmet youth mental health needs. Prior to identifying specific key informants, the Executive Director of Bluestone Child and Adolescent Psychiatric Hospital and independently hired consultant/researchers met to define the community served by the hospital facility. As recommended in Section 501(r)(3) of IRS guidelines, the hospital facility's community was determined by considering the geographic area and target populations served as well as the principal services offered. To identify the hospital's geographic footprint, the team examined data on primary residence of youth who sought care at Bluestone. The counties that were home to 70% of patients served were as follows: Ashtabula, Cuyahoga, Lake, Lorain, Stark, Summit, and Trumbull. Hospital staff then identified individuals and organizations representing public health, school districts, departments of youth services, child and family services, juvenile justice, advocacy organizations, care management entities, members of medically underserved communities, community mental health, hospitals, low-income populations, parents, and minorities groups such that all key demographics were represented in the seven-county service region.

Recruitment

Next, the Executive Director of Bluestone sent introductory emails to identified key informants inviting them to participate in a phone interview. In a few cases a potential key informant replied with the name and contact information for a colleague whom they felt was better positioned to speak to the topic. A member of the independent research team followed-up via email to schedule an interview with each key informant. In total, 29 individuals were contacted to participate in an interview. Upwards of three attempts were made to establish contact with potential key informants who failed to respond to the initial outreach. Twenty-three individuals, representing all of the hospital's service region, completed interviews (a 79.3% response rate). Saturation was achieved as similar responses emerged repeatedly across interviews.

Primary data collection

In collaboration with hospital staff, the research team created a 6-item key informant interview protocol designed to assess the following domains: challenges and strengths within the field of youth mental healthcare, unmet youth mental healthcare needs, awareness/access/availability of high quality care, and experiences interacting with hospital systems for youth mental healthcare. All key informant interviews were completed by phone or video and lasted between 11-39 minutes in length. With respondent consent, interviews were audio recorded for note taking purposes. Audio files were transcribed and summarized. Each transcript was read multiple times for familiarity to begin the coding process. Next, one member of the research team coded transcripts to identify themes. Once all transcripts were coded, responses were combined across interviews by question to arrange codes (themes) by frequency of report.



Key informants that participated in the stakeholder interviews included:

Table 1: Stakeholders Interviewed

Name	Title/Role	Organization	County Representing	Population Represented
Stacey Garske, MSW, LSW	Executive Director	Summit County Family & Children First Council	Summit	Child Welfare
Lisa Ramirez, PhD	Board-Certified Child & Adolescent Psychologist, Director, Child Psychology, Director, School Health Program Community and Behavioral Health	MetroHealth	Cuyahoga	Hospital
Jill Tayfel, MA, MFCS, PCC-S	CME OhioRISE Relationship Manager, Aetna	OhioRISE	State of Ohio	System Care Coordination
James Smith	Placement Administrator	Cuyahoga County Division of Children & Family Services	Cuyahoga	Child Welfare
Karen McHenry, LISW	Director of Community Engagement	Bellefaire JCB	Cuyahoga	Community mental health agency
Martha Halko, MS, RD, LD	Director of Population Health	Cuyahoga County Board of Health	Cuyahoga	Public Health
Seona Goerndt, MBA	Present and CEO	Recovery Resources	Cuyahoga	Substance Use
Sue Tager, MA, LSW, LIC-DC-CS	Site Director	New Directions	Cuyahoga/Lake	Substance Use
Ashlee Himes	Coordinator, Great Lakes Region Family Support Specialist Program	NAMI	Lake/Ashtabula	Advocacy
Lori Shelby, MSW, LISW	OhioRISE CME Coordinator, Director	Cadence Care Network in Northeast Ohio	Trumbull	Community mental health agency
Ryan Smith, MSW, LISW-S, LICDC	Chief of Behavioral Health Services	Ohio Department of Youth Services	State of Ohio	Juvenile Justice
Shelly Terrones	Parent of adolescent with mental health needs	-	Lake	Parents/Caregivers



Table 1: Stakeholders Interviewed (Continued)

Name	Title/Role	Organization	County Representing	Population Represented
Shay Brown	Advocate	NAMI	Lake	Advocacy
Mandi Workman, LPCC-S	Director, MRSS	Coleman Health Services	Trumbull	Community mental health agency
Danielle Miller-Cleckner, LSW	Mental Health Pre-screener	Coleman Health Services	Trumbull	Community mental health agency
Bridget Gibbons, LISW-S	Deputy Court Administrator	Cuyahoga County Juvenile Court	Cuyahoga	Juvenile Justice
Rebecca Jones, LPCC-S	Child and Adolescent Services Director	Mental Health, Addiction and Recovery Services Board	Lorain	Public mental health
Dina Douglas, MSSA, LISW-S	Assistant Director of Regional Offices, Director of Summit Regional Office	Bellefaire JCB	Summit	Community mental health agency
Meg Kelner, AAS, COT/L	Supervisor	Ravenwood	Ashtabula/Lake	System Care Coordination
Laura Toth	CME Supervisor for Care Coordination	Ravenwood	Ashtabula	System Care Coordination
Bridget Sherman, MA	Director of Youth and Recovery Services	Mental Health and Recovery Services Board	Ashtabula	Public mental health
Melissa Fields, MSA	Clinical Director	Mental Health and Recovery Services Board	Ashtabula	Public mental health
Andrew Burman	Director, Behavioral and Emotional Programming, Special Services	Stark County Educational Service Center	Stark	Education

Outreach efforts were also made to speak with a representative from:

- Aultman Health System
- Ashtabula Area City Schools
- Trumbull County Developmental Disabilities Board Member/Fairhaven School
- Community Counseling
- HOLA Ohio



Data Limitations

There are a variety of limitations to both the secondary and primary data collected and utilized in this study.

The Secondary data may be incomplete and lack accuracy depending on a variety of factors including but not limited to:

- The time lag from the time the data was collected to the time it was reported.
- The research design, methodology, sampling design and sources (target audiences, recruitment methods) do not necessarily match the population of this study and were not consistent.
- Data collection methods (qualitative and quantitative techniques) varied, with a variety of different methodologies used by the sources.

The primary data collection included in the study also has potential limitations that include but are not limited to:

- Data was obtained from a convenience sample of key informant stakeholders willing to participate.
- Data was largely qualitative.

Community Resources

Resources available in the region to address significant community needs include services provided directly by Bluestone Child & Adolescent Psychiatric Hospital as well as those offered in the broader community.

Instead of creating a static listing of resources available in the community to address health needs that would be dated upon publication, this report takes a different approach. Resources that are available in Bluestone's service area can be found through the service area counties' respective United Way's 211 network. Links to each county's resource listing are included in this report.

Prioritization

The Steering Committee met on January 29, 2026, to review primary and secondary data and discuss priorities. Upon review of both primary and secondary data, 15 potential priorities were identified for the hospital to possibly address through its Implementation Strategy. The Steering Committee reviewed this list, took into consideration the current implementation plan and progress made to date. The Steering Committee determined that all priority issues fell within the framework of the current implementation plan, with many of the identified needs remaining needs this assessment period. The committee recommended that Bluestone update the current implementation plan to reflect continued areas of need and incorporated any new priority areas. A total of 4 priority focus areas will be addressed, which will show up in the implementation plan published separately. The final set of goals and objectives was reviewed by the leadership team at Bluestone.



Approval

The Community Health Needs Assessment Report was approved by the Bluestone Child and Adolescent Psychiatric Hospital board on May 12, 2026.





EVALUATION OF 2023 IMPLEMENTATION STRATEGIES

Overview

In response to findings from the 2023 Community Health Needs Assessment, Bluestone Child & Adolescent Psychiatric Hospital developed a targeted Community Health Implementation Plan built around five strategic priorities. These priorities reflect Bluestone’s commitment to expanding access to behavioral health care, strengthening the services it provides to youth with autism and complex psychiatric needs, and building the internal capacity needed to sustain high-quality, mission-driven care.

This report evaluates progress made on each of the five goals, highlighting accomplishments achieved to date and identifying strategies that will continue to be advanced in the years ahead.

The following table summarizes the five goals and corresponding objectives addressed as part of the Implementation Plan.

Goal	Focus Area
1	Workforce shortage: Develop internal strategies to support employee retention, recruitment, and job satisfaction
2	Youth mental health: Expand IOP groups with different clinical specialties
3	Autism services: Improve access to inpatient care for individuals with autism and developmental disabilities
4	Access to mental health services: Address the barrier of medical clearance requirements to access services at Bluestone
5	Outreach: Educate autism providers, emergency departments, and community stakeholders on available services at Bluestone



GOAL 1: Workforce Shortage: Develop Internal Strategies to Support Employee Retention, Recruitment, and Job Satisfaction

Sustained, high-quality care depends on a stable and motivated workforce. Bluestone recognized that addressing workforce shortage required more than filling open positions — it required building the systems, culture, and tools that keep talented employees engaged and committed for the long term. Goal 1 reflects that commitment.

Objectives under goal one include:

- Increase employee retention
- Improve recruitment activities
- Increase employee job satisfaction ratings

Progress to Date

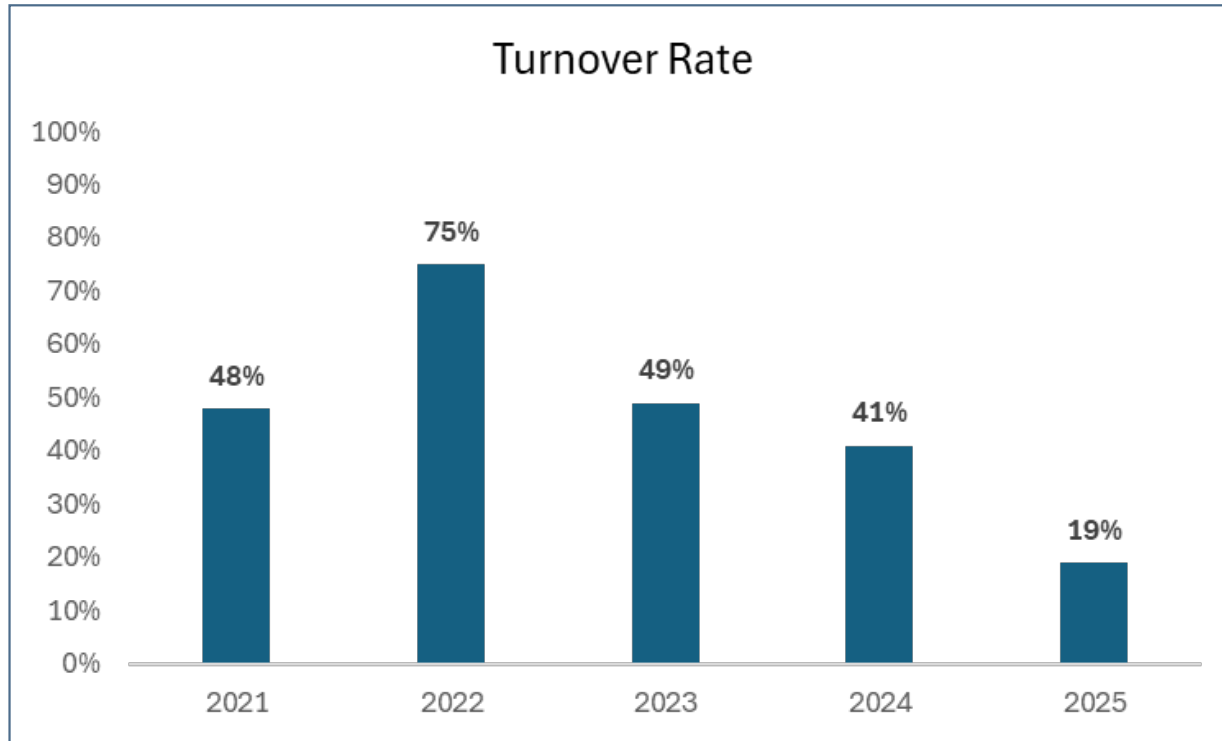
Bluestone has made meaningful strides in modernizing and systematizing its talent strategy. Several key initiatives have been implemented:

- Launched use of the Handshake platform to actively recruit college students and recent graduates, broadening the candidate pipeline into relevant academic programs
- Integrated Automated Data Processing (ADP) to distribute job postings across multiple recruitment platforms simultaneously, increasing reach and efficiency
- Planned implementation of engagement surveys in early 2026 to gather ongoing, structured feedback from staff — replacing the Stay Interview; model with a more scalable and data-informed approach
- Achieved measurable reductions in employee turnover, a key indicator that retention strategies are taking hold





The shift from *Stay Interviews* to *Engagement Surveys* reflects a deliberate and thoughtful evolution in Bluestone’s approach — moving toward a continuous feedback model that can surface concerns earlier and respond to staff needs at scale. The turnover decrease is an encouraging early indicator of the impact of these efforts.



GOAL 2: Youth Mental Health: IOP Groups with Different Specialties

Youth mental health needs in our region — and nationally — have grown significantly in recent years. Bluestone recognized an opportunity to extend its reach by exploring Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services tailored to adolescents and young adults with varying clinical needs, including autism spectrum disorders, general psychiatric conditions, and atypical presentations.



Objectives under goal two include:

- Provide an IOP group for youth ages 13–17 with Autism or other developmental disabilities
- Provide an IOP group for young adults ages 18–21 with Autism Spectrum Disorder or other disabilities
- Explore feasibility of an IOP group for atypical young adults ages 18–21
- Provide a mental health/general psychiatric IOP for youth ages 13–17
- Explore feasibility of offering a PHP
- Explore feasibility of a transition program for students who struggle at school

Progress to Date

Bluestone conducted a thorough feasibility analysis of IOP and PHP service offerings. Following careful consideration of regulatory requirements, staffing capacity, physical space, and patient need, the decision was made not to pursue IOP or PHP programs in their traditional form at this time.

This conclusion does not signal a retreat from serving youth mental health needs — rather, it reflects a strategic pivot. Bluestone plans to pursue Outpatient Psychiatry services for discharged patients, a model that may better align with current operational capacity while still extending the continuum of care for young people transitioning out of inpatient treatment. This approach ensures that patients do not fall through the cracks post-discharge and can access psychiatric support in a less intensive but clinically appropriate setting.

GOAL 3: Autism Services: Access to Inpatient Care for This Population

Individuals with autism and developmental disabilities face significant barriers to accessing inpatient psychiatric care, including environments that may not be sensory-appropriate, staff who may lack specialized training, and referral processes that can misalign patient acuity with available resources. Bluestone committed to addressing these barriers through concrete infrastructure and practice changes.

Objectives under goal three include:

- Ensure staff are adequately trained to support this population
- Develop a sensory room and soft/padded room for patients
- Provide sensory backpacks to appropriate patients
- Ensure staff have access to protective equipment



Objectives under goal three include (Continued):

- Establish safe communication systems for patients (e.g., visuals, storyboards)
- Establish a referral process that allows Bluestone to better gauge patient acuity level
- Explore models of family visitation that could benefit patients
- Explore possibility of conducting virtual assessments

Progress to Date

A critical milestone has been achieved: all staff now have the protective equipment required for their roles when serving patients with autism or behavioral complexity. This baseline infrastructure is foundational to providing a safe and therapeutic environment for both patients and care teams.

The remaining strategies — including sensory room development, communication supports, and updated referral protocols — represent a robust multi-year agenda. These are not deferred goals; they are active priorities that will continue to be resourced and implemented in upcoming years as Bluestone builds a more comprehensive, autism-informed inpatient environment.

GOAL 4: Access to Mental Health Services: Address the Issue of Medical Clearance

One of the most persistent access barriers facing patients seeking inpatient psychiatric care is the requirement for medical clearance prior to admission. For many youth and families in crisis, the requirement to obtain clearance through an external emergency department creates delays, adds burden, and can result in patients not receiving timely care. Bluestone identified this as a critical systems-level issue to address.

Objectives under goal four include:

- Ensure medical providers are available at Bluestone
- Ensure appropriate medical tools and equipment are available on site
- Establish a relationship with a local emergency department for cases that exceed Bluestone's on-site medical capacity
- Determine a secure, appropriate space for conducting medical exams
- Begin providing medical clearances on site



Progress to Date

This goal has seen some of the most operationally significant progress in the plan. Bluestone has established a Medical Clearance Partnership with MetroHealth Medical Center (MHMC), which is now fully operational. This partnership allows Bluestone to collaborate with MHMC to provide or coordinate medical clearances in a manner that reduces delays and streamlines the admissions process.

Early feedback and outcomes indicate that the partnership is having a positive impact on the patient and family experience. By removing or shortening the medical clearance bottleneck, more youth can access the psychiatric care they need more quickly — a direct realization of the goal's intent. This is a high-visibility accomplishment that reflects strong interorganizational coordination and a patient-first approach.

GOAL 5: Outreach: Education and Community Engagement on Available Services

Even the most effective programs cannot benefit the community if they are not known and accessible to those who need them most. Bluestone identified a strategic need to strengthen its presence among regional partners, emergency departments, autism providers, insurers, and community stakeholders — ensuring that the services Bluestone offers are visible, understood, and appropriately utilized.

Objectives under goal five include:

- Strengthen relationships with regional autism providers
- Educate regional autism providers on available services
- Develop personal relationships with key individuals, schools, and providers conducting assessments
- Ensure Bluestone is represented in the local, state, and national autism arena
- Position Bluestone as a regional expert in treating youth with autism
- Educate Emergency Department staff at area hospitals on Bluestone's services
- Establish relationships with area psychiatrists
- Ensure MRSS is aware of Bluestone and its available services
- Educate insurers on available services
- Strengthen relationships with early intervention programs
- Educate the community on existing and new programs and services at Bluestone
- Ensure representation in local, state, and national youth mental health arenas
- Expand staff capacity to support marketing and outreach efforts



Progress to Date

A key milestone in this area has been achieved: Bluestone has successfully educated Emergency Department staff at area hospitals on the services available at its facility. This effort directly strengthens the referral pipeline and ensures that ED teams — who are often the first point of contact for youth in behavioral health crisis — are equipped to connect patients with appropriate care at Bluestone.

The broader outreach agenda remains active. Building awareness among autism providers, psychiatrists, insurers, early intervention programs, and community stakeholders is a sustained effort that will be ongoing. Each relationship built and each educational touchpoint creates a stronger network of referral and support around the populations Bluestone serves.

Looking Ahead

Bluestone's 2023 Implementation Plan reflects a clear-eyed understanding of the challenges facing the communities and populations it serves — and a genuine commitment to addressing them in meaningful, sustainable ways. The progress documented here demonstrates real momentum: systems have been built, partnerships have been formed, and services have been refined.

The strategies that remain in progress are not unfinished — they are part of a long-term vision. Expanding autism-informed inpatient care, deepening community partnerships, and growing outreach capacity are multi-year undertakings that require ongoing investment, leadership, and organizational will. Bluestone's track record to date provides a strong foundation from which to continue building.





SERVICE AREA

CHILDREN & ADOLESCENT POPULATION

Demographic Snapshot

The primary service area for a hospital is defined as the geographic area where 70% of the inpatient population resides. For Bluestone Child & Adolescent Psychiatric Hospital, this includes youth ages 6-17 in a 7-county area in Northeast Ohio. Figure 5 illustrates the counties highlighted.

Figure 5: Primary Service Area

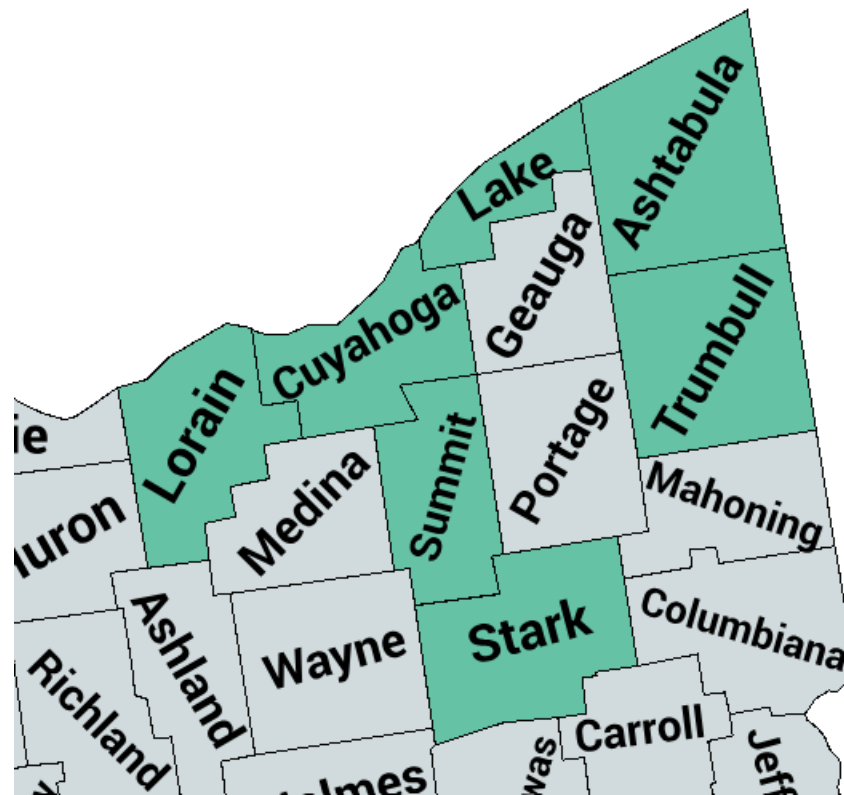




Table 2 displays the number of children under age 18 in the counties of the primary service territory and the state of Ohio overall. Ashtabula, Lorain and Stark have the highest percentage of children under the age of 18. Lake County has the lowest percentage of children under the age of 18 in the service territory. All counties in the service territory have a lower percentage of children under the age of 18 in comparison to the state.

Table 2: Children Under Age 18, 2023

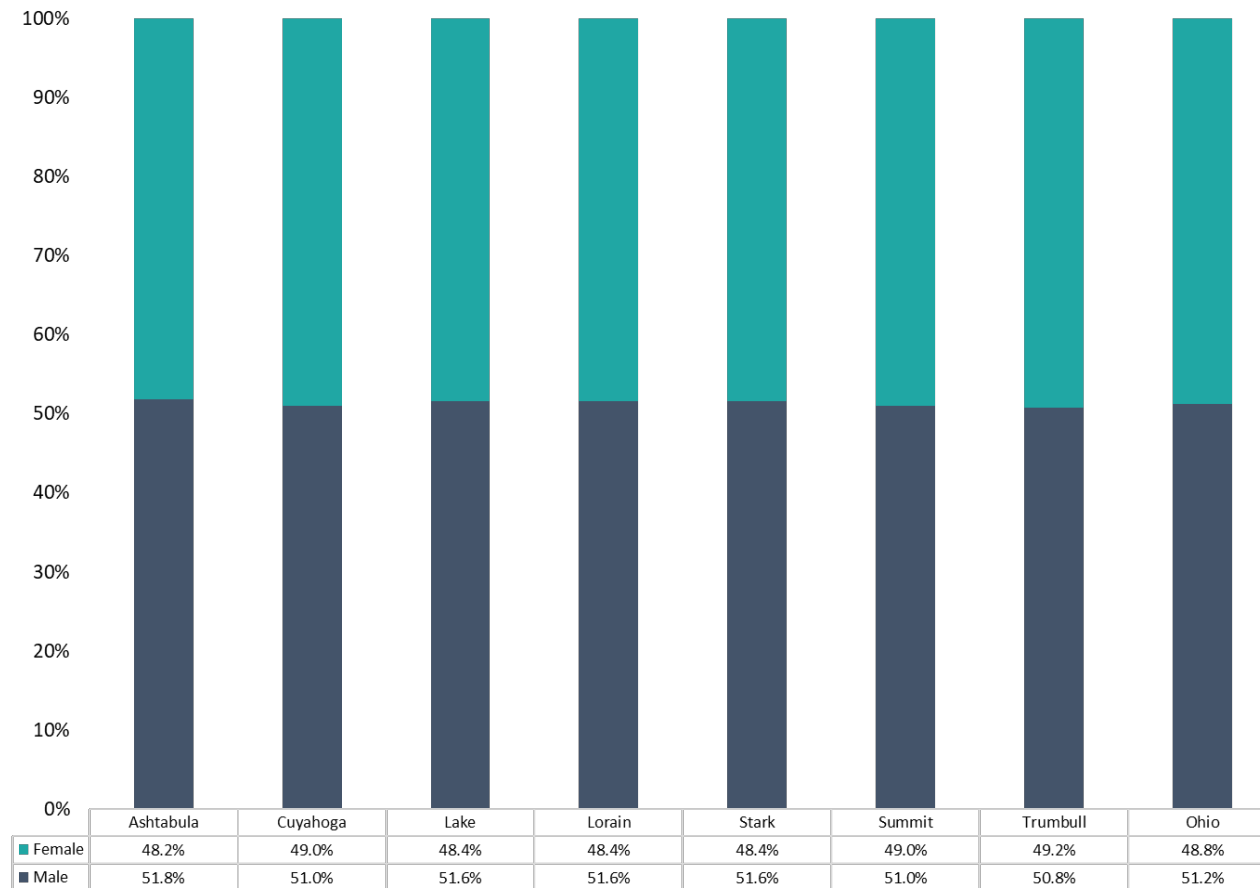
Geographic Area	Number	Percent of Total Population
Ashtabula County	21,359	21.9%
Cuyahoga County	257,627	20.6%
Lake County	45,377	19.6%
Lorain County	68,391	21.7%
Stark County	80,875	21.6%
Summit County	112,046	20.8%
Trumbull County	41,530	20.6%
Ohio	2,610,179	22.2%

Source: US Census Bureau, 5 Year Estimates



Of all of the counties in the service territory, Trumbull (49.2%), Summit (49.0%) and Cuyahoga (49.0%) have the highest percentage of female children aged 5-19, all just above the state (48.8%), as seen in Figure 6. In all of the counties in the service territory, as well as the state overall, more than half of the children aged 5-19 are male. Ashtabula County has the highest percentage of males aged 5-19 at 51.8%. In addition, Lake, Lorain and Stark Counties also have higher percentages of male children aged 5-19 than the state average of 51.2%.

Figure 6: Gender, Children Ages 5-19, 2023



Source: US Census Bureau, 5 Year Estimates



Figure 7 illustrates the percentages of children under the age of 18 by race in the primary service area compared to Ohio overall. The population of the service area is predominantly White, with more than 2/3 of the child population in most counties in this category. By far, Cuyahoga County has the highest percentage of Black Children (37.0%) followed by Summit County (19.4%). These are the only two counties in the service area with higher percentages of Black Children than the state average of 15.7%.

Cuyahoga County is the most diverse of the counties in the service area, having 9.4% Hispanic and 3.4% Asian in addition to the sizable Black Population (37.0%). Lorain County has the highest Hispanic population of children under the age of 18 at 15.9%. Summit County has the highest Asian population of the service area counties at 4.7%. Ashtabula County is the least diverse with 90.6% of the population of children under the age of 19 being White.

Figure 7: Race, Children Under 19, 2021

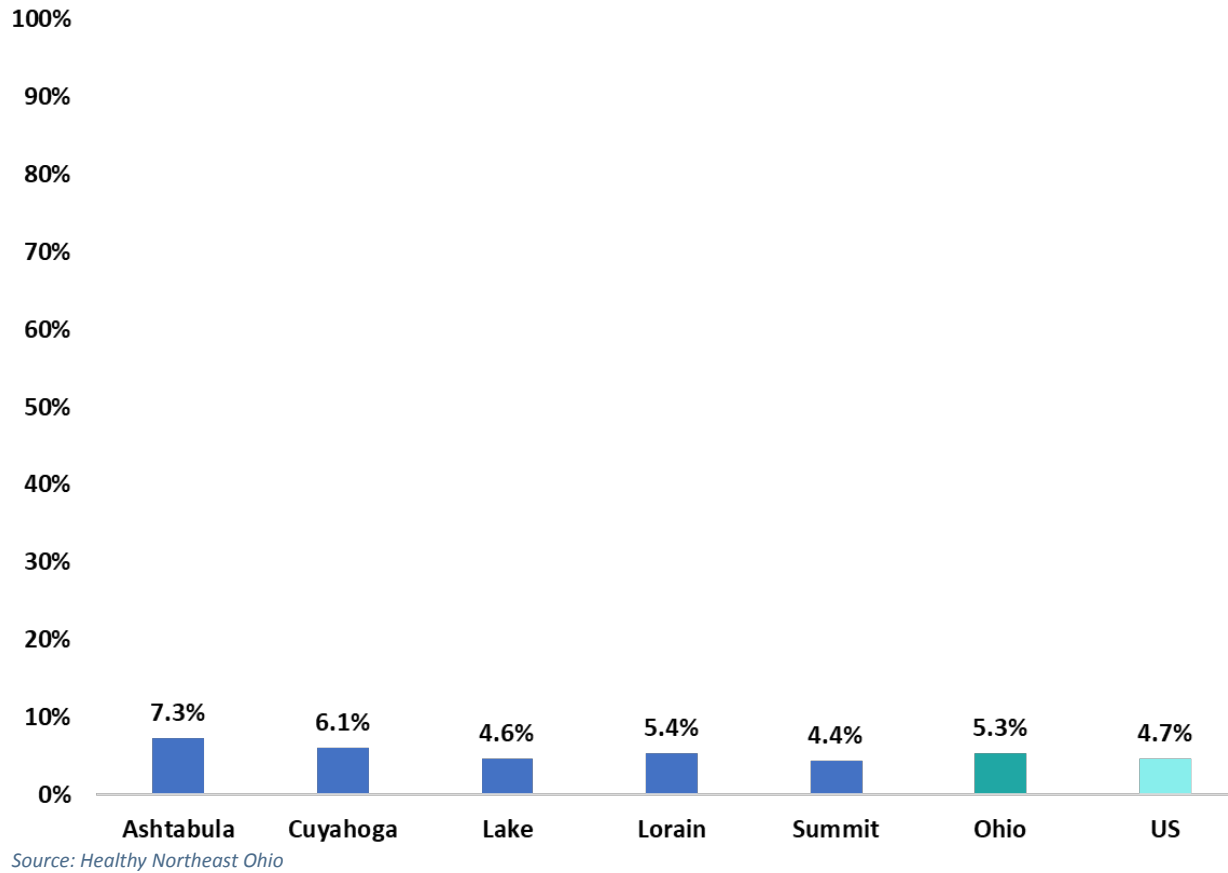


Source: Kids Count



As illustrated in Figure 8, the service area's rates of children with a disability range between 4.4% Summit County to 7.3% in Ashtabula County. Ashtabula (7.3%), Cuyahoga (6.1%) and Lorain (5.4%) have a higher percentage than Ohio (5.3%) and the nation (4.7%).

Figure 8: Children With a Disability, 2019-2023

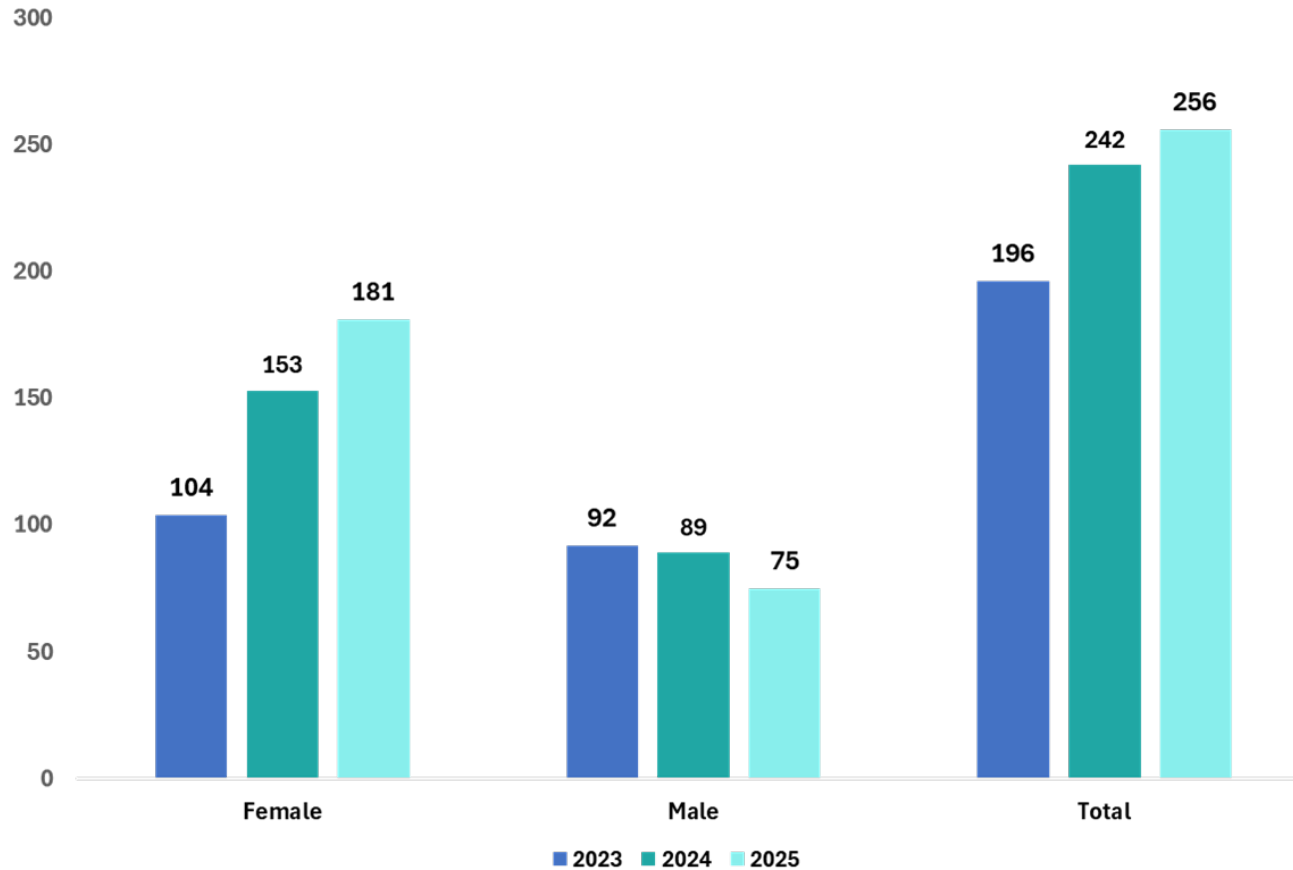




Utilization Demographics

As seen in Figure 9, Bluestone continues to serve more patients annually, with an increase observed for females and a decrease for male patients.

Figure 9: Discharges by Gender

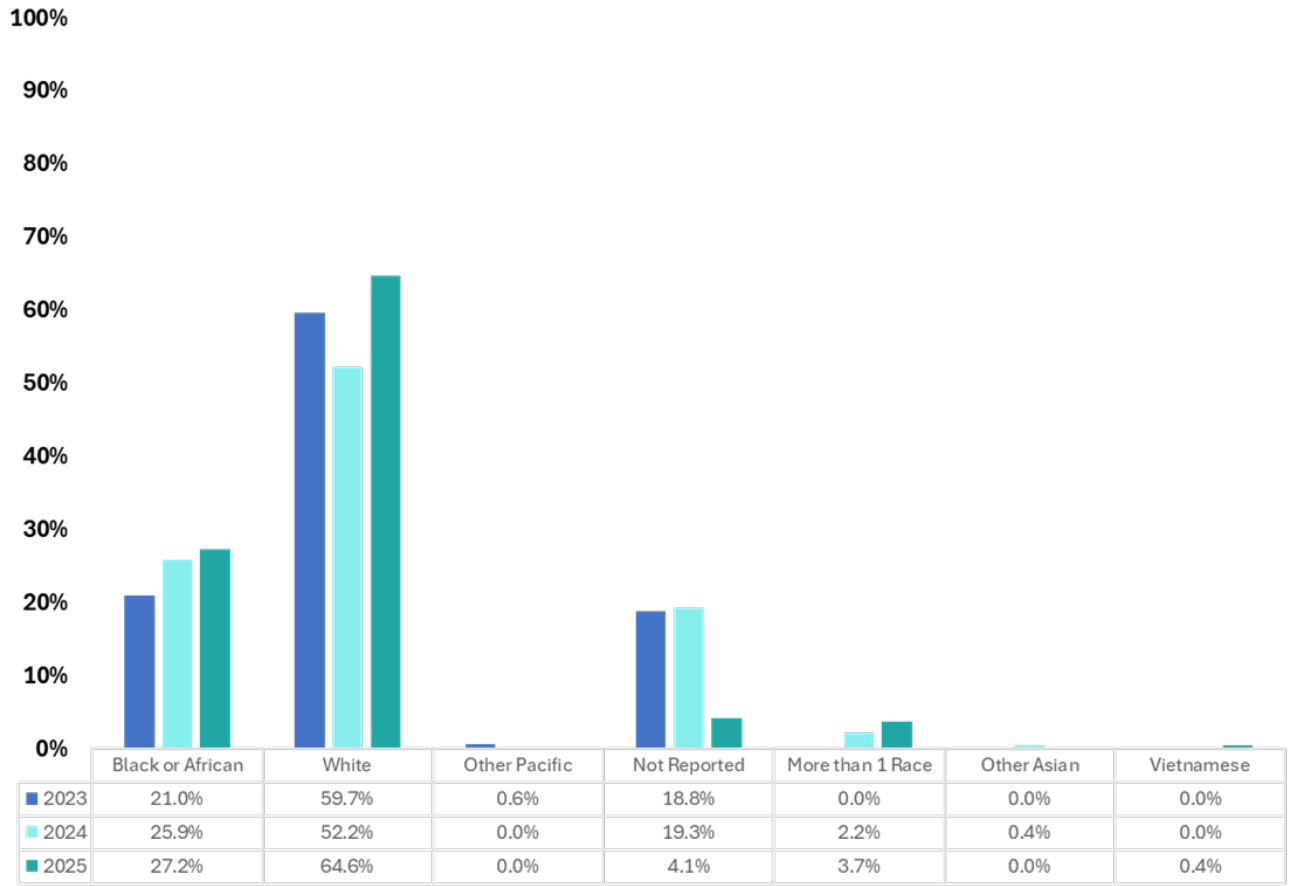


Source: Bluestone Child & Adolescent Psychiatric Hospital, 2026



Figure 10 shows discharges by race. Over half of the patients served are White, although the percentage has been increasing for Black or African patients.

Figure 10: Discharges by Race



Source: Bluestone Child & Adolescent Psychiatric Hospital, 2026



Since opening in January 2022, a total of seven patients have been admitted three times, with five of those individuals experiencing all three admissions within a 12-month period. In addition, 64 patients have been admitted twice. Among all readmissions, 20 occurred within 30 days of a prior discharge, indicating a subset of patients with more immediate return episodes.

Referral deflection occurs when a patient referred to Bluestone cannot be admitted or placed, due to factors such as acuity levels, bed availability, insurance limitations, or admission criteria. Bluestone has recently begun systematically tracking its referral deflection rate with the goal of identifying trends over time. This data will serve as a foundation for developing targeted strategies to address the barriers driving deflection and improve the likelihood of successful placement for referred patients.





SOCIAL DETERMINANTS OF HEALTH

Adverse Childhood Experiences

According to the Centers for Disease Control, Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation or household members being in jail or prison

These examples are not a complete list of adverse experiences. Many other traumatic experiences could impact health and wellbeing. ACEs are linked to chronic health problems, mental illness, and substance use problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities, and earning potential.

About 61% of adults surveyed across 25 states (including Ohio) reported they had experienced at least one type of ACE before age 18, and nearly 1 in 6 reported they had experienced four or more types of ACEs.¹



Table 3 illustrates the number of Child Abuse and Neglect intakes in the service area counties as well as Ohio. The number of intakes has decreased in Ohio overall as well as within the individual counties in the most recent years.

Table 3: Child Abuse and Neglect, Intakes

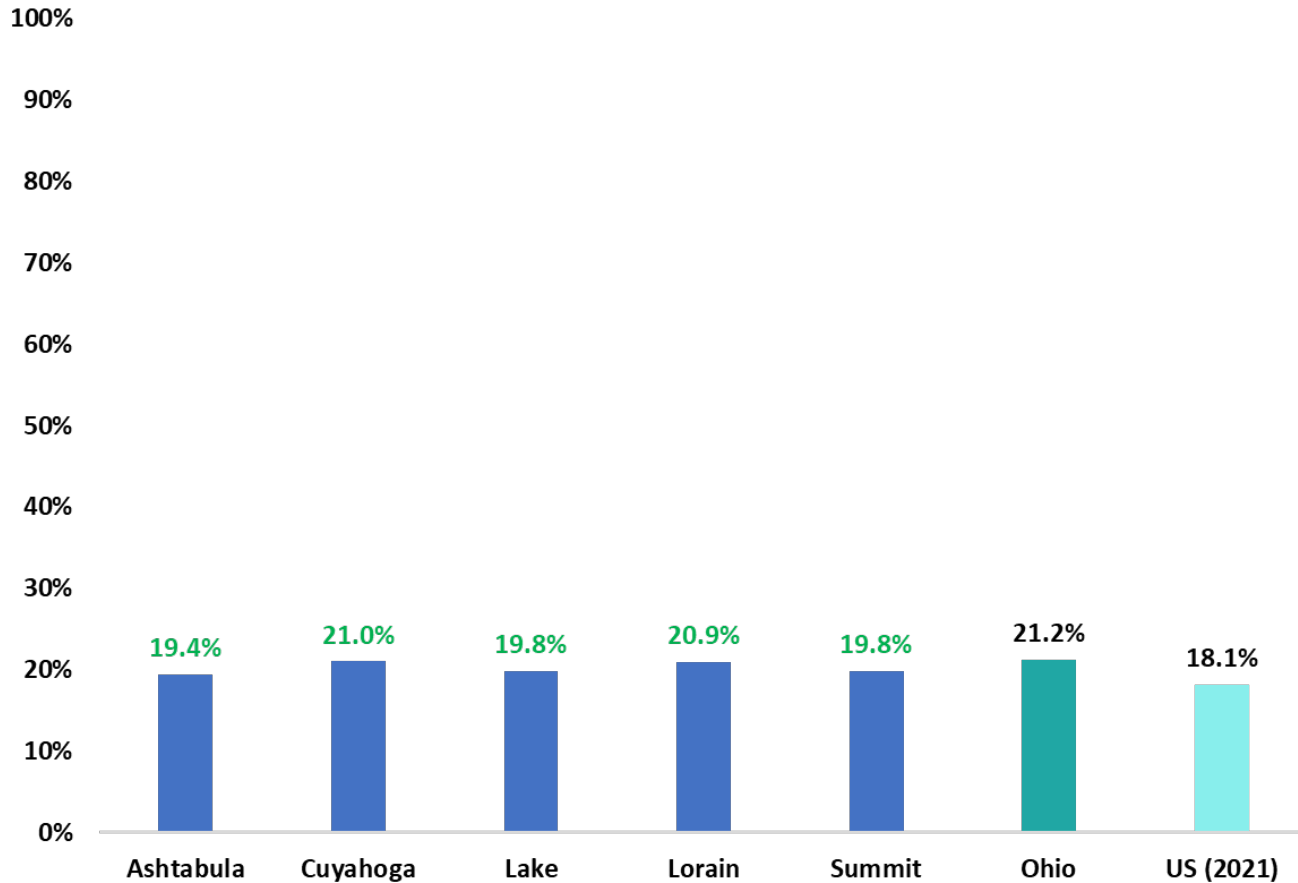
Geographic Area	2023	2024	2025
Ashtabula County	2,086	1,982	1,657
Cuyahoga County	19,370	19,844	17,722
Lake County	1,985	1,909	1,806
Lorain County	4,274	4,801	4,609
Stark County	7,052	7,044	6,696
Summit County	7,736	7,676	6,864
Trumbull County	3,016	3,485	3,324
Ohio	200,187	200,956	184,064

Source: Department of Children and Youth, DataOhio



About one in five adults in the service territory for the counties where data was available reported excessive drinking in 2022, ranging from a low of 19.4% in Ashtabula County to a high in Cuyahoga County of 21.0%. Data was not available for Stark and Trumbull counties. All counties with available data were lower than the state but higher than the nation.

Figure 11: Adult Excessive Drinking, 2022*



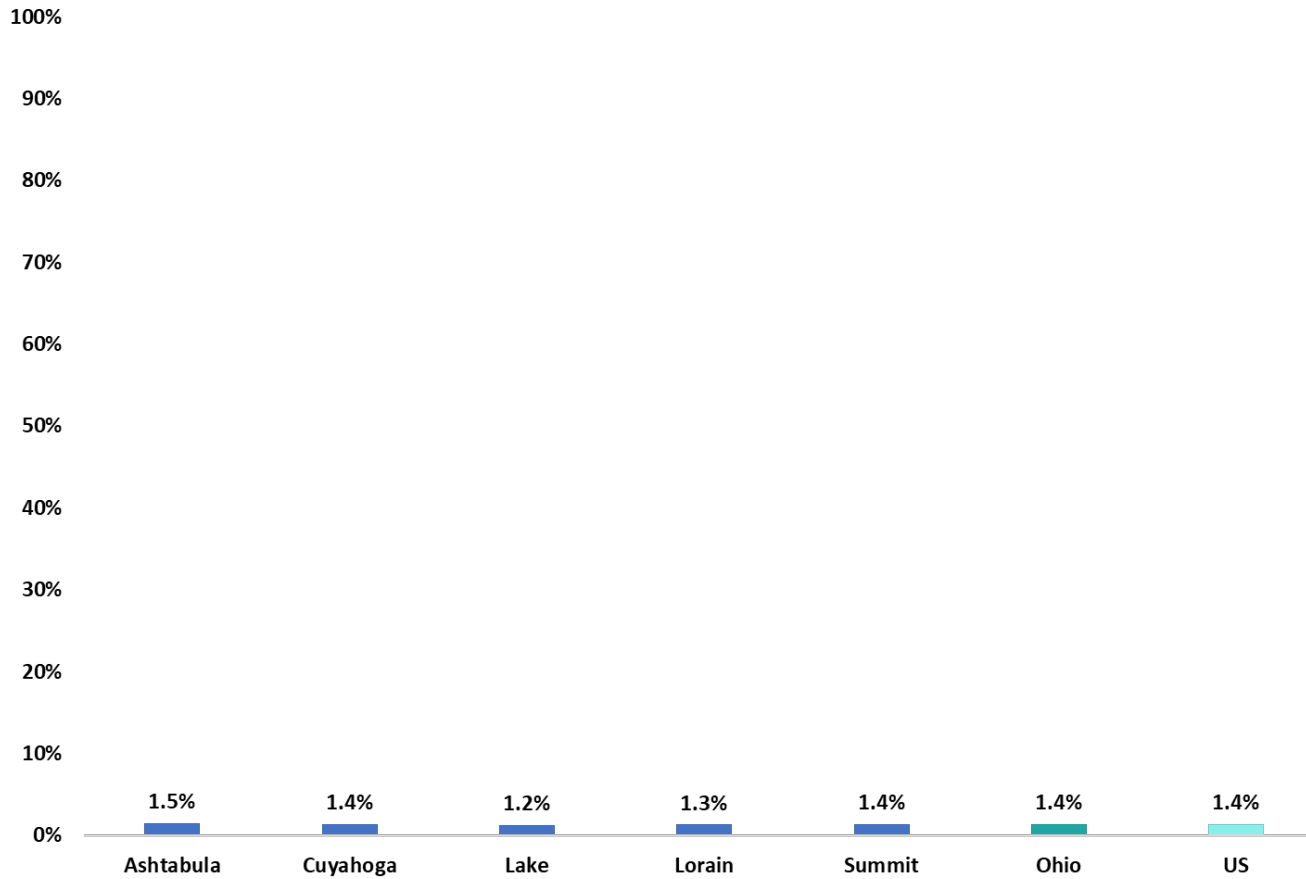
Source: Healthy Northeast Ohio

* percentage of adults who reported heavy drinking in the 30 days prior to the survey or binge drinking on at least one occasion during that period.



As outlined in Figure 12, a small percentage of households reported receiving substance abuse medical services during 2024 in the counties of the service territory where data was available, ranging from 1.2% in Lake County to 1.5% Ashtabula County. Ashtabula County was higher than both Ohio (1.4%) and the nation (1.4%). Data was not available for Stark and Trumbull counties.

Figure 12: Households Receiving Substance Abuse Medical Services, 2024



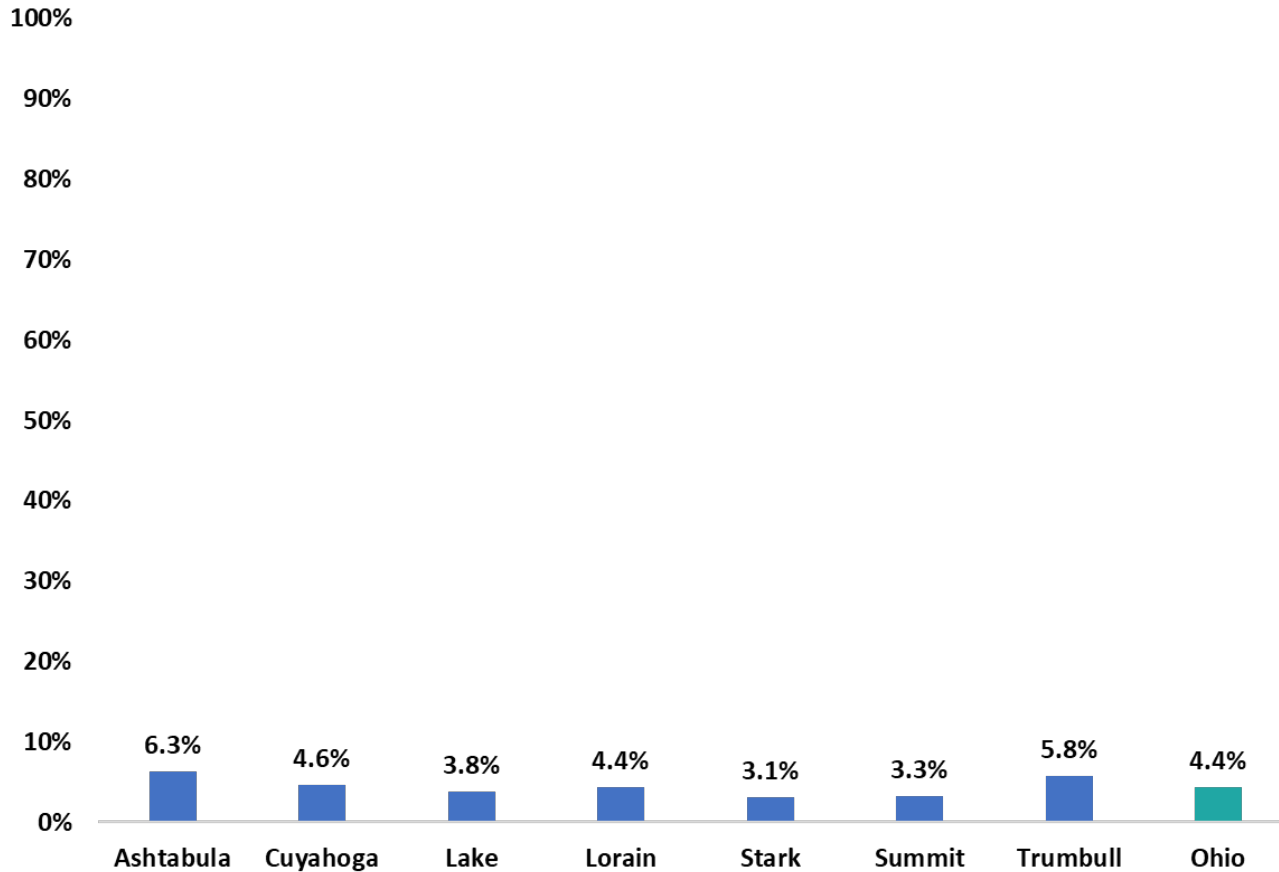
Source: Healthy Northeast Ohio



Other Social Determinants of Health

Figure 13 illustrates the percentage of children under the age of 19 without health insurance in the counties of the service area compared to Ohio (4.4%). Ashtabula (6.3%), Cuyahoga (4.6%), and Trumbull (5.8%) had a higher percentage of uninsured children in comparison to the state.

Figure 13: Uninsured Children, 2022

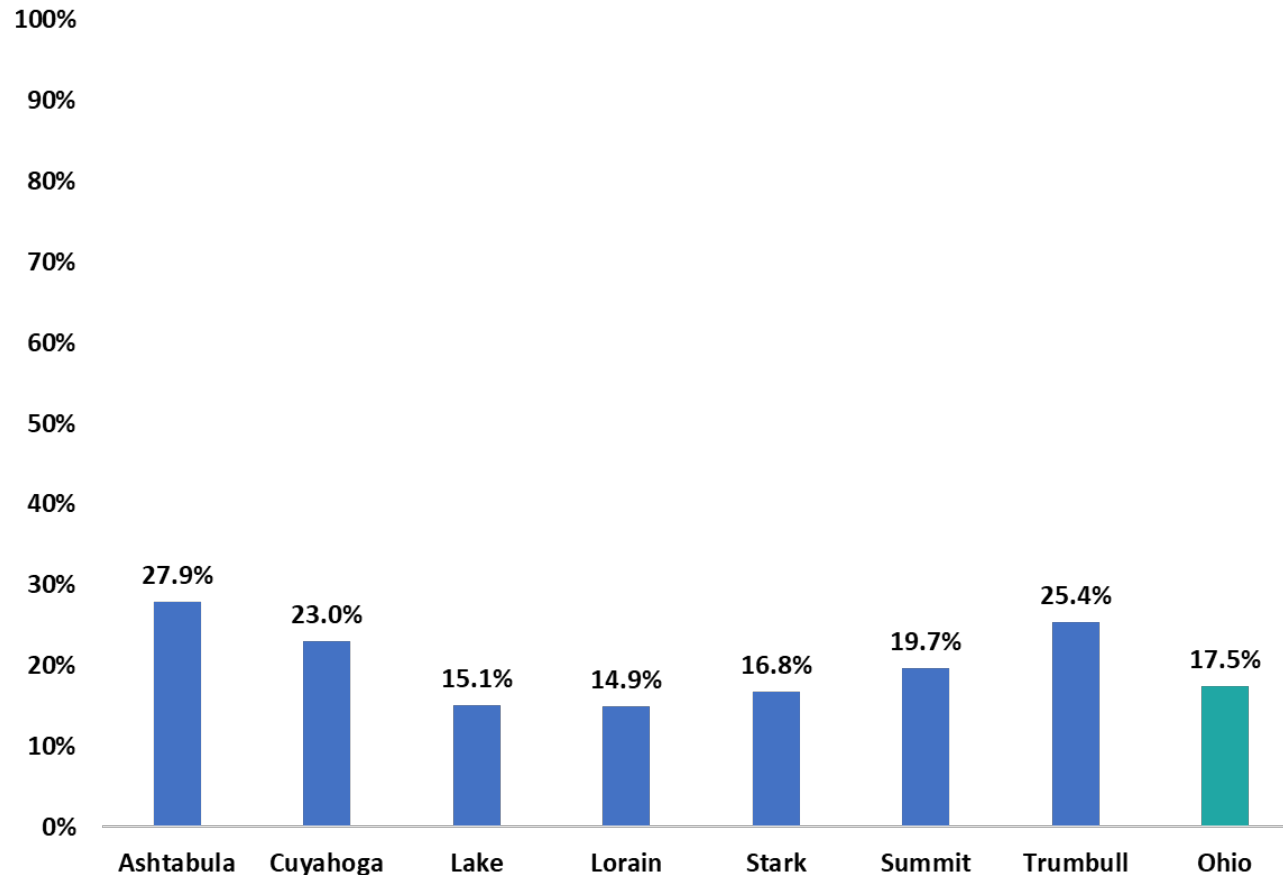


Source: County Health Rankings and Roadmaps



The percentage of children living below the federal poverty level in the service area varies by county as outlined in Figure 14. There is a higher percentage of children living below poverty in Ashtabula (27.9%), Cuyahoga (23.0%), Summit (19.7%) and Trumbull (25.4%) counties in comparison to the state (17.5%).

Figure 14: Children Living Below Poverty, 2023

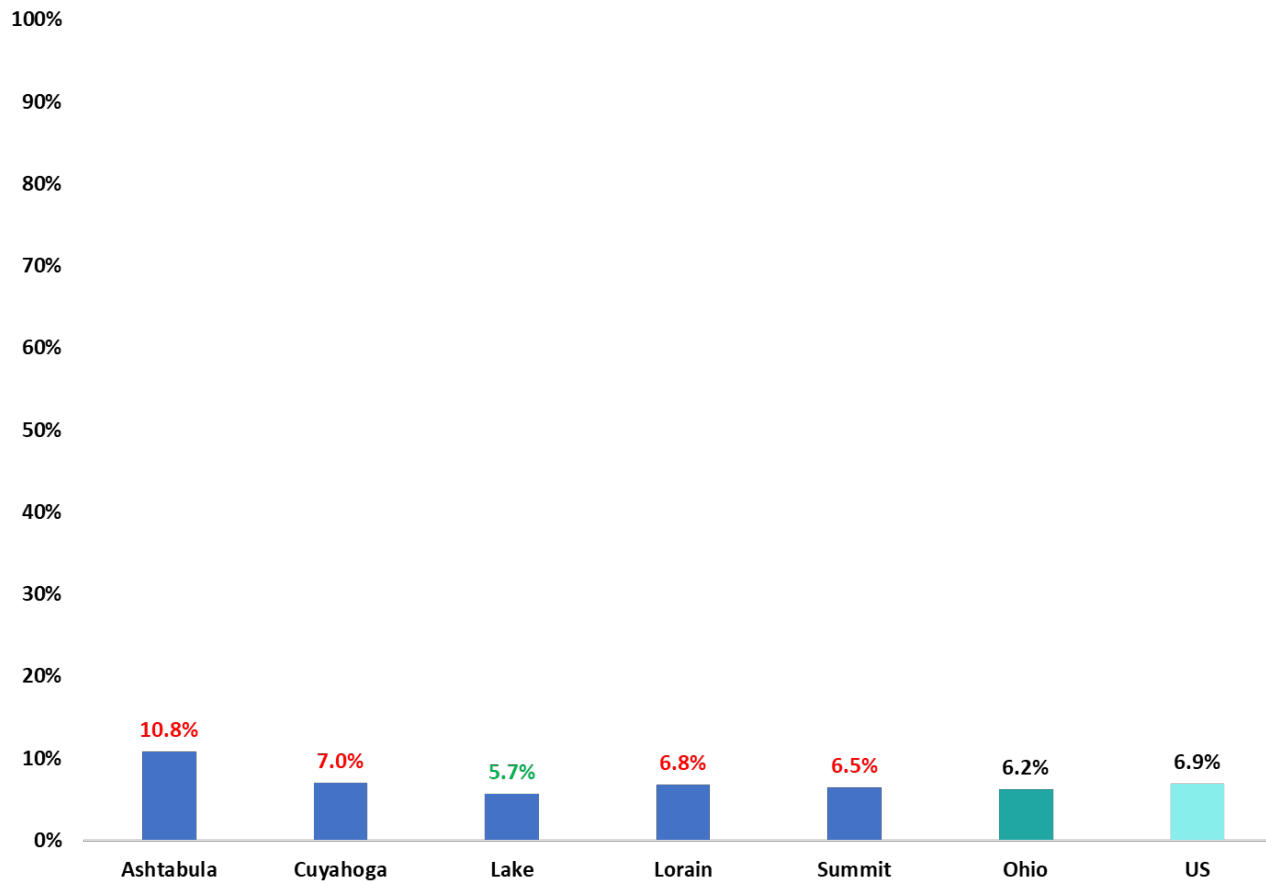


Source: County Health Rankings and Roadmaps



Figure 15 illustrates the percentage of youth not in school or working for the counties of the service territory compared to the state of Ohio (6.2%) for the combined years of 2019-2023. Data was not available for Stark and Trumbull counties. Ashtabula (10.8%), Cuyahoga (7.0%), Lorain (6.8%), and Summit counties all have a significantly higher percentage in comparison to the state (6.2%), while Lake County (5.7%) is significantly lower.

Figure 15: Youth (Ages 16-19) Not in School or Working, 2019-2023



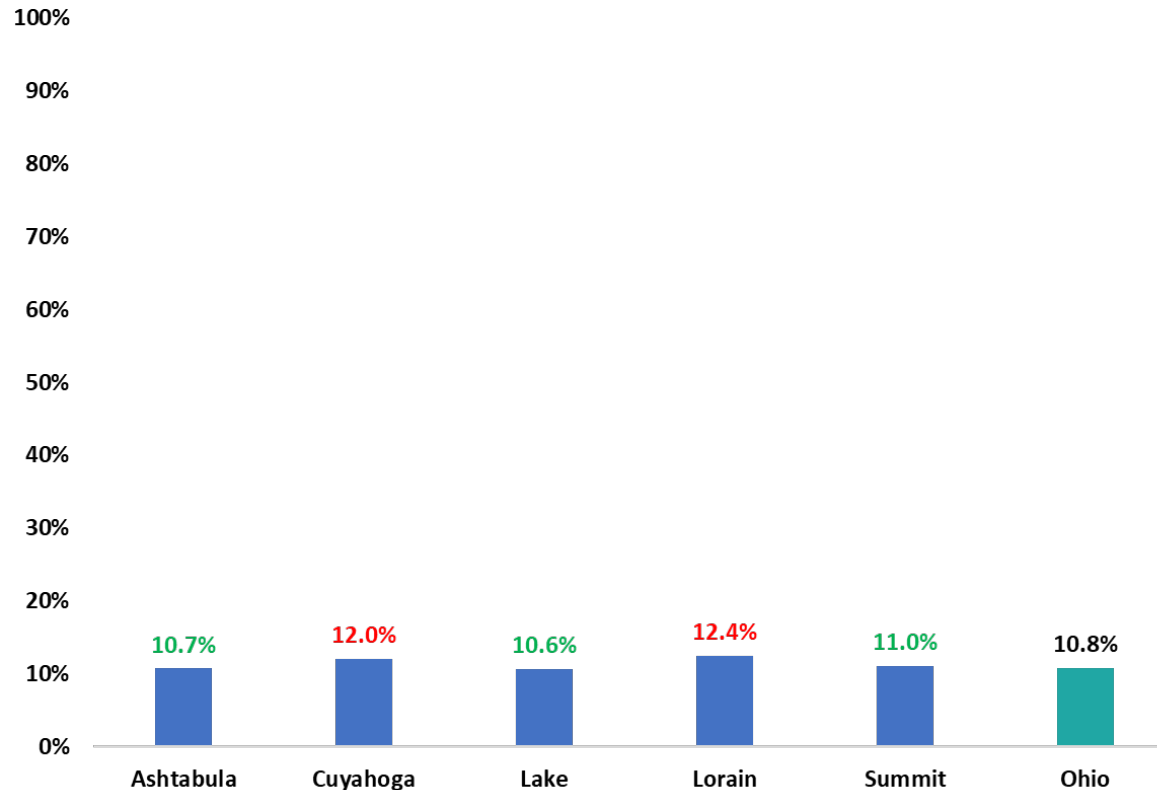
Source: Healthy Northeast Ohio, Ohio Department of Health, Vital Statistics



The experience of childhood adversity can have a lasting impact into and beyond the prenatal period, potentially increasing the risk of preterm birth, even among otherwise healthy women. Increasing our understanding of the potential perinatal outcomes associated with ACEs can help to inform how maternity services and partners offer trauma-sensitive support to mitigate some of the risks of early parturition, as well as target intergenerational cycles of adversity and poor health.²

Figure 16 illustrates pre-term births for the counties of the service area compared to Ohio overall (10.8%), where available. Data was not available for Stark or Trumbull counties. Cuyahoga (12.0%) and Lorain (12.4%) counties have significantly higher percentages than the state, while Ashtabula (10.7%), Lake (10.6%), and Summit (11.0%) counties had significantly lower percentages than the state.

Figure 16: Pre-Term Births, 2022



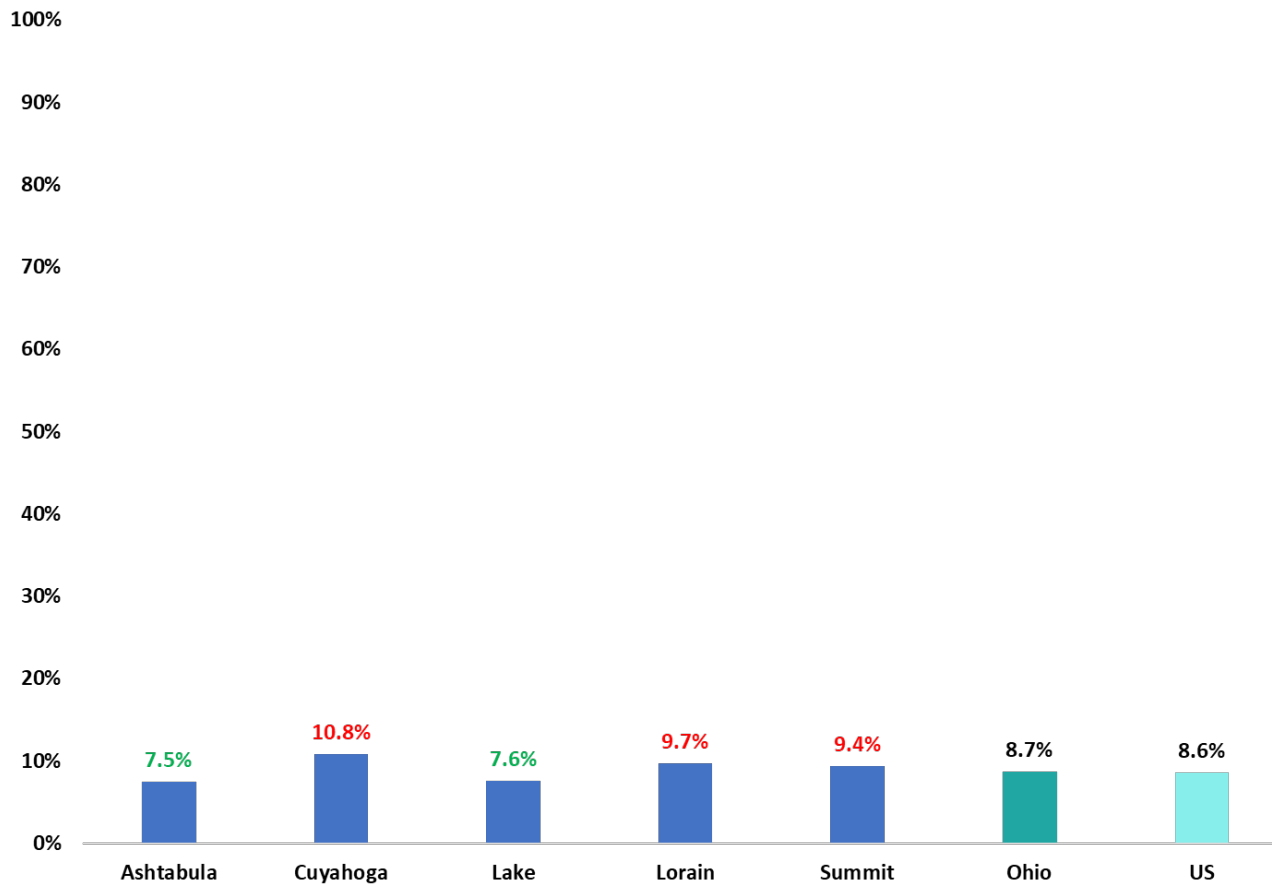
Source: Healthy Northeast Ohio

² National Institutes of Health: [https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-04454-z#:~:text=Preterm%20birth%20was%20significantly%20independently,6.23%2C%20p%20%3D%200.024\)%2C](https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-04454-z#:~:text=Preterm%20birth%20was%20significantly%20independently,6.23%2C%20p%20%3D%200.024)%2C)



Ohio's percentage of low birthweight babies in 2022 was 8.7%, slightly higher than the US percentage of 8.6%. This is outlined in Figure 17. Cuyahoga (10.8%), Lorain (9.7%), and Summit (9.4%) counties had percentages that were significantly higher than the state, while Ashtabula (7.5%) and Lake (7.6%) counties had percentages that were significantly lower than the state. Cuyahoga, Lorain and Summit were also higher in comparison to the nation. Data was not available for Stark or Trumbull counties.

Figure 17: Babies With Low Birthweight, 2022

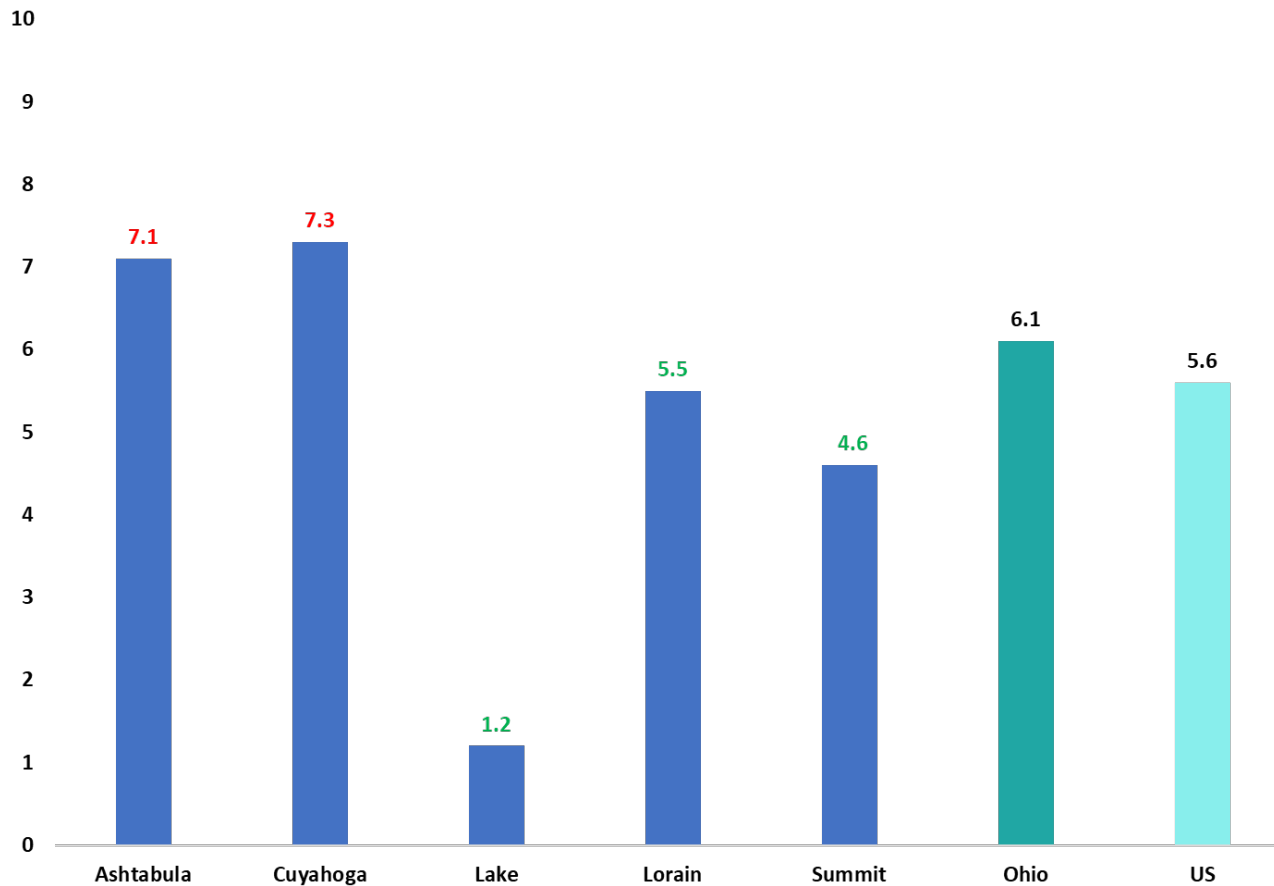


Source: Healthy Northeast Ohio, Ohio Department of Health, Vital Statistics



The teen birth rate per 1,000 females ages 15-17 in selected counties where data was available compared to Ohio (6.1) and the US (5.6) is outlined in Figure 18. Ashtabula (7.1) and Cuyahoga (7.3) counties had significantly higher rates than the state while Lake (1.2), Lorain (5.5) and Summit (4.6) counties were significantly lower. The rate for Stark and Trumbull was not available.

Figure 18: Teen Birth Rate, 2022*



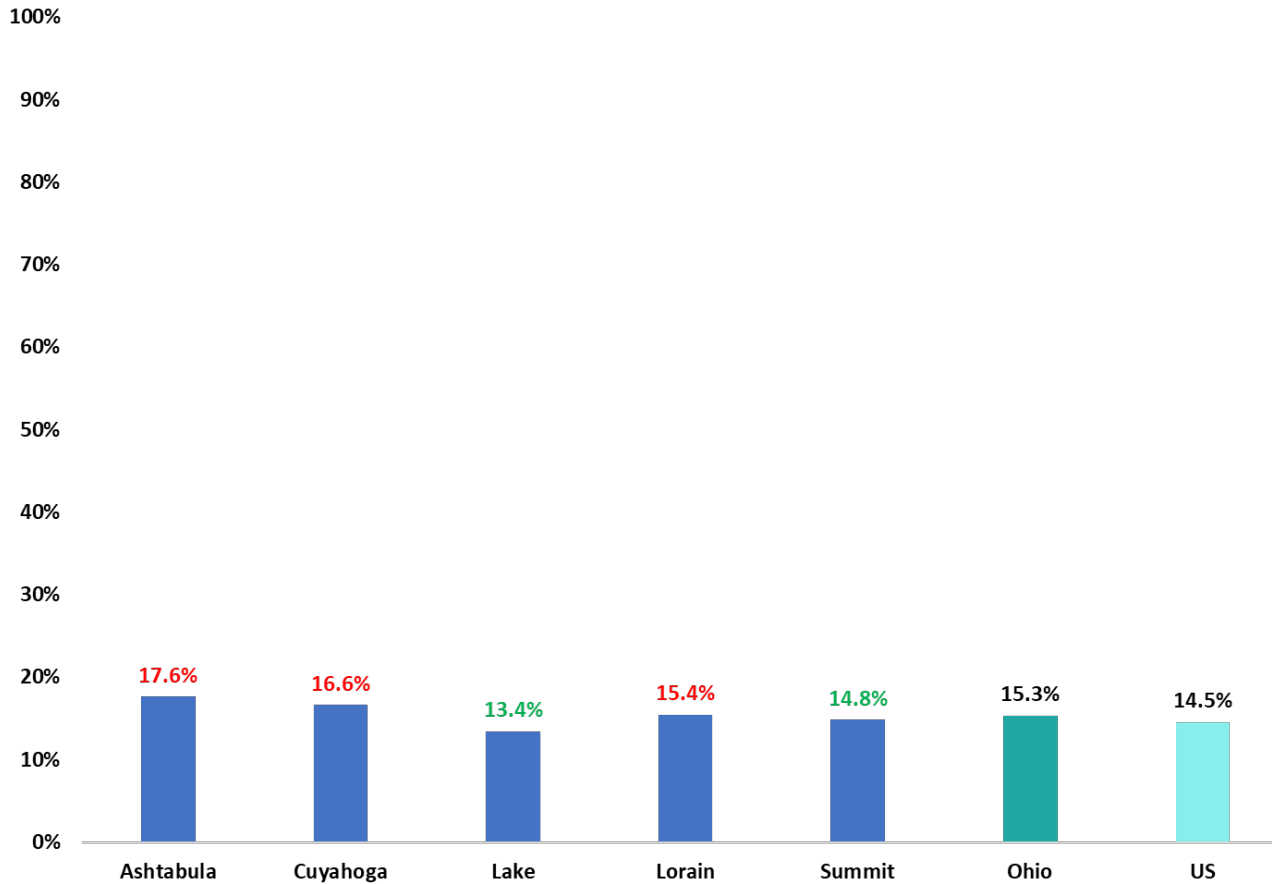
Source: Healthy Northeast Ohio, Ohio Department of Health, Vital Statistics

*live births per 1,000 females aged 15-17 years



Seen in Figure 19, the percentage of children with food insecurity in the state of Ohio was 15.3% in 2023, compared to the US percentage of 14.5%. Ashtabula (17.6%), Cuyahoga (16.6%) and Lorain (15.4%) counties had significantly higher percentages of food insecurity when compared to the state. Lake (13.4%) and Summit (14.8%) had significantly lower percentages. Data was not available for Stark or Trumbull counties.

Figure 19: Child Food Insecurity, 2023



Source: Healthy Northeast Ohio



Community Input

Stakeholders consistently described how social determinants of health are deeply intertwined with youth behavioral health needs and families' ability to access and sustain care. Poverty, food insecurity, housing instability, transportation barriers, and lack of childcare were repeatedly identified as compounding factors that prevent families from engaging in services or participating in discharge planning. In rural counties such as Ashtabula, long travel distances to hospitals, limited local providers, and geographic isolation further strain families who are already overwhelmed. Even when services exist, families may be unable to access them due to gas money, insurance limitations, or lack of coverage for behavioral health services.

Generational trauma and the ongoing impact of the opioid crisis were also highlighted as significant community-level factors shaping youth mental health needs. Providers described children born substance-exposed, high rates of kinship care, and layered trauma within families that contribute to complex, high-acuity presentations. Stakeholders emphasized that many caregivers are themselves managing vicarious trauma, shame, or prior negative experiences with child welfare systems, which can create fear, mistrust, and reluctance to seek help. As a result, families often present only when they are at a breaking point, exhausted and unsure how to navigate fragmented systems.

Insurance coverage and funding structures were repeatedly cited as structural barriers affecting access to care. Participants noted insufficient reimbursement rates, lack of parity for substance use treatment, competitive and declining philanthropic dollars, and insurance denials that interfere with timely treatment even when families are ready to engage. Workforce shortages—particularly in rural communities and in specialty areas such as substance use treatment, developmental disabilities, and autism—further limit availability of appropriate services.

Stakeholders also emphasized the need for stronger prevention, early intervention, and public education efforts to address upstream drivers of crisis. Many described a system that intervenes only at high acuity, rather than investing in earlier supports such as school-based services, family education, and community-based prevention programming. Without adequate lower-acuity supports and basic needs being met, families are left to navigate escalating challenges until emergency rooms, juvenile justice, or child welfare become the default entry points into care.



MENTAL HEALTH AND RELATED NEEDS

Autism

Autism spectrum disorder (ASD) is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. The disorder also includes limited and repetitive patterns of behavior. The term “spectrum” in autism spectrum disorder refers to the wide range of symptoms and severity. ASD includes conditions that were previously considered separate — autism, Asperger’s syndrome, childhood disintegrative disorder and an unspecified form of pervasive developmental disorder. Some people still use the term “Asperger’s syndrome,” which is generally thought to be at the mild end of autism spectrum disorder.

Autism spectrum disorder begins in early childhood and eventually causes problems functioning in society — socially, in school and at work, for example. Often children show symptoms of autism within the first year. A small number of children appear to develop normally in the first year, and then go through a period of regression between 18 and 24 months of age when they develop autism symptoms.³

The Centers for Disease Control reports that approximately 1 in 36 children in the U.S. is diagnosed with ASD. ASD is nearly 4 times more common among boys than among girls. The estimated state prevalence to ever been diagnosed with autism is below 2%. There are roughly 10,000 to 15,000 children in Ohio live with autism, many of whom are undiagnosed.

Autism Speaks also estimates that between 54-70% of people with autism also have one or more mental health conditions. In order of estimated prevalence, these include:

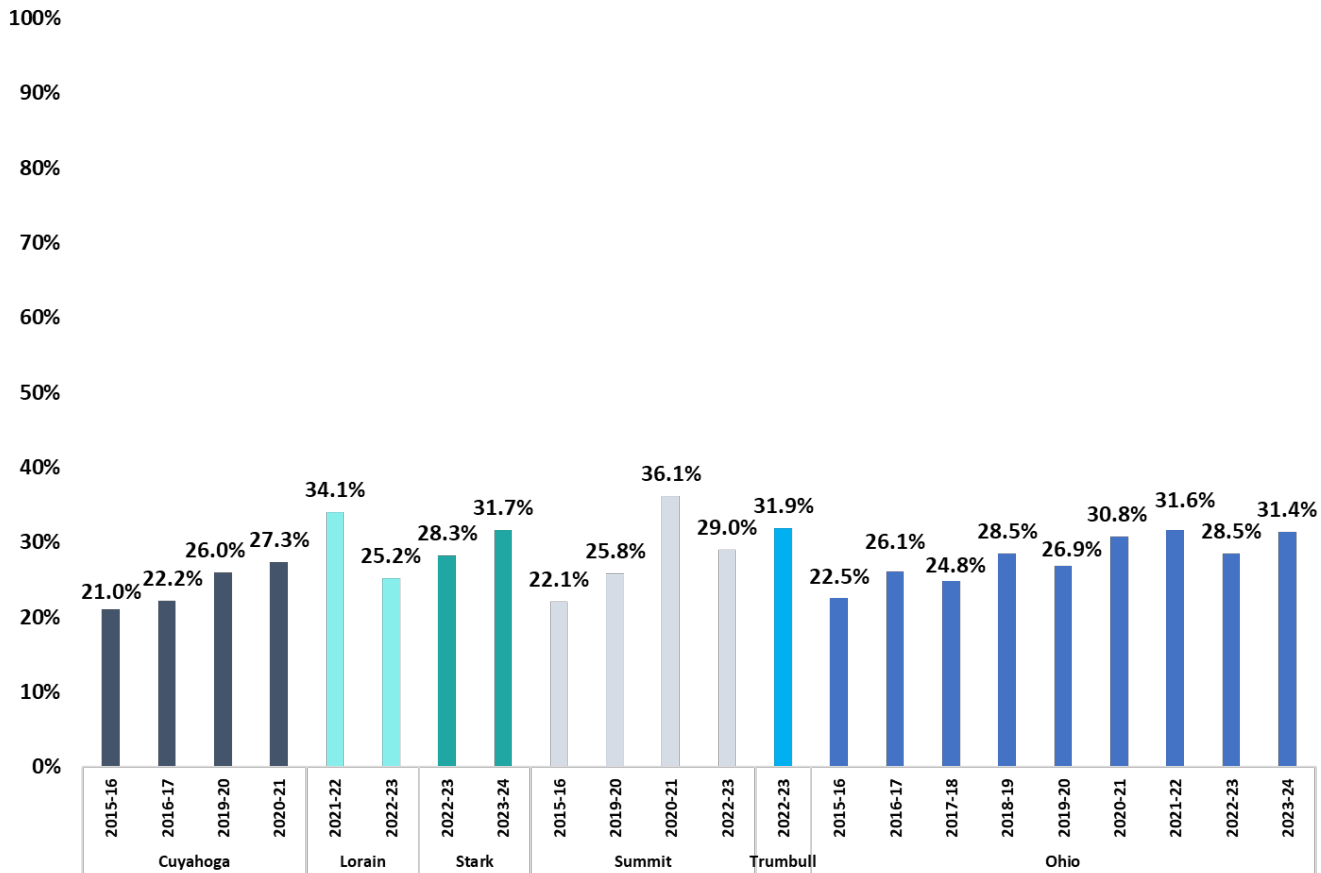
- **Attention deficit and hyperactivity disorder (ADHD)** affects an estimated 30 to 61 percent of people with autism (Goldstein 2004, Gadow 2006, Romero 2016)
- **Anxiety disorders** affect an estimated 11 to 42 percent of people with autism (Vasa 2016, White 2009, Romero 2016)
- **Depression** affects an estimated 7 percent of children and 26 percent of adults with autism (Chisolm 2015)
- **Schizophrenia** affects an estimated 4 to 35 percent of adults with autism (Chisolm 2015)
- **Bipolar disorder** affects between 6 and 27 percent of people with autism (Munesue 2008, Rosenberg 2011, Vannucchi 2014, Guinchat 2015, Croen 2015).

³<https://www.mayoclinic.org/diseases-conditions/autism-spectrum-disorder/symptoms-causes/syc-20352928#Overview>



Figure 20 illustrates the percentage of 7-12 grade students with anxiety issues warranting further exploration by mental health professionals for counties in the service area where the data was available. The percentage has been steadily increasing in Cuyahoga County from 21.0% in 2015-16 to 27.3% in 2020-21. The percentage also increased in Stark County from 28.3% in 2022-23 to 31.7% in 2023-24. The percentage decreased in Lorain from 34.1% in 2021-22 to 25.2% in 2022-23. The percentage in Summit has been increasing but decreased in most recent years from 36.1% in 2020-21 to 29.0% in 2022-23. In looking at years where counties have comparable data to the state, Cuyahoga and Lorain were lower in comparison and Stark, Summitt and Trumbull were higher. Data was not available for Ashtabula or Lake counties.

Figure 20: 7-12 Grade Students with Anxiety Issues Warranting Further Exploration by Mental Health Professional

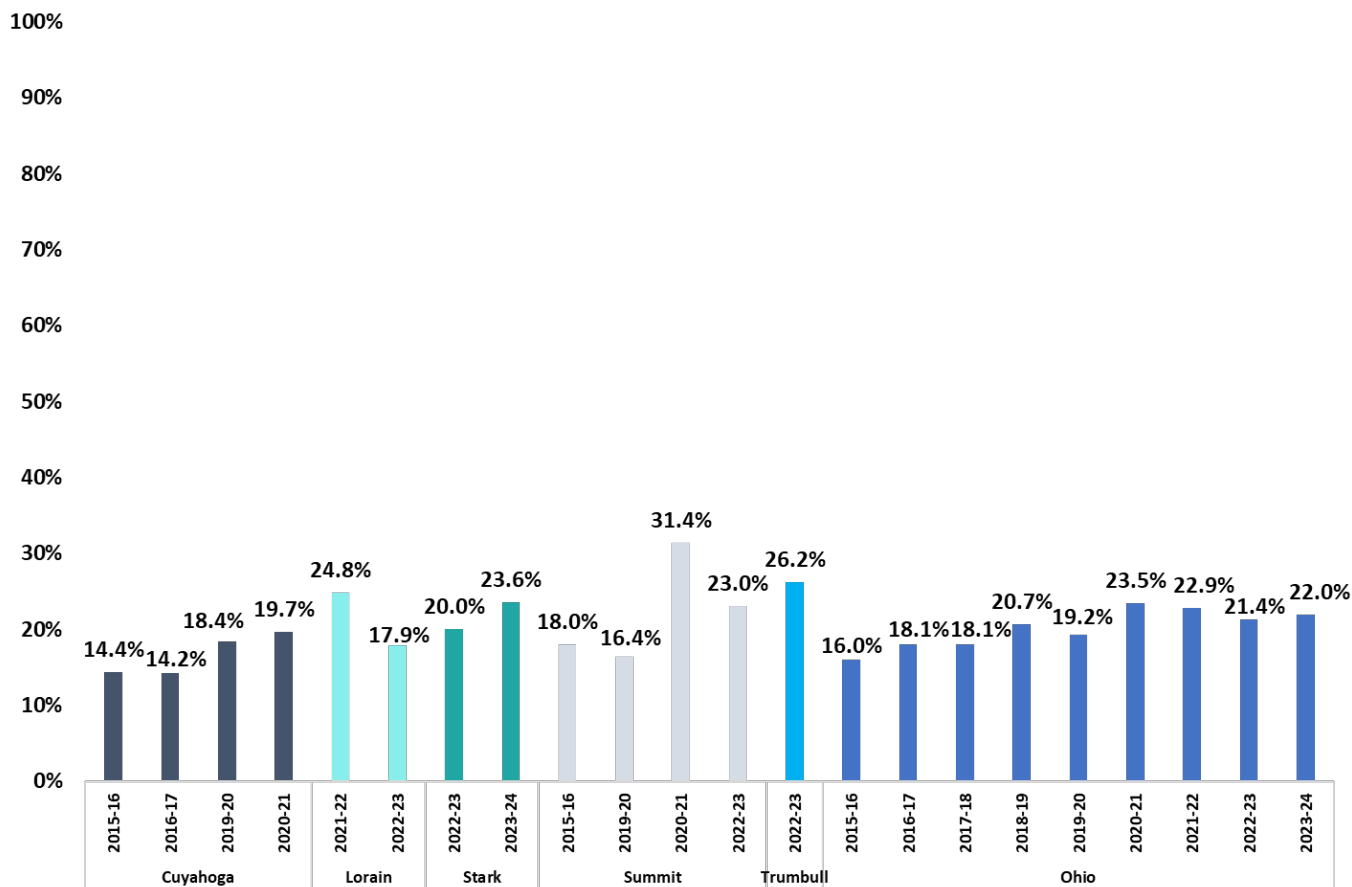


Source: Ohio Healthy Youth Environments Survey



The percentage of students with depression warranting further exploration by a mental health professional has increased in Cuyahoga County from 14.4% in 2015-16 to 19.7% in 2020-21 as seen in Figure 21. Stark County also saw an increase from 20.0% in 2022-23 to 23.6% in 2023-24. The percentage decreased in Lorain County from 24.8% in 2021-22 to 17.9% in 2022-23. Summit County nearly doubled between 2019-20 (16.4%) and 2020-21 (31.4%) but saw a decrease in 2022-23 (23.0%). In years where comparable data is available to the state, Cuyahoga and Lorain counties were lower while Stark, Summit and Trumbull counties were higher. Data was not available for Ashtabula and Lake counties.

Figure 21: 7-12 Grade Students with Depression Issues Warranting Further Exploration by Mental Health Professional

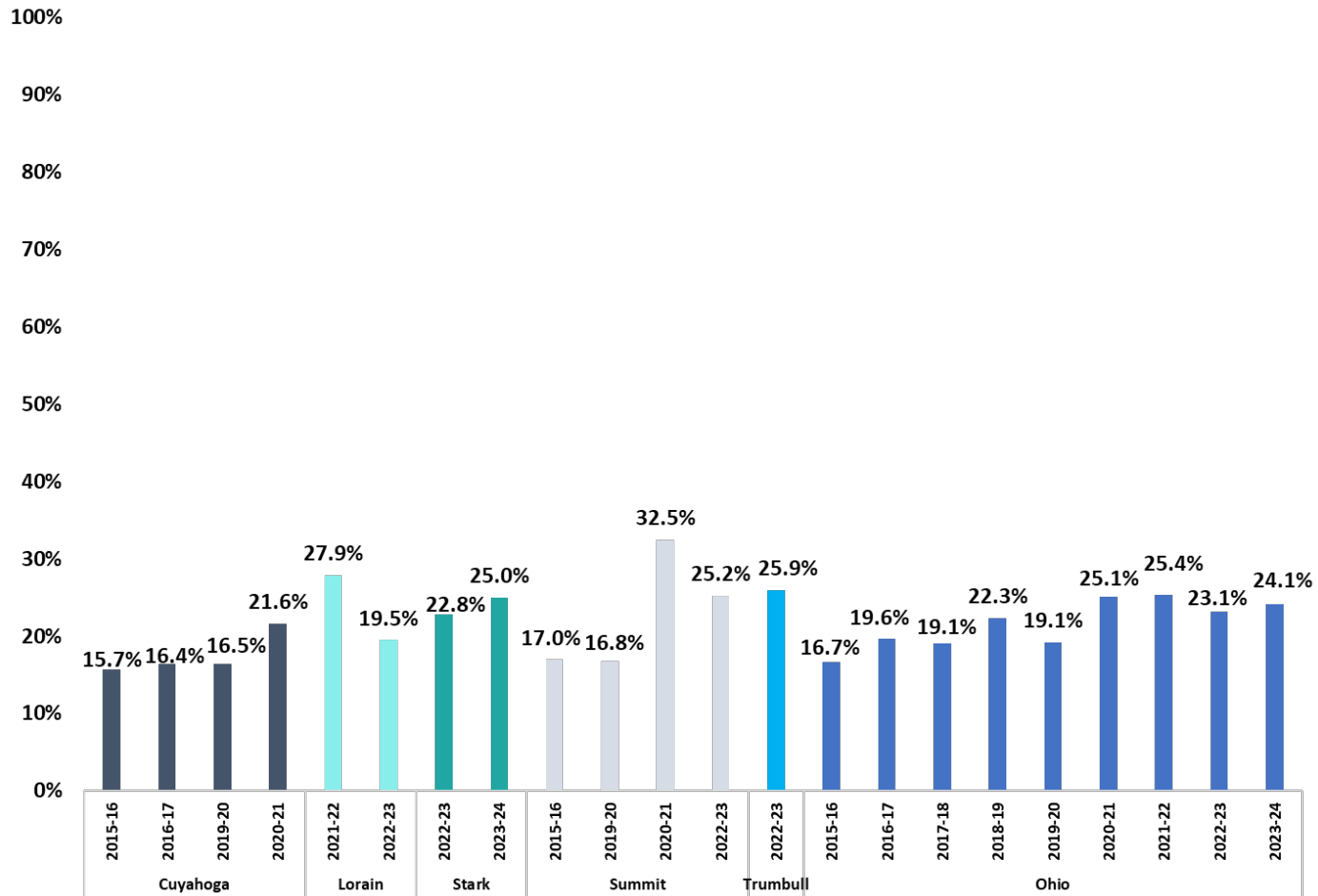


Source: Ohio Healthy Youth Environments Survey



Figure 22 illustrates the percentage of students with mental health issues warranting further exploration by a mental health professional which has increased in Cuyahoga County from 15.7% in 2015-16 to 21.6% in 2020-21. The same is true in Stark County (22.8% in 2022-23 to 25.0% in 2023-24). Lorain County (27.9% in 2021-22 to 19.5% in 2022-23) and Summit County (32.5% in 2020-21 to 25.2% in 2022-23) saw a decrease. In years where comparable data is available to the state, Cuyahoga and Lorain counties were lower while Stark, Summit and Trumbull counties were higher.

Figure 22: 7-12 Grade Students with Mental Health Issues Warranting Further Exploration by Mental Health Professional

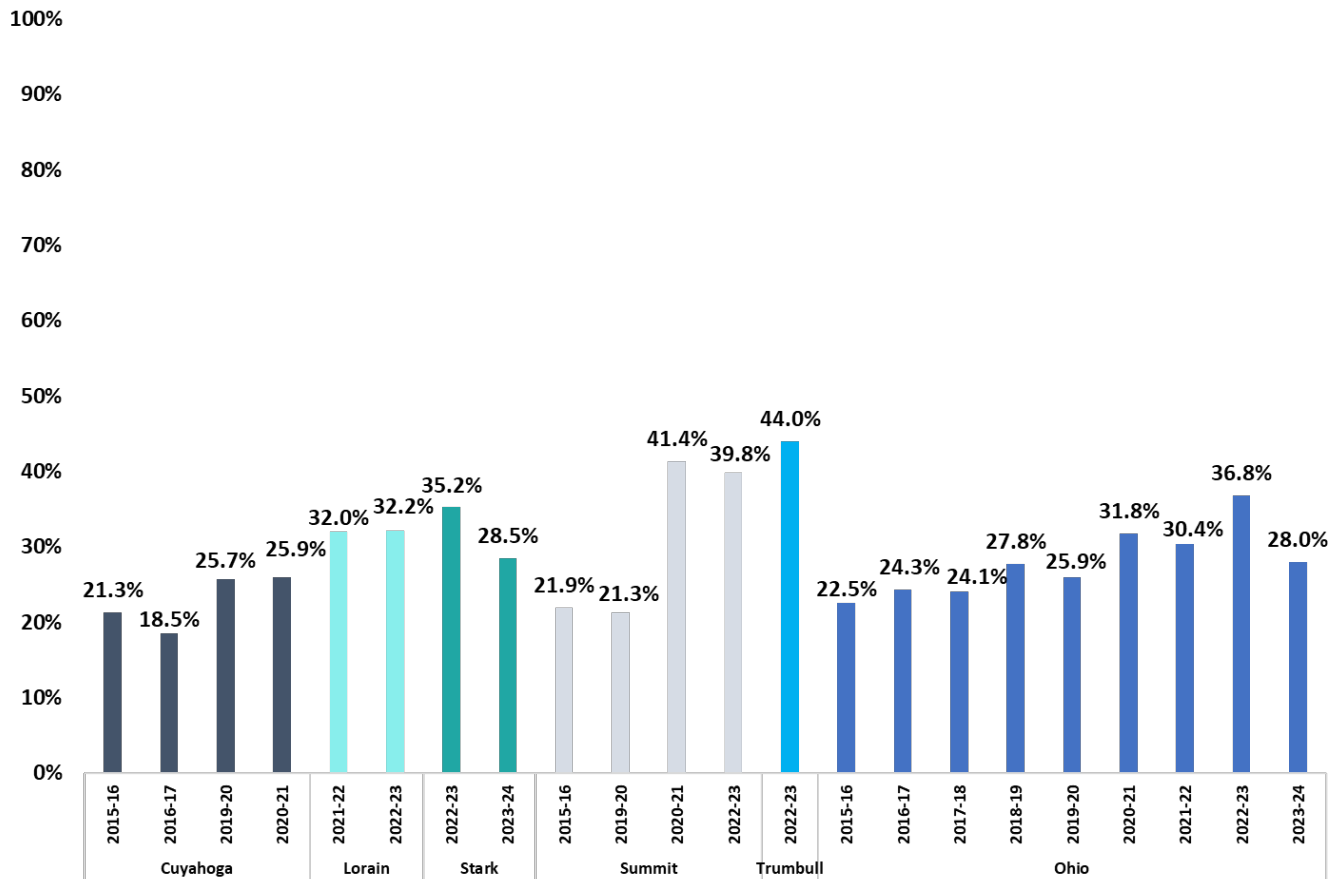


Source: Ohio Healthy Youth Environments Survey



The percentage of students who felt sad or hopeless every day for 2 weeks and stopped doing usual activities as a result has increased in Cuyahoga County (21.3% in 2015-2016 to 25.9% in 2020-2021) and Lorain County (32.0% in 2021-2022 to 32.2% in 2022-2023). The percentage decreased in Stark County (35.2% in 2022-2023 to 28.5% in 2023-2024) and Summit County (41.4% in 2020-2021 to 39.8% in 2022-2023). In comparison to the state, Cuyahoga and Lorain counties are lower while Stark, Summit and Trumbull counties are higher. Data was not available for Ashtabula or Lake counties.

Figure 23: 7-12 Grade Students who Felt Sad or Hopeless Every Day for 2 Weeks and Stopped Doing Usual Activities



Source: Ohio Healthy Youth Environments Survey



Table 4 displays the percentage of students in the Medicaid population with various conditions for the 2023-2024 school year. The highest percentage overall is for students experiencing serious emotional disturbance which is higher in Ashtabula (17.6%), Lake (15.4%), Stark (15.6%), Summit (14.0%), and Trumbull (15.5%) counties in comparison to Ohio (13.1%). There is a higher percentage of Medicaid students with anxiety in Ashtabula (12.2%), Lake (12.2%), Lorain (10.3%), Stark (11.6%), Summit (9.9%) and Trumbull (9.5%) counties compared to Ohio (9.4%). ADHD among this population is higher in Ashtabula (17.5%), Lake (14.7%), Stark (13.8%), and Trumbull (15.0%) counties compared to the state (13.7%). There is a higher prevalence of autism in Ashtabula (2.6%), Cuyahoga (2.6%), Lake (2.8%) and Trumbull (3.3%) counties than Ohio (2.5%). Depression is higher in Ashtabula (8.7%), Lake (8.1%), Lorain (7.4%), Stark (8.8%), Summit (8.2%) and Trumbull (7.8%) counties in comparison to Ohio (7.2%). This population with major depression is higher in Ashtabula (7.6%), Lake (6.9%), Stark (6.1%), and Trumbull (6.1%) counties than the state (5.4%). Substance Use Disorder is higher in Lake County (1.4%) than the state (1.0%).

When looking at Table 4, compared to the state:

- Anxiety is higher in Ashtabula, Lake, Lorain, Stark, Summit and Trumbull
- ADHD is higher in Ashtabula, Lake, Stark, and Trumbull
- Autism is higher in Ashtabula, Cuyahoga, Lake and Trumbull
- Depression is higher in Ashtabula, Lake, Lorain, Stark, Summit and Trumbull
- Major Depression is higher in Ashtabula, Lake, Stark and Trumbull
- Serious Emotional Disturbance is higher in Ashtabula, Lake, Stark, Summit and Trumbull
- Substance Use Disorder is higher in Lake



Table 4: Conditions Experienced by Medicaid Students

	Ashtabula County	Cuyahoga County	Lake County	Lorain County	Stark County	Summit County	Trumbull County	Ohio
Measure Name	2023-2024	2023-2024	2023-2024	2023-2024	2023-2024	2023-2024	2023-2024	2023-2024
Anxiety	12.2%	8.4%	12.2%	10.3%	11.6%	9.9%	9.5%	9.4%
Any Behavior Health Condition	37.4%	28.8%	31.7%	30.2%	33.1%	33.1%	33.2%	30.9%
Attention-Deficit/Hyperactivity Disorder	17.5%	12.1%	14.7%	13.6%	13.8%	13.4%	15.0%	13.7%
Autism	2.6%	2.6%	2.8%	2.4%	2.5%	2.1%	3.3%	2.5%
Depression (All)	8.7%	6.9%	8.1%	7.4%	8.8%	8.2%	7.8%	7.2%
Major Depression for Students with Medicaid	7.6%	5.2%	6.9%	5.4%	6.1%	5.4%	6.1%	5.4%
Serious Emotional Disturbance	17.6%	12.8%	15.4%	12.6%	15.6%	14.0%	15.5%	13.1%
Substance Use Disorder	1.0%	1.0%	1.4%	0.9%	1.0%	0.9%	0.9%	1.0%

Source: Ohio Department of Education

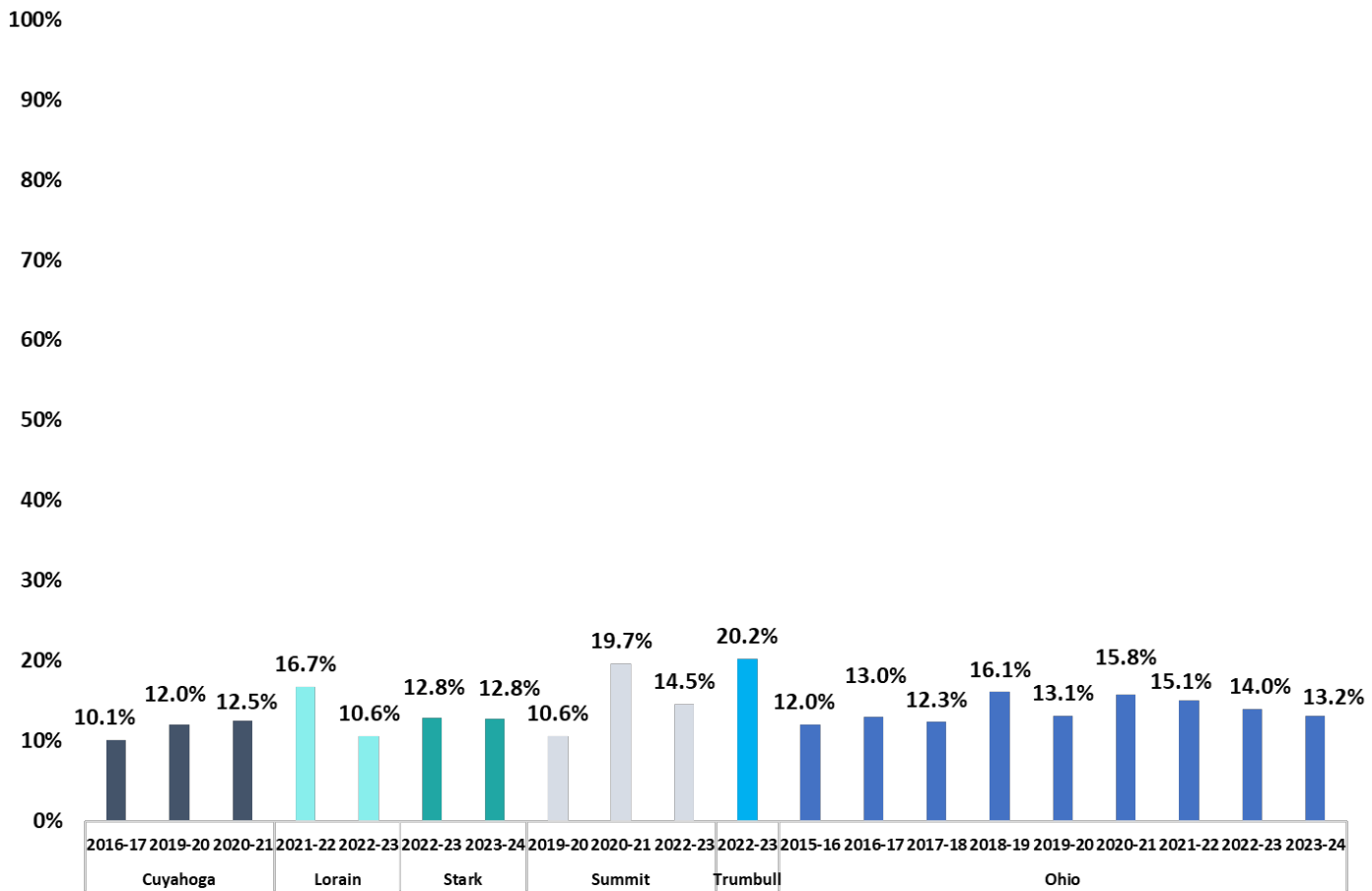
The National Alliance on Mental Illness (NAMI) reports that:

- Suicide is the 2nd leading cause of death among people aged 10-14 and the 3rd leading cause of death among those aged 15-24 in the U.S.
- Suicide is the 12th leading cause of death overall in the U.S.
- 46% of people who die by suicide had a diagnosed mental health condition.
- 90% of people who die by suicide may have experienced symptoms of a mental health condition, according to interviews with family, friends and medical professionals.



The percentage of students in grades 7-12 seriously considering attempting suicide in the past 12 months has increased slightly in Cuyahoga County (12.0% to 12.5%) as shown in Figure 24. The percentage decreased in Lorain (16.7% to 10.6%) and Summit (19.7% to 14.5%) counties. The percentage stayed the same in Stark County (12.8%). In comparison to the state, Cuyahoga, Lorain and Stark counties were lower and Summit and Trumbull counties were higher. Data was not available for Ashtabula or Lake counties.

Figure 24: 7-12 Grade Students Seriously Considered Attempting Suicide, Past 12 Months



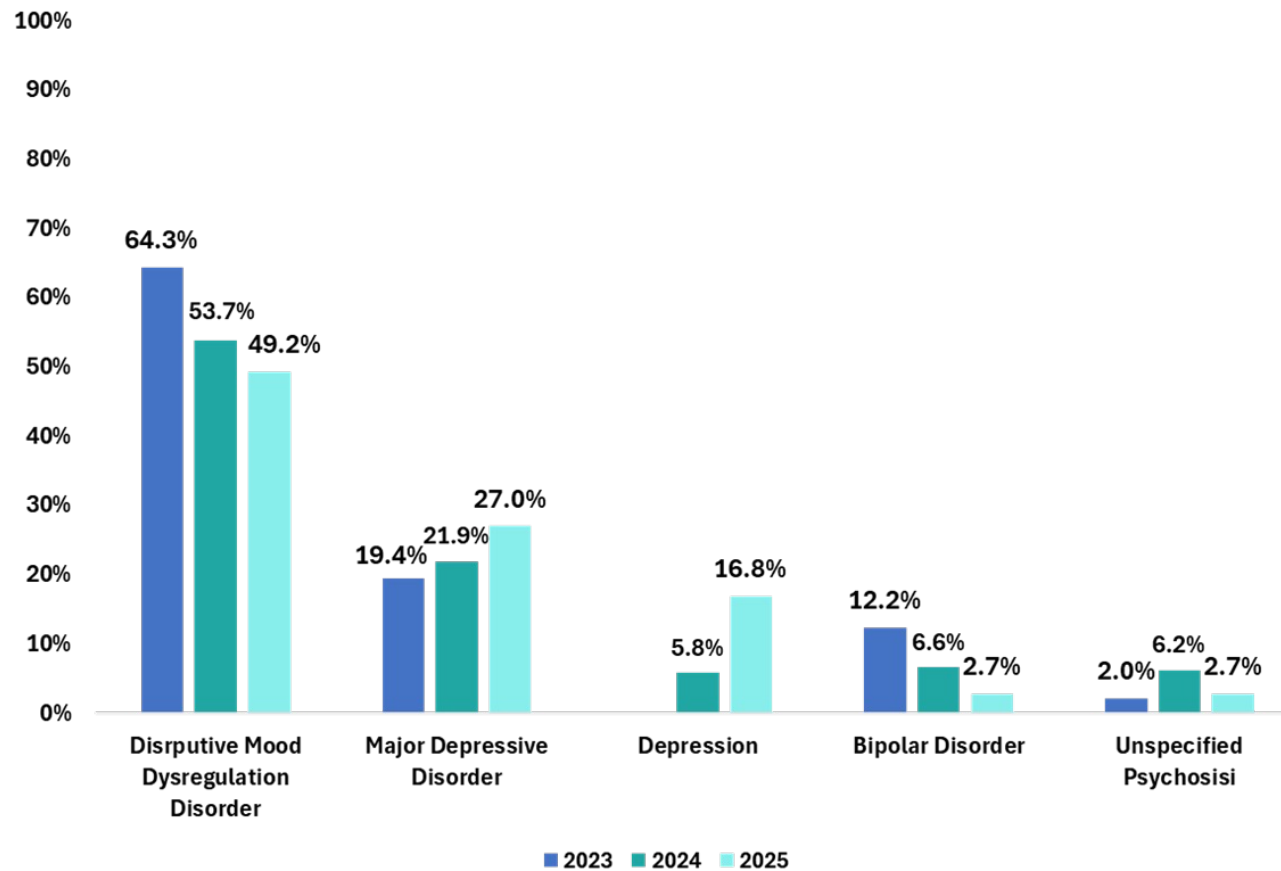
Source: Ohio Healthy Youth Environments Survey



Hospital Utilization

The number of discharges has increased each year, with 196 in 2023, 242 in 2024 and 256 in 2025. The top diagnosis at discharge continues to be disruptive mood dysregulation disorder, although the percentage has decreased each year, illustrated in Figure 25. Discharges for bipolar disorder have also decreased each year. Discharges for major depressive disorder have increased every year as have discharges for depression.

Figure 25: Top 5 Program Discharges



Source: Bluestone Child & Adolescent Psychiatric Hospital



Community Input

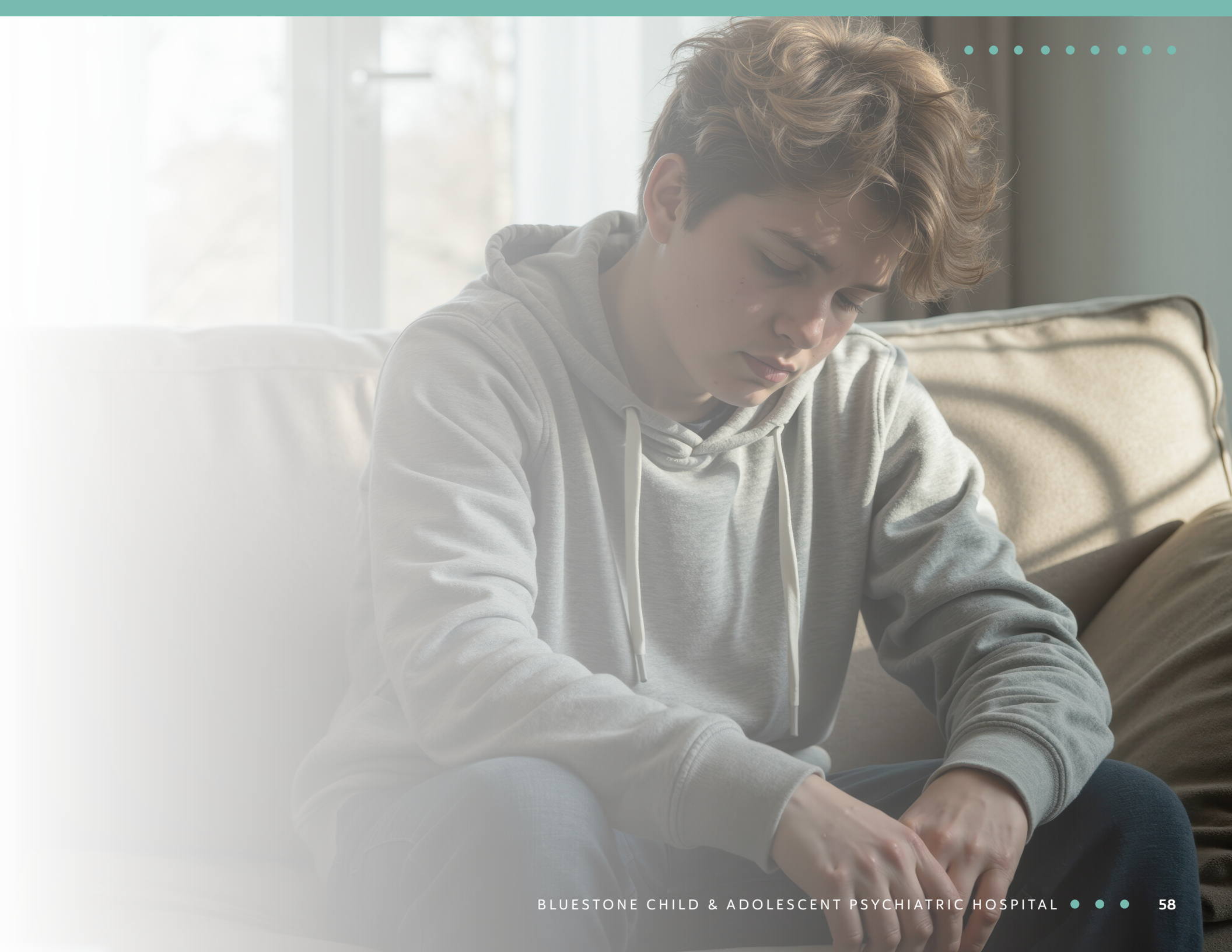
Stakeholders consistently described a youth mental health system that is overwhelmed, fragmented, and operating at or beyond capacity. Across interviews, providers from healthcare, schools, juvenile justice, child welfare, and community agencies reported that youth are presenting with increasingly complex and high-acuity needs, including aggression, co-occurring substance use disorders, developmental disabilities, autism, and layered trauma. Many emphasized that current services are not designed to adequately serve these youth, resulting in frequent rejections from hospitals, residential programs, and crisis settings.

A dominant theme was the lack of appropriate crisis stabilization options for youth who are unsafe at home but do not meet criteria for psychiatric hospitalization. Families are often directed to emergency rooms, law enforcement, or juvenile detention, none of which are clinically appropriate or therapeutic solutions. Youth frequently wait for hours or days in emergency departments, only to be discharged home without meaningful intervention or connection to follow-up care. Stakeholders described this as a “revolving door” that leaves families discouraged and traumatized.

Participants also emphasized the strain on families navigating the mental health system. Caregivers are often overwhelmed, isolated, and unsure how to access services or advocate for appropriate care. Many lack understanding of diagnoses, treatment options, or what different levels of care can realistically accomplish. Without sufficient psychoeducation, family therapy, and peer advocacy support, youth often return home to the same stressors that contributed to the crisis.

Workforce shortages compound every aspect of the system. Stakeholders cited shortages of licensed clinicians, psychiatrists, specialized providers (including those trained in autism, developmental disabilities, and substance use disorders), and school-based professionals. High turnover, insufficient reimbursement, and recruitment challenges limit continuity of care and increase wait times. Rural counties in particular face limited provider availability, long travel distances, and minimal crisis infrastructure.

Overall, stakeholders described a system that is filled with dedicated professionals but lacks the capacity, coordination, and resources necessary to meet the level of need in the community.



Recommended Services and Identified Gaps



1. Crisis Stabilization & Higher Levels of Care

Gaps Identified

- » Lack of short-term crisis stabilization or respite beds (including 23-hour options)
- » Insufficient psychiatric inpatient beds for youth
- » Limited Psychiatric Residential Treatment Facility (PRTF) options, particularly locally
- » No appropriate placement for youth with aggressive/violent behavior, autism, developmental disabilities, or co-occurring SUD
- » Youth sent out-of-county or out-of-state for care

Recommended Services:

- » Trauma-informed crisis stabilization units
- » Short-term respite placements
- » Expanded PRTF capacity in-region
- » Specialized programming for high-acuity and multi-system youth

3. Family Support, Education & Navigation

Gaps Identified

- » Limited caregiver psychoeducation about diagnoses and treatment options
- » Lack of consistent family peer support and advocacy
- » Families overwhelmed by complex, multi-system navigation
- » Poor follow-up after ER visits or hospital discharge

Recommended Services:

- » Embedded family peer advocates
- » Structured caregiver education programs
- » Proactive follow-up calls post-discharge
- » Public education campaigns about mental health services and expectations

2. Community-Based & Intensive Services

Gaps Identified

- » Insufficient intensive home-based treatment (IHBT) capacity; long waitlists
- » Limited step-down services following hospitalization
- » Inadequate adolescent substance use disorder treatment providers
- » Few services tailored to younger children with escalating needs
- » Limited services for youth with both mental health and developmental disabilities

Recommended Services:

- » Expanded IHBT, MST, and FFT models
- » Partial hospitalization and “in-between” day programs with family components
- » Community-based SUD treatment for adolescents
- » Holistic programs integrating family therapy and medication management



4. Coordination, Communication & System Integration

Gaps Identified

- » Lack of centralized intake or real-time bed tracking
- » Minimal community provider involvement in discharge planning
- » Insufficient detail in discharge summaries
- » Silos between hospitals, schools, juvenile justice, and community providers

Recommended Services:

- » Centralized intake and referral coordination systems
- » Routine inclusion of community providers and schools in discharge planning
- » Improved cross-system collaboration and warm handoffs

5. Workforce & Funding

Gaps Identified

- » Shortage of licensed clinicians and youth psychiatrists
- » Insufficient reimbursement rates and funding constraints
- » Limited SUD-trained youth providers
- » High turnover disrupting continuity of care

Recommended Services:

- » Workforce expansion initiatives
- » Differential reimbursement for high-acuity and school-based settings
- » Increased funding for youth behavioral health and prevention programming

Together, these findings underscore the need for a more robust, coordinated, and family-centered continuum of mental health care that emphasizes early intervention, builds community-based capacity, and creates specialized options for the highest-need youth.





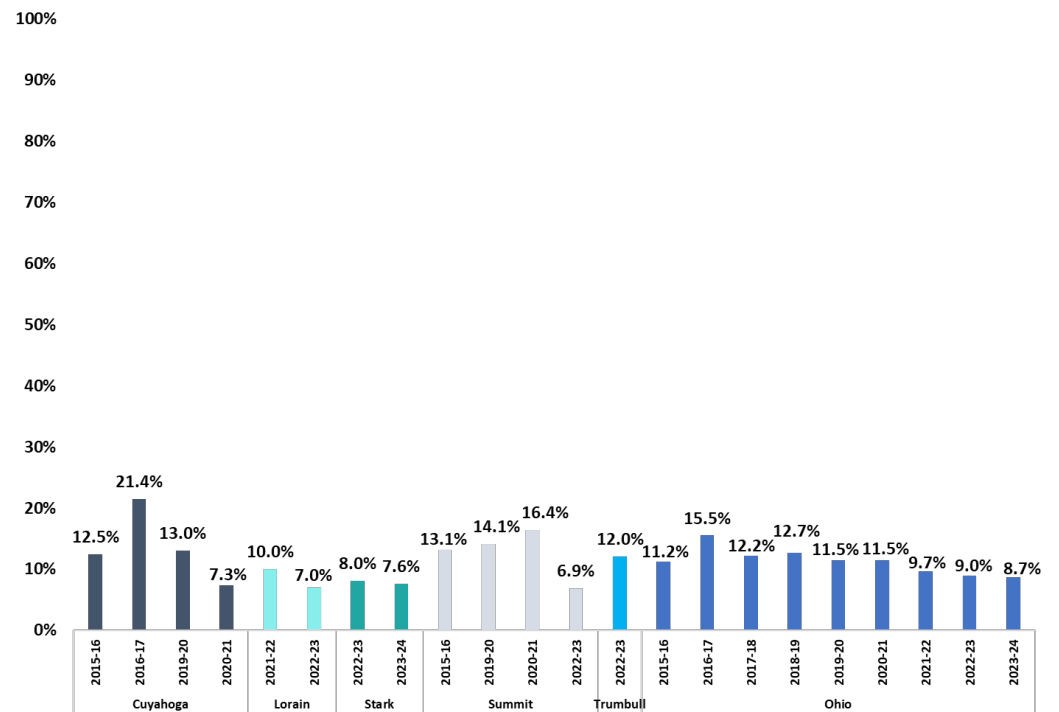
SUBSTANCE ABUSE

According to the National Institutes of Health, Substance use disorder (SUD) is a treatable mental disorder that affects a person’s brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.

People with a SUD may also have other mental health disorders, and people with mental health disorders may also struggle with substance use. These other mental health disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others. ⁴

Figure 26 illustrates the percentage of 7-12 grade students who drank 1 or more alcoholic beverages in the past 30 days for the counties in the service area where data is available. The percentage has decreased in all counties in the service area where data is available as well as the state. In comparison to the state, all counties with available data have a lower percentage of students in grades 7-12 who reported that they drank 1 or more alcoholic beverage in the past 30 days. Data was not available for Ashtabula and Lake counties.

Figure 26: 7-12 Grade Students Drank 1 or More Alcoholic Beverages, Past 30 Days



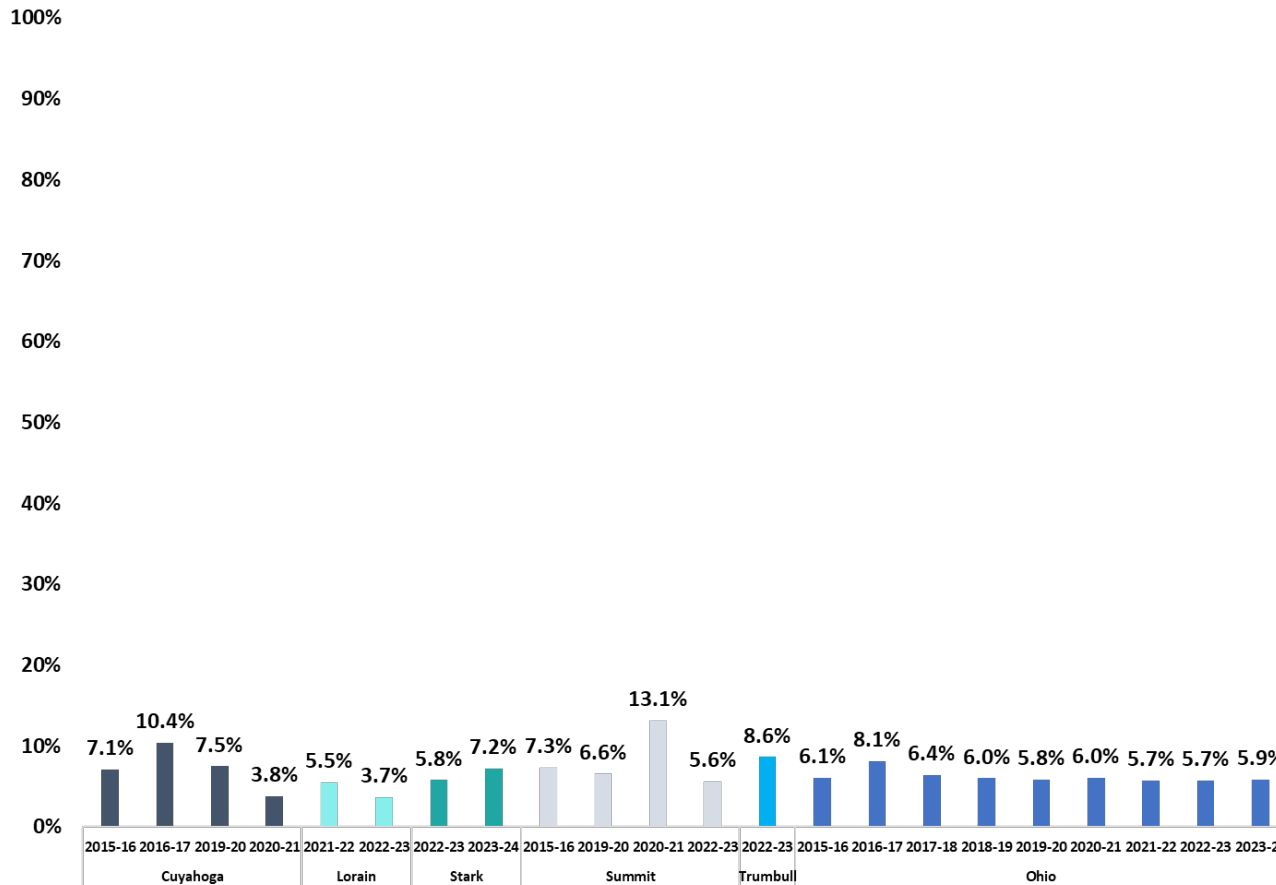
Source: Ohio Healthy Youth Environments Survey

⁴[https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#:~:text=Substance%20use%20disorder%20\(SUD\)%20is,most%20severe%20form%20of%20SUD.](https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#:~:text=Substance%20use%20disorder%20(SUD)%20is,most%20severe%20form%20of%20SUD.)



The percentage of students in grades 7-12 who have used marijuana or hashish in the past 30 days has decreased in the most recent years data is available for Cuyahoga, Lorain and Summit counties, while increasing in Stark County and Ohio. When comparing the counties to the state for the most recent year data is available, Cuyahoga, Lorain, and Stark counties are lower while Summit and Trumbull counties are higher. This is illustrated in Figure 27. Data was not available for Ashtabula or Lake counties.

Figure 27: 7-12 Grade Students Used Marijuana or Hashish, Past 30 Days



Source: Ohio Healthy Youth Environments Survey



Community Input

Stakeholders described substance use—particularly among adolescents and youth with co-occurring mental health conditions—as an escalating and complex concern across the region. Providers reported seeing younger children presenting with co-occurring mental health and substance use disorders (SUD), often accompanied by trauma histories and involvement with child welfare or juvenile justice systems. Youth with dual diagnoses are frequently described as among the most difficult to place, as many psychiatric facilities and residential programs are not equipped or willing to manage both behavioral health and substance use needs simultaneously.

The opioid crisis was identified as a significant upstream driver of youth behavioral health and substance use challenges. Stakeholders discussed high rates of prenatal substance exposure, kinship care arrangements, generational addiction, and layered trauma affecting families and communities. These dynamics contribute to complex developmental, emotional, and behavioral needs that require integrated, long-term support.

Access to adolescent-specific substance use treatment remains limited. Participants noted a shortage of clinicians trained to treat youth SUD, particularly in rural counties, as well as insufficient inpatient and residential treatment capacity for adolescents. Funding constraints, lack of parity between mental health and substance use reimbursement, and insurance barriers further limit service availability. Families who are ready to engage in treatment may face delays, coverage denials, or difficulty identifying appropriate providers.

Stakeholders also emphasized the importance of prevention and early intervention efforts to reduce future substance use risk. School-based prevention programming, evidence-based social-emotional learning initiatives, and education around healthy decision-making were described as valuable but under-resourced. Retention challenges in youth prevention programs were also noted, particularly among high-risk populations.

Recommended Services and Identified Gaps

1. Treatment Capacity & Specialized Services

Gaps Identified

- » Limited adolescent-specific SUD treatment providers
- » Shortage of clinicians trained in co-occurring mental health and substance use disorders
- » Insufficient inpatient and residential treatment options for youth with dual diagnoses
- » Youth turned away from placements due to behavioral complexity and substance use

Recommended Services:

- » Expanded adolescent SUD treatment programming
- » Integrated dual-diagnosis treatment models
- » Increased residential and step-down capacity for youth with co-occurring disorders
- » Workforce development focused on youth SUD specialization

3. Prevention & Early Intervention

Gaps Identified

- » Insufficient early intervention before youth reach crisis levels
- » Retention challenges in prevention programming
- » Limited awareness among families and schools about available services

Recommended Services:

- » Expanded school-based prevention and evidence-based curricula
- » Community education campaigns on early warning signs of substance use
- » Stronger linkages between prevention programs and treatment providers



2. Funding & Insurance Barriers

Gaps Identified

- » Lack of parity between mental health and substance use reimbursement
- » Insurance denials or partial coverage for behavioral health treatment
- » Competitive and declining funding streams, including philanthropy

Recommended Services:

- » Improved reimbursement structures and parity for SUD services
- » Increased public funding for adolescent substance use treatment
- » Simplified and coordinated funding pathways for families



4. Geographic & Rural Disparities

Gaps Identified

- » Very limited SUD-trained providers in rural counties
- » Long travel distances for inpatient or specialty treatment

Recommended Services:

- » Increased regional treatment capacity
- » Expansion of accessible community-based SUD services for youth

Overall, stakeholders emphasized that substance use among youth cannot be addressed in isolation from mental health, trauma, family stressors, and systemic barriers. They called for integrated, trauma-informed, and family-centered approaches that expand prevention, strengthen treatment capacity, and address funding and workforce limitations to better meet the needs of adolescents and their caregivers.





COMMUNITY RESOURCES

There are a variety of services and resources available to meet the needs of the community available through Bluestone Child & Adolescent Psychiatric Hospital. They include but are not necessarily limited to:

- » A full psychiatric evaluation within 24 hours of admission and daily assessment thereafter until discharge.
- » A full nursing evaluation at admission and daily thereafter.
- » A full history and physical exam within 24 hours of admission and as needed thereafter.
- » A full psychosocial evaluation completed within 24 hours of admission by a clinical services team member. Individual meetings with the clinical service team throughout admission as needed.
- » A full evaluation from a recreational therapist within 24 hours of admission.
- » Parent/guardian meetings with the clinical services team within 24 hours of admission, as needed throughout treatment and on the day of discharge.
- » Group services provided throughout the day, 7 days per week, a minimum of 3 groups per day.
- » Aftercare/discharge planning completed by clinical services team, ensuring that mental health treatment is arranged post discharge.

In addition, resources that are available in Bluestone's service area to respond to the significant health needs of the community can be found through the service area counties respective United Way's 2-1-1 and other community partners who are maintaining these databases. These searchable databases are part of the national 2-1-1 Call Centers initiative that seeks to provide an easy-to-remember telephone number and web resource for finding health and human services– for everyday needs and in crisis situations. Residents can search the United Way's vast database of services and providers to find the help they need. Residents can also access the national Suicide and Crisis Lifeline at 988.

The following are links to the available 2-1-1 resources:

Ashtabula County: <https://www.211ashtabula.org/resource-portal>

Cuyahoga County: <https://www.211oh.org/how-we-help/services>

Lake County: <https://lclifeline.org/2-1-1/2-1-1-database/>

Lorain County: <https://211lorain.org/>

Stark County: <https://www.starkhelpcentral.com/>

Summit County: <https://www.211summitmedina.org/>

Trumbull County: <https://www.helpnetworkneo.org/>



Community Input



Across counties, wraparound and care coordination services were frequently described as working well. Team-based, in-home wraparound services and OhioRISE care coordination were highlighted as effective in preventing crises and helping youth remain in their homes and communities. Stakeholders noted that these services improve cross-system communication and allow for more collaborative planning. Warm handoffs prior to discharge or release, such as those implemented by the Ohio Department of Youth Services, were also described as positive examples of continuity of care.

Several community-based therapeutic models were identified as strong resources. Intensive Home-Based Treatment (IHBT), Functional Family Therapy (FFT), and Multisystemic Therapy (MST) were described as particularly effective when working with high-need youth within the context of the family system. Group services available in the community and school-based mental health programming were also noted as beneficial, particularly when they provide structured afterschool support, therapeutic programming, and meals. Prevention-focused efforts, including social-emotional learning programs delivered in schools and early childhood initiatives such as Early Ages Healthy Stages and PREP, were recognized as important early-intervention strategies.

Stakeholders also emphasized the value of mobile crisis and urgent response services. Mobile Response and Stabilization Services (MRSS) and behavioral health urgent care programs were described as meeting a critical need for youth who are not actively suicidal or homicidal but require immediate support. These services help divert youth from hospitalization and juvenile justice involvement and allow them to remain in their homes and schools. Recently launched MRSS services in rural counties were viewed positively and as filling a longstanding gap.

In addition, family peer support and advocacy services were repeatedly cited as essential resources. Family Support Specialists and NAMI advocates help parents navigate complex systems, understand diagnoses and treatment options, and feel less isolated. Stakeholders noted that when families are connected to advocates, they are better equipped to participate in treatment planning and sustain progress at home.

Finally, some stakeholders shared positive feedback about specific hospital processes and partnerships. Bluestone's intake and referral process, particularly the ability to obtain caregiver consent by phone, was described as more streamlined and less burdensome than other hospital systems. Increased access to psychiatric services through telehealth and nurse practitioners was also noted as an improvement in some communities.

Overall, while providers consistently described the system as under-resourced and overwhelmed, they also identified meaningful strengths within the existing continuum of care, particularly in wraparound coordination, community-based treatment models, mobile crisis response, school-linked services, prevention programming, and family advocacy supports.

CONCLUSIONS

Quantitative Secondary Data

Improving Indicators

Lake (4.6%) and Summit (4.4%) counties have a lower percentage of children with a disability in comparison to the state (5.3%) and nation (4.7%).

The number of child abuse and neglect intakes has declined in all counties in the service area as well as the state. Ashtabula, Lake, Stark, and Summit counties saw a consistent decline year over year from 2023 to 2025, while Cuyahoga, Lorain, Trumbull counties and the state saw a slight increase from 2023 to 2024 with a decrease between 2024 and 2025.

Lake (3.8%), Stark (3.1%), and Summit (3.3%) counties have a lower percentage of uninsured children than Ohio (4.4%).

Lake (15.1%), Lorain (14.9%), and Stark (16.8%) counties have a lower percentage of children living in poverty compared to the state (17.5%).

Disconnected youth are those ages 16-19 who are not in school or working. Lake County (5.7%) has a significantly lower percentage of youth not working or in school compared to Ohio (6.2%) and also lower compared to the nation (6.9%).

Ashtabula (7.5%) and Lake (7.6%) counties have a significantly lower percentage of low birthweight babies compared to the state (8.7%). Ashtabula (10.7%), Lake (10.6%) and Summit (11.0%) counties have a significantly lower percentage of pre-term births in comparison to the state (10.8%).

Lake (1.2), Lorain (5.5) and Summit (4.6) counties have a significantly lower teen birth rate compared to Ohio (6.1) and are lower in comparison to the nation (5.6).

Lake (13.4%) and Summit (14.8%) counties have a significantly lower percentage of children who are food insecure compared to the state (15.3%), with Lake County also lower in comparison to the nation (14.5%).

Ashtabula (19.4%), Cuyahoga (21.0%), Lake (19.8%), Lorain (20.9%) and Summit (19.8%) counties have a significantly lower percentage of adults who report excessive drinking compared to the state (21.2%), although all are higher in comparison to the nation (18.1%). Data was not available for Stark or Trumbull counties.



Cuyahoga County has a lower percentage of Medicaid participating students with anxiety, any behavioral condition, ADHD, depression, major depression, and serious emotional disturbance compared to the state. Lorain County has a lower percentage of Medicaid participating students who have any behavioral condition, ADHD, autism, serious emotional disturbance or substance use disorder compared to Ohio. Summit County has a lower percentage of Medicaid participating students with ADHD, autism and substance use disorder compared to the state. Trumbull County has a lower percentage of Medicaid participating students with substance use disorder compared to the state.

The percentage of children in grades 7-12 with anxiety warranting further exploration by a mental health professional decreased in Lorain County (34.1% to 25.2%) between the 2021-22 and 2022-23 school year. The same is true for those with depression warranting further exploration by a mental health professional (24.8% to 17.9%). The percentage of children in grades 7-12 with mental health issues warranting further exploration by a mental health professional decreased from 27.9% in 2021-22 to 19.5% in 2022-23 in Lorain County and in Summit County from 32.5% in 2020-21 to 25.2% in 2022-23.

The percentage of students in grades 7-12 who felt sad or hopeless almost every day for 2 weeks or more in a row decreased from 35.2% in 2022-23 to 28.5% in 2023-24 in Stark County.

The percentage of students in grades 7-12 who considered attempting suicide decreased in Lorain County from 16.7% in 2021-22 to 10.6% in 2022-23.

The percentage of students in grades 7-12 who drank one or more alcoholic beverages decreased from 13.0% in 2019-20 to 7.3% in 2020-21 in Cuyahoga County, and from 10.0% to 7.0% in Lorain County between 2021-22 and 2022-23. In Stark County the percentage decreased from 8.0% in 2022-23 to 7.6% in 2023-24 and from 16.4% in 2020-21 to 6.9% in 2022-23 in Summit County.

The percentage of students in grades 7-12 who have used marijuana in the past 30 days decreased from 7.5% in 2019-20 to 3.8% in 2020-21 in Cuyahoga County and from 5.5% in 2021-22 to 3.7% in 2022-23 in Lorain County. In Summit County the percentage decreased from 13.1% in 2020-21 to 5.6% in 2022-23.

Community Needs

Ashtabula (7.3%), Cuyahoga (6.1%) and Lorain (5.4%) counties have a higher percentage of children with a disability compared to Ohio (5.3%) and the nation (4.7%).



Ashtabula (6.3%), Cuyahoga (4.6%), and Trumbull (5.8%) counties have a higher percentage of uninsured children than the state (4.4%).

Ashtabula (27.9%), Cuyahoga (23.0%), Summit (19.7%) and Trumbull (25.4%) counties have a higher percentage of children living in poverty compared to the state (17.5%).

Ashtabula (10.8%), Cuyahoga (7.0%), Lorain (6.8%) and Summit (6.5%) counties have a significantly higher percentage of youth not working or in school compared to Ohio (6.2%) and Ashtabula and Cuyahoga counties are also higher compared to the nation (6.9%).

Cuyahoga (10.8%), Lorain (9.7%) and Summit (9.4%) counties have significantly higher percentage of lower birthweight babies compared to the state (8.7%) and higher than the nation (8.6%). Cuyahoga (12.0%) and Lorain (12.4%) counties have a significantly higher percentage of preterm births than the state (10.8%). Ashtabula (7.1) and Cuyahoga (7.3) counties have a significantly higher teen birth rate compared to the state (6.1) and the nation (5.6).

Ashtabula (17.6%), Cuyahoga (16.6%) and Lorain (15.4%) counties have a significantly higher percentage of children living with food insecurity compared to the state (15.3%) and the nation (14.5%).

The percentage of students in grades 7-12 with anxiety issues warranting further exploration by a mental health professional has increased in Cuyahoga County (26.0% in 2019-20 to 27.3% in 2020-21) and Stark County (28.3% in 2022-23 to 31.7% in 2023-24). The same is true for those with depression with Cuyahoga County increasing from 18.4% in 2019-20 to 19.7% in 2020-21 and Stark County increasing from 20.0% in 2022-23 to 23.6% in 2023-24. The percentage of students in grades 7-12 with mental health issues warranting further exploration by a mental health professional also increased in Cuyahoga County (16.5% in 2019-20 to 21.6% in 2020-21) and Stark County (22.8% in 2022-23 to 25.0% in 2023-24).

The percentage of students in grades 7-12 who used marijuana or hashish in the past 30 days increased in Stark County from 5.8% in 2022-23 to 7.2% in 2023-24.

Ashtabula County has a higher percentage of Medicaid participating students with anxiety, any behavioral condition, ADHD, autism, depression, major depression, and serious emotional disturbance compared to the state. Cuyahoga County has a slightly higher percentage of Medicaid participating students with autism than the state. Lake County has a higher percentage of Medicaid participating students with anxiety, any behavioral condition, ADHD, autism, depression, major depression, serious emotional disturbance, and substance use disorder compared to the state. Lorain County has a higher percentage of Medicaid participating students with anxiety and depression compared to the state. Stark County has a higher percentage of Medicaid participating students



Community Needs

The following identify community needs by county. These are areas of opportunity based on trend data, comparisons to the state and/or nation.

Ashtabula County

- Children with a disability
- Medicaid students with anxiety
- Medicaid students with ADHD
- Medicaid students with depression
- Medicaid students with serious emotional disturbance
- Uninsured children
- Children living in poverty
- Disconnected youth (not in school or working)
- Teen births
- Child food insecurity

Lake County

- Medicaid students with anxiety
- Medicaid students with ADHD
- Medicaid students with autism
- Medicaid students with depression
- Medicaid students with serious emotional disturbance
- Medicaid students with substance use disorder
- Students in grades 7-12 who felt sad or hopeless

Lorain County

- Children with a disability
- Medicaid students with anxiety
- Medicaid students with depression
- Disconnected youth (not in school or working)
- Low birthweight babies
- Preterm births
- Child food insecurity

Cuyahoga County

- Children with a disability
- Medicaid students with autism
- Uninsured children
- Children living in poverty
- Disconnected youth (not in school or working)
- Low birthweight babies
- Preterm births
- Teen births
- Child food insecurity
- Students in grades 7-12 with anxiety
- Students in grades 7-12 with depression
- Students in grades 7-12 who considered attempting suicide
- Students in grades 7-12 with mental health issues
- Students in grades 7-12 who felt sad or hopeless

Stark County

- Medicaid students with anxiety
- Medicaid students with ADHD
- Medicaid students with depression
- Medicaid students with serious emotional disturbance
- Disconnected youth (not in school or working)
- Students in grades 7-12 with anxiety
- Students in grades 7-12 with depression
- Students in grades 7-12 who used marijuana
- Students in grades 7-12 with mental health issues



 **Summit County**

- Medicaid students with anxiety
- Medicaid students with ADHD
- Medicaid students with depression
- Medicaid students with serious emotional disturbance
- Children living in poverty
- Low birthweight babies
- Students in grades 7-12 with anxiety
- Students in grades 7-12 with depression
- Students in grades 7-12 who considered attempting suicide
- Students in grades 7-12 with mental health issues
- Students in grades 7-12 who felt sad or hopeless

 **Trumbull County**

- Medicaid students with anxiety
- Medicaid students with ADHD
- Medicaid students with autism
- Medicaid students with depression
- Medicaid students with serious emotional disturbance
- Uninsured children
- Children living in poverty
- Disconnected youth (not in school or working)
- Low birthweight babies
- Students in grades 7-12 with anxiety
- Students in grades 7-12 with depression
- Students in grades 7-12 who considered attempting suicide
- Students in grades 7-12 who drank alcoholic beverages
- Students in grades 7-12 who used marijuana
- Students in grades 7-12 with mental health issues
- Students in grades 7-12 who felt sad or hopeless



Community Input

The qualitative findings reflect a clear and consistent message from stakeholders: the youth behavioral health system is filled with committed professionals and valuable programs, yet it is structurally under-resourced to meet the growing and increasingly complex needs of children and families. Youth are presenting with layered mental health challenges, co-occurring substance use disorders, developmental disabilities, trauma exposure, and multi-system involvement at younger ages and higher levels of acuity. While mobile response services, school-based supports, wraparound programming, and care coordination efforts are viewed as important advancements, demand continues to outpace available capacity across nearly every level of care.

A central and urgent gap identified throughout the interviews is the lack of appropriate crisis stabilization and intermediate levels of care. Youth who are unsafe at home but do not meet criteria for inpatient psychiatric admission frequently cycle through emergency departments, law enforcement, or juvenile detention, often without sustained intervention or coordinated follow-up. Limited inpatient psychiatric beds, insufficient Psychiatric Residential Treatment Facility (PRTF) capacity, and a lack of placements for youth with aggressive behavior, autism, developmental disabilities, or co-occurring substance use disorders contribute to repeated system breakdowns. Rural communities face additional barriers, including long travel distances, limited provider availability, and poverty-related access challenges.

Stakeholders also emphasized that sustainable improvement requires addressing upstream drivers and strengthening family-centered, community-based infrastructure. Prevention, early identification, caregiver education, family peer support, and intensive home-based services were consistently described as critical to reducing crisis utilization and keeping youth safely in their homes and communities. At the same time, workforce shortages, reimbursement limitations, insurance barriers, and fragmented communication across systems continue to undermine continuity of care and long-term stability.

Collectively, stakeholders called for a more integrated, trauma-informed, and geographically responsive continuum of care that prioritizes early intervention while expanding capacity for youth with the most complex needs. The input gathered through this assessment provides a clear roadmap for strengthening the system through coordinated investment, cross-system collaboration, and expansion of services that meet youth and families where they are.



Recommended Services Identified by Stakeholders

- » Short-term crisis stabilization and respite beds (including 23-hour options)
- » Expanded inpatient psychiatric capacity for youth
- » Increased local Psychiatric Residential Treatment Facility (PRTF) options
- » Specialized placements for youth with aggressive behavior, autism, developmental disabilities, and co-occurring mental health and substance use disorders
- » Expanded Intensive Home-Based Treatment (IHBT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT)
- » Partial hospitalization and intermediate “in-between” day programs with integrated family therapy components
- » Increased adolescent-specific substance use disorder treatment services, including dual-diagnosis programming
- » Expanded family therapy, caregiver education, and structured psychoeducation programs
- » Embedded family peer support and advocacy services
- » Centralized intake and referral coordination systems with real-time capacity tracking
- » Improved discharge planning processes, including detailed summaries and warm handoffs to community providers and schools
- » Workforce expansion initiatives, including differential reimbursement for high-acuity and school-based settings
- » Increased school-based prevention, social-emotional learning, and early intervention programming
- » Public education campaigns to improve understanding of behavioral health services and appropriate levels of care
- » Enhanced cross-system collaboration among hospitals, schools, child welfare, juvenile justice, and community-based providers

Together, these recommended services reflect a comprehensive approach aimed at filling critical gaps, improving coordination, strengthening families, and building a more responsive and sustainable youth behavioral health system.





PRIORITIZATION

On January 29, 2026, the Steering Committee met to review the primary and secondary data collected through the needs assessment process and discussed needs and issues present in Bluestone’s primary service territory. Strategy Solutions, Inc. presented the secondary data to the Steering Committee and facilitated discussion about the needs of the local area and refined the potential needs that were not reflected in the data collected. A total of 15 possible needs/priorities were identified and shared with the committee based on the data collected. The Steering Committee discussed these needs in relation to the prior implementation plan and made the recommendation to update the current plan as opposed to starting with new priorities. This was made based on a review of progress made to date taking into consideration where opportunities continue to exist.

All of the priority focus areas will be addressed in Bluestone’s Implementation Strategy, which will be published under a separate cover and made accessible to the public. The 4 areas that Bluestone Child & Adolescent Psychiatric Hospital will be focusing on over the next three years through the Implementation Strategy Action Plan are:

GOAL 1: Workforce Shortage:

Continue to develop internal strategies to employee retention, recruitment, job satisfaction

- A. Continue to increase employee retention
- B. Continue to improve recruitment activities
- C. Increase employee job satisfaction ratings
- D. Ensure staff receive ongoing training to meet the changing needs of our population as well as learn strategies to prevent burnout

GOAL 2: Access to mental health services: Work to address barriers and explore service gaps

- A. Continue to expand relationship with outside Emergency Departments to support medical clearances
- B. Explore possibility of offering crisis stabilization services
- C. Strengthen internal discharge planning
- D. Explore shared planning among providers and Emergency Departments
- E. Increase family supports



GOAL 3: Community education/outreach on available services at Bluestone

- A. Educate community on existing and new programs and services at Bluestone
- B. Ensure Bluestone is represented in the local, state and national youth mental health arena
- C. Establish relationships with area Psychiatrists
- D. Ensure MRSS programs across the State are aware of Bluestone and available services

GOAL 4: Autism services: Access to inpatient care for this population as well as outreach to providers

- A. Ensure staff are adequately trained to support this population
- B. Develop a sensory room/soft padded room/sensory room for patients
- C. Establish safe communication system for patients (i.e. visuals, storyboards)
- D. Establish referral process that allows Bluestone to better gauge acuity level
- E. Explore possibility of conducting virtual assessments
- F. Strengthen relationship with regional and early intervention autism providers

Review and Approval

This CHNA was adopted by the Bluestone Child & Adolescent Psychiatric Hospital Board of Directors on May 12, 2026.

The report is widely available to the public on the hospital's website (<https://www.bluestone.org/>), and a paper copy is available for inspection upon request by reaching out to Pam Budak, Executive Director of Bluestone Child and Adolescent Psychiatric Hospital at budakp@bluestone.org or (216) 320-8565. Written comments on this report can be submitted to Pam Budak, Executive Director of Bluestone Child and Adolescent Psychiatric Hospital (Bluestone Child and Adolescent Psychiatric Hospital, 2575 Belvoir Boulevard, University Heights, Ohio 44118) or by email to (budakp@bluestone.org).